Professional Series

GROUP INSURANCE

SEVENTH EDITION

Daniel D. Skwire
Principal Editor

Associate Editors
Kristi M. Bohn
Margaret D. Cormier
Stephen J. Kaczmarek
Sara C. Teppema

William F. Bluhm
Founding Editor

ACTEX Publications
New Hartford, CT

Request for permission should be addressed to:
ACTEX Publications
PO Box 715
New Hartford CT 06057

Cover Design by Jeff Melaragno

ISBN: 978-1-62542-903-2

TABLE OF CONTENTS

◂SECTION SIX▸
GROUP INSURANCE FINANCIAL REPORTING

◂SECTION SEVEN▸
FINANCIAL AND ACTUARIAL ANALYSIS

PREFACE

Like so many others, I initially encountered Bill Bluhm's *Group Insurance* text when studying for actuarial exams. Then in its first edition, the book was a model of breadth and clarity, covering an immense range of subjects in a straightforward manner that was both technically precise and easy to understand. I never imagined at the time that this book would become such an important part of my own career.

Some 15 years ago, Bill invited me to write a chapter on claim reserves for this text. That chapter originally appeared in the fourth edition, published in 2003. With each passing edition, Bill encouraged me to take on a little greater responsibility, from revising and updating several other chapters in the fifth edition to serving as an associate editor for the sixth edition.

Now that Bill has retired from Milliman and moved on to run the Dancing Dragonfly winery, I find myself serving as Principal Editor for this seventh edition of *Group Insurance*. It is an honor to serve in this capacity, and I am deeply grateful to Bill for providing me with both the encouragement and the opportunity to succeed him in this role. The success of this text is an extraordinary legacy Bill has left to our profession. I hope that this edition will live up to the high standard he has set over the past 25 years.

I am very thankful for the dedication of the four hard-working associate editors who have done much of the heavy lifting to create this book: Kristi Bohn, Maggie Cormier, Steve Kaczmarek and Sara Teppema. Their combination of technical knowledge and editorial talent has been instrumental in planning the changes and enhancements for this edition and in working with our long list of authors to make the vision a reality. Without their labors over the past 18 months, I would probably still be making notes on a legal pad about ideas for new chapters!

Thank you also to the many authors who devoted their time and effort in order to share their knowledge with our readers. Their willingness to invest their personal time to inform and educate the next generation of actuaries is a tremendous service to our profession, and all of the other editors and I appreciate and acknowledge their commitment.

The editorial staff at Actex Publications has been a pleasure to work with. I would particularly like to acknowledge Gail Hall, who has been so helpful in leading this first-time editor through all of the steps involved in producing a volume of this scope. Best wishes in your retirement, Gail—we will miss you!

I am fortunate to have a family that is very supportive of my professional efforts, not only on this textbook, but in all aspects of my career. I do my best to balance my commitments to work and family, but there are inevitably times when projects like this temporarily pull me away from those I love. Denise, Adam and Luke—thank you for your understanding!

One of my earliest memories is walking to the local library with my parents and two sisters, pulling a red wagon behind us. Each member of the family was permitted to check out five

books each week, and the wagon was the only way to carry them back and forth. Books and reading have always been part of my life.

The same is true of writing. My father is a professor of English, now retired, and from my first school days through my most recent writing endeavors, he has been my one indispensable teacher, editor, and critic. His own textbooks on English composition helped support our family and my education, and to this day there is nowhere I would rather be than in his study, trading thoughts on favorite books and writers while soliciting advice on whatever project I have underway.

This book is lovingly dedicated to my father, in happy anticipation of many more hours together, only some of which will be spent discussing the comma splices I failed to catch in this manuscript.

Portland, Maine
April, 2016

Daniel D. Skwire, FSA, MAAA
Principal Editor

SECTION ONE

INTRODUCTION

1 THE GROUP INSURANCE MARKETPLACE

Kara L. Clark

OVERVIEW OF GROUP INSURANCE

Group insurance is an effective and efficient means of providing protection from the adverse financial impact of unforeseen events to individuals who share a common bond. Group insurance, as used throughout this text, means a benefit program where coverage is provided to a group of individuals. These programs include not only traditional coverage provided under insurance policies, but also include self-insured benefit programs provided by employers, associations, labor unions, government programs, and health care service corporations such as health maintenance organizations.

