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GROUP LONG-TERM CARE (GLTC) TRANSFER OF BUSINESS

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Panelists will identify and discuss issues involved in:

- *GLTC Plan Upgrades*
- *Experience Rating*
- *Transfer of Business*

MR. NARAYAN S. SHANKAR: Plan upgrades are tricky to implement since long-term care is not a typical group insurance product with annual renewable premiums. In fact, it is a permanent, level-premium insurance plan that develops reserves.

First, there is the issue of flexible benefit plans. A typical flex plan works in such a way that the insured picks among a variety of options including life insurance, health insurance and so on, and this is often an involuntary program. There are thousands of dollars of premium associated with each and every participant. The employer pays all these premiums and wants to administer a flex program and pick up the tab for all the expenses in administering a flex plan. The first issue is that, in most cases, GLTC insurance premiums are paid for by the employees, not the employer. GLTC is a relatively inexpensive plan. The average premium coming in from a participant might be $200 or $300 a year, and so it becomes expensive to administer a flex type of program.

Another issue is antiselection. Right now this is not a problem because these GLTC programs have been around only for a few years, something like 3–4 years for probably the majority of plans. That being the case, the main reason why a participant wants to move from one plan to another is usually confusion. Participants aren't very familiar with what they have bought, and they look at these other options. They're not sure whether there is one that's better for them, and also they are tailoring their benefits around their budget and the amount of money they have. They might pick a plan and find it's too expensive and then desire to drop to something which is cheaper. This sort of thing is the main reason why you see changes now. But 10–15 years later, when the case matures and you see older participants, you might offer them the opportunity to move from one plan to another, and you might find that the poorer risks are moving to the richer plans. When that happens, you can limit that with underwriting, but if you underwrite constantly year after year as people move from one plan to another, you're getting into a situation where you're facing a huge underwriting expense.

Without going into too many details, I will just quickly go over the remaining issues involved with plan upgrades. Product design dictates whether or not the product is suitable for being administered in this way. Underwriting is an issue that I've covered already. Rating. The proper reserve credit becomes more and more complicated as you have multiple changes. If somebody has been through four or five changes, what is the proper reserve credit after the fifth change? How do you communicate such a myriad of plans to people every year without confusing them? How do you communicate the

premiums that you have calculated? It's not easy to explain the new premium you came up with, especially when it varies from one person to another and is not picked off easily from a table.

Reserving is an issue. If you have had a change in the plan, what is the correct reserve? It's common to calculate reserves using some kind of net premium methodology. Now, what is the net premium after you have a change? What issue date do you use to calculate premiums? The extensive recordkeeping is also a problem. If someone has been through five or six changes, you end up keeping a huge history for each person. Carrying just the current plan is already an administrative nightmare because it is such a complex product. You have to keep a great deal of different information associated with the current plan: the elimination period, the benefit period, the daily maximum, the type of inflation protection, the kind of nonforfeiture provision (and there are many different kinds of nonforfeiture being sold). All these things vary from case to case and, within a case, from plan to plan. So, you're talking about something that is fairly extensive in terms of recordkeeping, and when you get into cafeteria-style plans, you're ballooning to a huge database for maybe a single case.

MR. ROGER J. GAGNE: Right now I'm going to move into the second part of our talk. I'll spend some time talking about the subject of experience rating. There are many issues on experience rating yet to be decided. The product, of course, is so new that most of the business doesn't have much experience to rate yet, but let's talk about some of the issues that will be involved when and if each of your companies is faced with this question of how to do experience rating for GLTC.