Group insurance is provided to a group of individuals who are connected to one another through some common characteristic. Typical groups include employees of a single employer or group of employers, debtors to a common creditor, members of professional or trade associations, labor unions, or individuals eligible under a government plan.

A fundamental principle underlying all insurance is the pooling of risk. The risks covered by insurance policies are typically infrequent and potentially costly events, although in the case of health insurance, even relatively small and frequent risks can be included under the policy. The policyholder pays a relatively small, predetermined amount in the form of the insurance premium to the provider of the insurance coverage. In return, the provider of the coverage pays for the cost of the insured's covered event, or provides services directly, should the event occur. In this way, the participants in any particular insurance program share in the financial risk of the covered events.

Another key principle underlying insurance programs is the concept of insurable interest. That is, the policyholder and beneficiaries of a program must experience loss or hardship if the covered event should occur, and therefore have a vested interest in mitigating the risk. Insurable interest on behalf of the policyholder and beneficiaries is required for an insurance program to be financially, and often legally, viable.

Group insurance shares these basic principles with other types of insurance. Group insurance differs from individual insurance in that the provider of the insurance coverage considers the entire group of eligible individuals as a whole in evaluating the risk, in deciding whether or not to insure the risk, and in setting the price for the risk. In this determination, emphasis is placed on the characteristics of the group (for example, is the sponsoring entity viable with a good history of financial performance?). Individual members of the group often have to meet requirements that proxy individual underwriting requirements, such as enrolling at the first opportunity and being actively at work on the day that coverage begins. Often a key factor in underwriting groups is participation, since low participation among eligible lives often implies

the possibility of antiselection on the part of those that enroll. Antiselection is to be avoided, since the presence of a disproportionate percentage of high claimants in a group leads to the need to raise rates, which in turn causes healthier lives to seek cheaper alternatives outside the group, in turn leading to the need for further rate increases for those still covered under the group plan. An external subsidy, such as a payment by an employer, is often sufficient to ensure good participation, while the structure of benefits and underwriting provisions for self-supporting groups can be complex.

Group plans also provide a more efficient means of marketing and delivering insurance programs. The primary level of marketing is to the plan sponsor, which can be an employer, an association or other entity. A secondary level of marketing is to eligible individuals, and is typically accomplished in a common setting, either in the workplace or through other regular communications to the group, such as association newsletters. Group plans are marketed through a variety of distribution networks, including agents, brokers, consultants, and by direct sales. However, instead of needing to make the sale with every potential insured, the primary sales effort can be focused toward the sponsor decision-makers. Therefore, the cost of the marketing effort is typically lower on a per-participant basis than for individual insurance. Likewise, administrative expenses are typically lower on a per-participant basis for group insurance, because individual premium billing is not required, and plan sponsors often provide low-cost access to participants for communication and information distribution.

The group insurance market includes a diversity of product lines. Medical coverage represents a large portion of group coverage in the United States, and may include medical indemnity insurance, preferred provider organization (PPO) plans, point of service (POS) plans, and health maintenance organization (HMO) plans, as well as products to supplement or replace the government-sponsored Medicare and Medicaid programs, which are available only to certain disabled, needy and older Americans. In Canada, where nearly all residents are covered by the provincially sponsored health care system known as Medicare, private group medical plans cover only those benefits not generally available under the public system. Therefore, while group medical coverage is widespread in Canada, it is not as large a part of the total group insurance market as it is in the United States. In both the United States and Canada, a variety of other coverages are also sold on a group basis, including indemnity and managed dental plans, short and long term disability income coverage, life insurance, vision and hearing coverage, long term care insurance, pre-paid legal, group property and casualty, and other special risk coverages such as accidental death and dismemberment and travel accident.

HISTORY OF GROUP INSURANCE

Group insurance has its roots in ancient times, as far back as the Romans. For example, medieval craft guilds used insurance concepts in their operations, and membership groups such as "Friendly Societies" in the U.K. operated much like mutual insurance programs, providing a source of financial protection for sickness or old age. Large numbers of people participated in these societies prior to the establishment of social insurance programs toward the end of the nineteenth and into the early twentieth century.

In the early 1900s, academics began to identify the economic security needs of individuals related to accident, illness, old age, and death, and interest in socially based solutions to these issues began to grow. A sickness insurance program as well as the first social insurance program for old age was established in the late 1800s in Germany. The National Insurance Act of 1911

in the U.K. established sickness and unemployment benefits, and the U.S. passed Social Security legislation in 1935, providing benefits for old age and unemployment.

The industrial revolution also contributed to the growth of group insurance concepts late in the nineteenth century. As transition occurred from an agricultural to an industrial economy, many workers moved from self-employment to larger employers. Employer liability law began to develop, and employee benefit programs began to emerge.

The first group plans offered in the late 1800s were typically cash accident and sickness (disability) plans. These were followed by group prepaid medical services plans; Baylor University Hospital's prepaid hospital services plan in the 1929 was the first of its kind and a precursor to the early Blue Cross programs. A number of group insurance plans were already in place by the 1940's, when United States governmental price-wage controls limited employers' opportunities to increase wage scales to attract and retain employee talent. In order to differentiate themselves in the marketplace, employers looked to other benefits, including group insurance coverages that could be provided to employees without violating the wage control regulations. The 1950s brought additional governmental price-wage controls, further spurring the growth in group insurance coverages. Additional support for group insurance growth was provided through a landmark court decision in 1949 (the *Inland Steel* decision), which allowed for pension and other employee benefits to be included in the scope of collective bargaining.[1] Tax policy has also often favored benefits provided through group insurance coverages, further contributing to their proliferation. For all these reasons, insurance coverages became an integral part of many employee compensation packages.

By the mid-20th century, major medical plans emerged as a melding of the prepaid medical services approach used by early Blue Cross/Blue Shield carriers ("the Blues") and the indemnity (fixed dollar) reimbursement approach used by traditional insurance carriers. Self-insurance became popular in the 1970s among larger employers, who viewed the concept as a way of saving some group insurance costs, through the elimination of premium taxes and the opportunity for control of invested assets. The Employee Retirement Income Security Act of 1974 (ERISA), while primarily addressing pension issues, also had an impact in the group insurance market by preempting state regulation of self-insured health plans (although what is considered "self-insured" under ERISA has at times been subject to legal interpretation).

In the United States, Internal Revenue Code Section 125 was established by the Revenue Act of 1978, which stipulated that otherwise nontaxable benefits provided under Section 125 plans would not be subject to the doctrine of constructive receipt (and therefore taxed), even if the plan participants could have elected to receive cash instead.[2] In the 1980s, medium and large-sized employers began offering their employees flexible benefit plans under Section 125, as a means to limit employer cost while providing employees the appeal of choice. Under flexible benefit plans, employers provided employees with some predetermined amount of funds or credits, which the employee could then use to purchase coverage from among a range of benefit offerings to best suit the employee's particular financial needs.

The Health Maintenance Organization (HMO) Act of 1973 provided funds to stimulate the growth of HMOs and required certain employers to offer HMOs (later legislation altered the impact of this Act). Rapid increases in health insurance costs instigated the move toward more

[1] Jerry S. Rosenbloom and G. Victor Hallman, *Employee Benefit Planning*, 3rd Edition.
[2] Ibid.

managed health plan offerings in the 1980s and 1990s, including Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point of Service (POS) plans. Plan sponsors gave up some freedom of choice in provider selection and agreed to care guidelines, in return for much lower premiums than available under traditional indemnity plans. The 1990s also saw the emergence of laws and regulations designed to increase access to health care insurance coverage, including the extension of coverage to individuals for whom the period of coverage would have typically terminated, as well as limitations on health status underwriting. Late in the 1990s, the public's dissatisfaction with restrictive managed care increased. This dissatisfaction, in conjunction with less willingness from provider groups to accept managed care payment discounts, and the concern of employers over potential liability, led to a move toward less restrictive managed care plans, such as PPO plans.