A couple of items make experience rating for GLTC considerably different than the experience rating that most of us are used to doing with other group coverages. First, it is a level premium, permanent product. That's how it's currently being sold. And, second, it's generally sold on a guaranteed renewable basis, meaning that the coverage cannot be canceled as long as the insured continues to pay premiums, and premiums can only be changed if they are changed due to experience of an entire class or block of insureds. These two items have many implications for how to experience rate. Contrast this with a typical group insurance plan where each year you might, for instance, for a medical plan or a dental plan, look at this year's claims, and calculate whether you're in a surplus or deficit position. Perhaps you'll trend those claims forward next year with medical inflation or whatever is appropriate for the product you're looking at. Then add on something for expenses. Figure out how to take care of any deficits or surpluses. There's also the issue of the rate for the next year. GLTC is sold with the understanding that premium increases and decreases, if made at all, will be made only occasionally. It's sold as a level-premium product.

Once you understand the differences between GLTC and other group coverages, you can think of different ways to actually measure how you're doing versus what you priced, and there's at least two methods I can think of quickly. One is to look at actual versus pricing claims. One limitation of this method is that it only looks at how the existing population of insureds at the time you're doing your experience analysis compares with what the pricing assumptions say they should be producing for claims, but there are many other pricing assumptions besides just the level of claims for each person, such as the level of lapses and

the level of investment income, and so on, that also could affect profitability and, therefore, might want to be entered into the premium adjustment calculation.

You could also look at actual versus pricing loss ratios. This has the advantage that it does tend to take into account, depending how you do it, the expected decrements such as lapses and mortality from your pricing. In other words, you can compare the loss ratio for the block whom you expected to insure with the loss ratio that's actually being produced by the block of actual insureds. It also is not perfect. For instance, it's generally more difficult to explain to customers the subject of loss ratios. Second, it still doesn't take into account every cash-flow item that enters into the profitability of a GLTC block of business. For instance, investment income is only indirectly taken into account in your calculation of loss ratios. So, it's very difficult to find a measure that is easy and still very accurate to use to compare actual to expected claims. Your job, as the actuary evaluating experience who recommends adjustments for premiums, is going to be to make sure that you know whatever limitations exist for the measure you're using, be it actual to expected claims, loss ratios, or something else, and to make sure that you understand those limitations and convey them, if necessary, to both your internal customers and your external customers.

Once you've decided on a measure that you're going to use, you have to decide exactly how you're going to calculate a premium adjustment, that is the mathematics of it. The calculation of the experience adjustment will depend, of course, upon the amount of deviation from expected, but it will also depend on several other things such as trends. This business tends to be select in nature. The business is either underwritten or actively at work in order to get coverage, and the initial year or two of experience may or may not reflect what the ultimate level of claims is going to be relative to what you priced. So, you have to be cautious to look not only at what's happened so far but at the trend. In addition, there's a subject of credibility. This product is typically sold, at least the group product, to people in their 40s and 50s largely, although it is available to retirees and parents. Average issue ages for many companies are to people in their 40s. You're not going to see claims for quite a while on most of your people. So, early on, this product does tend to develop low frequency and sometimes high amount claims which makes it difficult to obtain a significant amount of credibility until a number of years has passed.

Some other decisions you have to make when you calculate the premium adjustment that would be needed are: are you going to do it retrospectively or prospectively only? In other words, does your formula allow you to recoup past losses or give back past gains to your customers, or are you always going to look forward? Also, are there any guaranteed factors in your pricing? Occasionally, especially for the larger customers, they will during the negotiation process ask you to guarantee, for instance, that nonclaims items will only be a certain percentage of premium (a guaranteed loss ratio, in effect) or they may ask you to guarantee that your investment earnings will be at least a certain percentage. The area of items that could be asked to be guaranteed depends only on the imagination of your customers, and, of course, any guaranteed factors will have to be taken into account when you calculate your premium adjustment.

I want to talk a moment about antiselection. You have to anticipate that if you are talking about a premium increase (I don't believe this would be a factor for a decrease) that faced with that choice of paying a higher premium or dropping coverage altogether, a certain number of people are going to lapse, and more than likely, the people that lapse will be the

ones that feel that it's least likely they'll take advantage of the coverage. You want to try to anticipate that antiselection and perhaps take that into account when you calculate the size of your needed premium increase. You might want to even think about limiting the size of a needed premium increase to try and avoid this. Those of us who have been in medical for a few years remember some assessment spirals that happened in some of those cases.

Now some other issues to consider. It's not just all mathematics, I believe, when you are dealing with the experience rating of a level premium permanent product like this. There are other issues that you have to consider before deciding whether you need to change rates and, if so, by how much. One important item to consider is the reason for the deviation, and there's a couple of reasons for this. First, you want to know whether this deviation is temporary or whether you think it's permanent, whether you think it's getting better or whether you think it's getting worse. For instance, if it appears as though experience was just off in, say, the first year, it might have been that your underwriting didn't match what you thought your pricing would do. On the other hand, if it's a systematic year-after-year type of a deviation, you may need to worry about it more and take more forceful corrective action. Another reason for understanding the cause of the deviation is because you may be able to develop a plan or work with your customer to develop a plan for corrective action. Changing rates isn't necessarily the only thing that you could do in order to eliminate a discrepancy between what you priced and what you're seeing. You may be able to adjust underwriting guidelines or plan design in some way for the future to reduce the discrepancy in experience over time.

Another consideration is the rate guarantee period. Obviously, rate guarantees, if they do exist, have to be taken into account when you do a premium-adjustment calculation. I've seen typical rate guarantees range between three and five years from the date of the issue of the policy, although I'm sure that variations exist based on what the customer demands in the marketplace.

Another issue that I want to touch on is rating classes. The actuary, when measuring experience, has to come up with a trade-off between accuracy and stability. Initially, when you sell a group, it probably will be all experience rated as a whole because it takes a while to develop experience. In fact, many of the smaller groups may be pooled together for purposes of experience rating. Eventually, once experience develops in sufficient quantities, the actuary might want to consider splitting the experience into different rating classes. The reason for this would be because there are many parameters among which the rates can vary, such as underwriting status, plan design, age, presence of benefit options, and so on. You might want to look at the pricing for each one of those items separately to determine whether the rates are correctly sloped by age or whether you added the right amount for this benefit option. You may be able to look at the rating classes separately with and without that benefit option. One caution on this note is that when you split the experience into different rating classes, you have to make sure that each rating class still, by itself, is big enough to be generating credible experience that you can believe in.

Another item is minimum loss ratios. Several states do have loss-ratio requirements that apply to GLTC, as well as to all of our other lines of business, and obviously before you implement or recommend a rate change, you'd want to make sure that, if it's a rate increase, you're not violating any state-mandated minimum loss ratios, and along the same

line, there is also the subject of rate stabilization, another regulatory concern. Recently the NAIC added to its model regulation a section on rate stabilization that essentially limits, under certain circumstances, the amount by which an insurance company could raise its premium rates, particularly for the older population. You, as the actuary, need to be aware of that regulation and make sure that nothing you're recommending is in conflict with it.

There are some totally nonmathematical things that still should be considered when an actuary decides what he/she should do to recommend premium increases or decreases on a GLTC coverage. One concern is the consequences of waiting. If it's a rate increase, the actuary may be tempted to say, "Maybe I can wait another year." Before you decide to do that, you have to think about the important question: is it likely that if I wait, the eventual rate increase I will have to make is going to be even larger? Or is there a good reason to wait because it may be a temporary deviation and the trends are favorable, and thus, perhaps I can avoid making a rate increase, or be able to make a smaller one later on which would be less disruptive and better for the plan's experience? This is a judgment call the actuary has to make.

Another issue is the effect on image, and this is something you shouldn't discount, even though it's not mathematical. Here I'm talking about the image of not just the plan itself, but the image of the employer sponsor as well. The image of the plan may be important for bringing in new insureds at future enrollment opportunities, and the actuary may think about whether a rate increase will hurt the image of the plan and actually keep people (new, healthy lives) from coming on board in the future. Also the image of the employer sponsor should be considered since there are marketing concerns, and you have customer relation concerns. None of these should sway an actuary from doing what he or she needs to do, but these are all things that should be considered and may influence either the size of the increase, the timing, or the way it's communicated to your various customers.