Around the year 2000, Health Savings Accounts and Health Reimbursement Accounts began to gain industry, government, and media attention. While there are many variations, these arrangements often involve an employer-provided amount of funds (the "account") for each employee, combined with a high-deductible health plan. Funds in the account can then be used by the employee to cover their out-of-pocket costs (for example, the deductible, coinsurance amounts, or possibly care not covered by the insurance plan at all). These plans are intended to involve the employee more closely in health care purchasing decisions, and they often include access to consumer education and other support tools specific to these decisions.

In 2014, 52% of U.S. employees with health coverage were enrolled in a PPO plan, compared to 14% in HMOs, 24% in a high deductible health plan with savings option (HDHP/HRA or HSA-qualified HDHP), 10% in POS plans, and 1% in conventional plans.[3]

In March 2010, the Affordable Care Act ("ACA"), was signed into law. This act represented the most significant set of reforms to the U.S. health care system since the establishment of Medicare and Medicaid through the Social Security Act in 1965 and was intended to address all aspect of the "Triple Aim": to expand access, lower costs, and increase quality. Key provisions of the ACA include (but are not limited to): a requirement that individuals not covered by Medicare, Medicaid, or other government programs carry health insurance or face financial penalties (there are some exceptions to the requirement); a requirement that employers with more than 50 employees offer a health insurance option or face "shared responsibility" payments; changes in provider payment mechanisms to focus more on outcomes rather than volume; limitations on health plan underwriting and pricing practices; requirements with respect to health plan benefit designs; the establishment of health insurance exchanges in each state; and the opportunity to expand Medicaid eligibility. The ACA has had a significant impact on the health care marketplace. It has expanded coverage and standardized benefit levels to facilitate sound cost comparisons. It has also contributed to a wave of consolidation for both providers and health plans.

In Canada, the public health care system was initiated with the passage of the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966. These two acts established the health insurance programs that covered medically necessary services for nearly all Canadian residents. The Canada Health Act of 1984 replaced the two prior acts, although it

[3] *Employer Health Benefits, 2014 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust.

maintained their basic premises. In addition, the 1984 Act included provisions to discourage user fees and extra billings as related to insured health care services.[4]

Flexible benefit programs in Canada received increased attention in the 1980s for many of the same reasons these programs became popular in the United States. These reasons included the change in workforce demographics since the origin of employee benefit programs, as well as government rulings that enhanced the ability of employers to offer choice to meet different employee needs and manage benefit costs.[5]

Regulation of group insurance occurs at both the state and federal level in the United States. Federal regulations apply to employer benefit plans, which include those plans provided on a self-insured basis. State law generally applies to the business of insurance. Therefore, insured benefits provided by an employer must comply with state laws, since the state regulations will apply to the insurance company providing the insurance program. On the other hand, self-insured benefits provided by an employer are not considered "the business of insurance" and are therefore not subject to state regulations. However, the lines of distinction can be blurry, as the federal government has implemented legislation which impacts health insurance, especially with regard to the availability and continuation of coverage.

Insurance companies in Canada may also be subject to both federal and provincial regulations. Companies that elect to be federally registered because they operate in more than one province are subject to federal law. Companies must also have a license from each province in which they do business, no matter where they are registered.

BUYERS OF GROUP INSURANCE PRODUCTS AND SERVICES

State or provincial laws and regulations may define valid groups eligible for group insurance. The National Association of Insurance Commissioners' (NAIC) model law provides a typical list. In general, the individual members of a group share some common characteristic or trait, independent of being covered by the same insurance policy. That is, the group should already have a purpose and should not be formed solely for the purpose of obtaining insurance coverage. The NAIC model law has been adopted by all states.

There are many different categories of group insurance purchasers:

SINGLE EMPLOYERS

Group insurance plans issued to a single employer cover the employees and their dependents. The employer is usually the policyholder, although in some cases a trust may be established and becomes the policyholder. Single employers may choose to purchase coverage from an insurer or managed care organization in return for a fixed premium, or in the case of larger employers, may elect to self-insure some or all of the risk. In fully insured plans the employer pays premiums, but employees are often required to contribute to the cost. In self-insured plans, the employer may similarly require the employees to contribute to the cost of the coverage. Self-insured employers may administer their own insurance plans, but more commonly purchase administrative services only (ASO) contracts from an insurance company or third-party

[4] The History of Health Care in Canada, 1914-2007; http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php
[5] Robert J. McKay. *Canadian Handbook of Flexible Benefits*, Third Ed.

administrator. Under such arrangements, the employer bears the risk of claims exceeding projected levels while the plan administrator (often an insurance company) provides services associated with building provider networks, processing claims and providing customer service to employees covered by the plan.