You should think about available alternatives to rate increases or decreases. I've already mentioned a few of these. Sometimes, depending upon the reason for the deviation, it might be appropriate to try to change some underwriting rules or some claims administration rules for the future, if they differ from what was priced. Perhaps that could at least limit the size of the discrepancy that you expect to see over time. Another option you may consider, particularly if it's a rate increase, would be to, at the same time you offer the increase, offer insureds a no-premium increase option where they can accept a slightly lower, leaner plan design at no change in rates. This may help people who can't afford the increase but who still think the coverage is important to stay with the plan and reduce lapses.

I want to spend just a quick moment talking about implementation. Now, John Hancock itself hasn't actually implemented any rate increases or decreases on existing blocks, but we have thought about all the work it's going to be if we ever do, and certainly it's something that we should think about before implementing a rate change.

One is, of course, rate filings. This may actually impact the lead time you need between the time you decide a rate increase or decrease is needed, and the time you can actually implement that rate change (more problems exist if you must make an increase).

Active life reserves—this is my reminder to all the actuaries to remember to close the loop. If you think that experience is different from expected because of claims, tell your pricing and valuation actuaries about it, and close that loop because there may be implications as far as the correct active life reserves that the actuary should hold, and certainly there may be implications as to future pricing of business, if you now know something that differs from what was originally expected when the plans now in force were priced.

I think throughout my remarks you can see that communication is extremely important to the employer, to the insureds themselves, and to your internal customers (other LTC actuaries, other departments, company management, and so forth). Clearly, you want to make sure that everybody knows the reasons for a rate change that you believe is justified, that available alternatives (if it's a painful change, like an increase) have been considered, and that this is the right course of action to take. One important responsibility of actuaries is to make sure that no misunderstandings take place as to what's going on; your customers in particular will need to know that.

Last is the administrative work. This is a catch-all for all the stuff that hopefully we don't have to do, but somebody in your organization has to be sure to update all your tables, change all your systems, and change your billing. A great deal of work needs to be done there.

Now, in conclusion, there are a couple of points I'd like to make. One is that I believe it's desirable, as much as possible, to try to minimize both the frequency and the size of premium adjustments. Let me spend a moment talking about the concept of minimizing the frequency. I think there's one exception to that rule, and that is if you find that you need a large rate increase, you may want to consider actually doing that in steps in order to avoid too much antiselection at any one time; in that case you may not want to minimize the frequency. You may actually want to just minimize the size. To the extent we can, I think it's important and consistent with the promises that our insureds have relied upon when they bought the coverage to try to minimize the frequency and the size of adjustments and make them only when they're required by experience—only when it's clear-cut.

Of course, close monitoring is also essential. Obviously, the actuary needs to know as quickly as possible if anything is going amiss not only because the quicker you do a rate change, the smaller it needs to be, but also it gives you more lead time to try to take other types of corrective action that might limit or eliminate the discrepancy between what you're seeing and what you priced. And so my theme here is ongoing communication; it is very important both with your employer, with your valuation actuaries, with your pricing actuaries, and eventually if the time comes, with your ultimate insured population.

MS. PATRICIA J. FAY: I'd like to spend some time talking about a fairly new development in the GLTC market. This is the transfer of business from one carrier to another. By this I don't mean the purchaser's sale of an entire block of business, but rather the transfer of one employer's business from one carrier to another. Aetna was one of the first to be involved with such a transfer, and to date, we've been involved on both sides. I don't expect to be able to give any answers. I just wanted to bring up some of the issues you might encounter and give you a little food for thought.

First, let's get our terminology straight. I'll call the carrier that will be transferring the reserves the *pitcher*. The carrier that will be receiving these reserves will be the *catcher*. There are a couple of things that should be considered when bidding as the catching carrier. First and foremost, what is the level of the reserves to be transferred? Often there's a difference of opinion between actuaries as to what the level should be. In order to get a quick idea during the proposal process, one might want to request sample reserve factors from the pitching carrier. This way you can compare them to your own level of reserves. Next, the catcher will want to find out whether there are any additional charges that will be made due to the transfer. This can also affect the size of the reserve that's transferred.

Another item that should be considered is the experience of the plan. It's important to look at initial penetration. How good did the pitching carrier do? Do you, as the catcher, think you can do better? Can you reasonably expect to attract some of the current nonbuyers? It's also important to consider the lapse rates that are currently being experienced by the plan. Are these at an acceptable level? Is there anything you can do as the catcher to retain these people?

Last, and most important, is the claim experience. Underwriting rules have varied over the years and still vary by carrier. Comparison of current claim experience to expected can give the catcher an idea of the relative health of the population. If the business is fairly new, there may be little or no claim experience. In this case, the catcher will want to find out as much as possible about how the case was originally underwritten. Once the catcher has gotten an idea of the rate adjustments needed, you need to determine who to charge and for how long. This can be a sticky issue. If the rate adjustment is made for existing insureds only, there's a consistency issue. If the rate adjustment is made for both current and new participants, there's an equity issue where new participants are subsidizing some of the current, transferring participants' rates. Then, once you know who and what you want to charge, you need to determine for how long. This may be for a limited period of time or for the entire premium-paying period. Once the business has been awarded, it's important to establish and stick to an implementation timeline. The timing for a transfer can be significant. It can take well over nine months from notification to transfer. There should be at least six months before the desired effective date; otherwise problems with meeting this date can occur.

The first issue that needs to be resolved is the definition of who will be eligible for transfer. If limited to active employees, how will current claimants be handled? There may be a significant period of time between election of transfer and effective date. How will recoveries or claim incurrals during that period be handled? A second implementation issue is defining the effective date of the transfer. Normally, this should be fairly easy, but keep in mind that time is of the essence. Current insureds may need two or more full months to respond. If not, the desired effective date could be compromised. Another issue that's involved is defining the default for conversion. In most cases this would be retaining with the pitcher on a portable basis. Last, the proper means to cancel coverage needs to be defined. Since the pitcher currently has the liability, any forms designed must make the pitcher feel comfortable that the reserve—the liability—has indeed been transferred. The pitcher or the catcher may want to design a form that includes a written signature. Perhaps one or both carriers has a hotline number. Can cancellations be accepted without a signed

form? If so, whose hotline can accept those cancellations? Is it only the pitcher, or can it be both the pitcher and the catcher?

Some administrative issues can surface around the payment of premium. There's usually some time period between the time an insured elects transfer and the actual effective date. If the premium is direct billed, there is a strong possibility that these insureds will discontinue premium payments during this period of time. How will this be handled? Certainly the pitcher may not want to transfer funds on behalf of this participant without, at the very least, deducting the unpaid premiums. However, the pitcher could choose to treat this insured as a lapse. Marketing materials should clearly state the consequences for non-payment of premium so there's no misunderstanding on the part of these insureds.

The other problem that can arise is duplication of coverage—sometimes it's just for lack of a cancellation form but also for duplicate payment of premiums. Where there is no cancellation form, the pitcher may be unwilling to transfer any funds since it is not clear that the liability has also been transferred. This could result in the insured being treated as a lapse and no funds being transferred. Duplicate premiums present a similar problem with respect to the transfer of funds but it also brings up the issue of overinsurance.

One of the biggest legal hurdles will be getting the lawyers to sign-off on the transfer agreement. Once this hurdle is crossed, there are some smaller legal issues that should be considered. The first is the existing contract with the policyholder. Very often these contracts contain a description of the transfer methodology and state who has a right to determine the amount of the transfer. It's important to understand what's included in the contract. A second and related issue with the catcher is the approval of all needed state filings. If the catcher does not have approval, consider whether insureds will be allowed to transfer in the first place, and, if so, the effective dates may need to be staggered. With respect to the contracts, many contain language allowing a free look or rescission of coverage. The transfer agreement must be drafted to consider these provisions, including some type of reconciliation between the pitcher and the catcher to allow for needed adjustments to the transfer fund. An interesting legal issue that remains is the definition of the policyholder for the insureds that remain with the pitcher. If the employer agrees, he can remain the group policyholder. However, if he declines, an alternative is to establish a trust. It can be expensive to establish one for each transferring policyholder if the number of insureds retained is small. On the other hand, establishing one trust to use for portables from several transferring policyholders subjects the trust to multiple employer trust issues.

Another issue involves the claims that are reported after the effective date of the transfer. Sometimes claims are not reported for months after the incurral date. If these insureds were disabled but were somehow able to transfer, the question becomes: Who is liable for their claims? Since the incurral date is before the transfer, these claimants and their portion of the transfer fund should have remained with the pitcher. If these claimants paid premiums to the catcher after the incurral date, it's likely they've paid premiums that now need to be refunded. A final issue is the NAIC model law, which does contain a few sections that are applicable to a transfer situation: portability and determination of entry age. Both the pitcher and the catcher should be familiar with these sections of the model law.

Finally, and probably most important, is the fund balance methodology. There are many variations that can be used by different actuaries. First is the basis. If the fund is calculated on a paid basis, it is basically an accounting of cash-in less cash-out. Under this basis a separate deduction needs to be made for the disabled-life reserve, the incurred-but-not-reported (IBNR) reserve, and the premium-waiver reserve. If the fund is calculated on an incurred basis, however, deductions for these reserves have already been included with the incurred claims charge. Another variation within the fund balance methodology is the use of experience rating. Different carriers may apply different levels of credibility to the same cases. When including some experience in the fund balance, it's important to ensure that there is consistent treatment of gains and losses. The next issue is the reserve method used by the carrier. These run the gamut from net level premium to two-year preliminary term. Whatever method is used, including a deduction for unamortized expense charges, should basically level the reserves. Finally, the carrier needs to determine what additional charges should be made in a transfer. These can include a market-value adjustment, a termination charge, unamortized acquisition expenses, and so on. The market-value adjustment is one that most carriers will choose to include. Keep in mind that this reflects the changes in the value of the asset during the period from purchase to liquidation rather than the interest generated from the current asset portfolio. Termination charges are used to recover the additional expenses incurred due to the processing of the transfer. The carrier needs to keep in mind the minimum loss-ratio requirements and review how these apply in a transfer situation.

That's about all I have to say. I hope you take a few things with you. The first is informed pricing. Make sure, as the catcher, you find out all you can before you bid. There's much room for professional disagreement between actuaries in a transfer situation. In addition, keep in mind that this is a fairly complex arrangement. There are many issues to resolve. I've pointed out some, but by no means is this an exhaustive list. And, finally, remember that through it all, the satisfaction of the customer is paramount. All issues need to be resolved so that they not only make sense but they are also fair to the current population of insureds.

MR. GAGNE: I'd like to ask Narayan a question. In your experience with plan upgrades, do you see that it's going to be the employers that are most often asking for these, or the insureds, and then the employers on behalf of the insureds, or is it going to be because the insurance company decides it's time to try to make existing plans more competitive with those that are now on the market?

MR. SHANKAR: I think it's a combination of the insurance company wanting to put them in place and the employer who has a fiduciary responsibility to keep his plan up to date. I think the majority of the insureds aren't very knowledgeable about long-term care and its benefits and what's happening out there with other competing policies possibly being better than their plans.

MR. FRANK E. KNORR: I have two questions. One is regarding the transfer. I was wondering what reasons make an employer want to switch carriers? To do the research to get one carrier to begin with and then switch just a short while after that seems complicated, especially if the employer will remain group policyholder for the people staying with the pitcher as well as for those transferring to the catcher. And my second question is

whether the long-term care experience reporting forms, A, B, and C, are used in rating? Is the pitcher's experience one of the things a catcher looks at?

MS. FAY: Well, the first question was about why a transfer might happen. I know in one case a carrier that was pitching was not interested in staying in the business anymore, and the employer chose to go out and seek a carrier to transfer to. In other cases it's like a marriage that doesn't last forever. For instance, there may be service problems. There could be any number of reasons why an employer doesn't want to remain there. Sometimes they're not even related to long-term care. They can be related to the other coverages. Then you asked about the experience reporting forms. We have not used them. I suppose they could be a good source of information.

MR. SHANKAR: I'd like to add to the example that Pat gave about the carrier who didn't stay in the business anymore. That ties in with the fact that once a carrier stops selling the business, they're not going to put in any upgrades or any improvements in the plan, and so there isn't much prospect for the plan to evolve and keep pace with what's out there years down the road. Employers know that, and so they're going to run as soon as the carrier decides not to stay in the business.

MR. GAGNE: I can also see situations where perhaps an employer might be bought out by a parent company whose insurance is already with somebody else, and they may choose to consolidate carriers. Now, this isn't as simple as just bringing everybody into the same vision or prescription drug plan, but there are certainly innocuous reasons like that as opposed to the other reason of service problems. Sometimes, at the same time you announce a rate increase, they shop the business similar to what we've seen in other group coverages. I think eventually, and I see this starting to happen already, this product will become more of a commodity. It will become more standardized. Everybody will have done dozens of transfers, and perhaps then it'll be much more commonplace.

MS. FAY: I just wanted to add one thing about remaining the group policyholder. The employer who agrees to remain group policyholder for the insureds wanting to stay with the pitcher isn't actively managing the contract as a group policyholder. They're just continuing so the original contract stays in place, and the insureds are managed on a portable basis, and there isn't a strong connection to their employer at that point.

MR. FREDERICK J. YOSUA: In terms of experience rating, I know you talked about claims and credibility, and you mentioned interest rates, but you didn't go into that in any depth. If the average issue age is, say, 40 or so, a 1% change in interest rates is probably worth 15% or 20% on the premium rates, and so I'm wondering if you have any comments on how to deal with that.

MR. GAGNE: That is a complicated subject and one that certainly isn't well-understood by our customers, the employers. They're used to the typical group insurance plan where investment income is a relatively minor part of the whole thing, and it is actually conveniently ignored when you talk about a loss ratio being just claims over premium. Interest rates and investment income earnings do play a very significant part with younger issue ages and can perhaps generate more of the money to eventually pay claims than premium income, if you're thinking about paying claims decades later. That is a significant pricing determinant and is something that would be good to directly take into account in the

experience rating formulas. In other words, we can say we'll change rates if claims are high or low, and we can change rates, by the way, if interest rates or our investment earnings are high or low. I don't see a perfect mechanism for doing that right now.

Some of the regulations do talk about loss ratios, but loss ratios tend to focus on claims and premiums. There is a way to partially take into account investment earnings by talking about loss ratios over the whole lifetime of the plan and taking your present values at the lower experience interest rate. In other words, if you earned less than you thought, you may end up getting some relief in the loss ratio so that you could raise rates if you needed to, but I think you'd have to do many trial calculations with your own pricing assumptions to see whether that would be possible. Even if it is possible, it's not going to be a dollar-for-dollar thing. I think that's a difficult subject and not one that's well-treated by either the regulators in terms of minimum loss ratio requirements or the customers in their understanding of the role investment income plays in the experience of their plans.