MULTIPLE EMPLOYER TRUSTS

Two or more employers may join together to form a multiple employer trust for the purpose of buying and funding group insurance for their employees. In this case, the trust is the policyholder, and the employers are known as participating employers. As with single employers, coverage may either be purchased on a fully insured basis, or be self-insured. Employees may be required to contribute toward the cost of coverage, whether the plan is fully insured or self-insured. Participating employers usually elect to join the trust because they anticipate greater purchasing power or spreading of risk if they combine their covered workforce with that of other employers. In some cases, the participating employers may have found it difficult to be accepted as an individual employer by an insurer, given their particular risk status. Joining a multiple employer trust allows for a greater pooling of risk that an insurer may then be willing to accept. Some multiple employer trusts are formed by insurance companies or third party administrators in order to make coverage available to smaller employers more efficiently. In addition, participating employers might also have unique administration requirements (such as an employee hours bank), and a multiple employer trust may provide a more efficient means of providing for those needs.

ASSOCIATIONS

An association may also offer group insurance coverage to its individual members. Associations are defined as groups of individuals or institutions that share common professions, interests, activities, or goals. Associations include, among others, professional organizations, trade organizations, and alumni organizations. Other groups, often known as affinity groups, also may be purchasers of group insurance. These groups are formed because members have a common interest. Examples are the American Automobile Association (AAA) and the American Association of Retired Persons (AARP). The association or a trust formed by the association is the policyholder.

Most often, the full cost of coverage is borne in some manner by the association member. The association member may remit the premium directly to the association for payment to the insurance provider, to a third party administrator working on behalf of the association, or directly to the provider of the insurance coverage.

Associations may automatically provide their members with some types of group insurance coverage, such as group accident or term life, and the premiums may be included as part of the membership dues. This is an important underwriting provision because it avoids the antiselection inherent in the purchase decision on the part of a non-subsidized insured. Associations may be in the market for group insurance coverage simply to provide an additional benefit to their membership for the dues that members pay.

LABOR UNIONS

A labor union may be the policyholder of a group insurance plan. A union may also negotiate benefits with employers participating in a Taft-Hartley multiple employer trust (named after the

U.S. federal law which authorized such trusts), in which case the trustees are the policyholders. Coverage may be fully insured or self-insured. Benefits and employee contributions, if any, are generally provided for in a collective bargaining agreement. Premiums may be required of the union, the employers, or the union members. Benefits are paid directly to the union members or their dependents, or may be assigned to a provider of medical services.

GOVERNMENT EMPLOYEE GROUPS

Collectively, the United States government is the largest employer in the country and the largest purchaser of group insurance for employees and their dependents. Some of the most prominent plans are the Federal Employees' Group Life Insurance (FEGLI) and Federal Employees' Health Benefits (FEHB) plans, in addition to numerous smaller agency plans and state and local government sponsored plans.

TRICARE provides health benefits to the retired members of the United States military and their dependents, as well as dependents of active service personnel. The program covers services rendered outside of military treatment facilities, and includes medical, dental and other services.

At the federal level, employees often have a choice of plans. At the state level, plans are often established for state employees and local governments are given the option to join. The governmental sponsor is the policyholder, and the plans may be insured or self-insured, and trusts are often used.

GOVERNMENT SOCIAL INSURANCE PROGRAMS

In the United States, the government also sponsors group insurance coverage in the form of many social insurance programs, including Medicare (health care for the aged and disabled), Medicaid (health care for those with limited income and financial resources), and Social Security disabled-worker and survivor benefits (disability and life benefits for disabled workers and their dependents).

In Canada, the vast majority of the general population is covered by provincial government sponsored health coverage, also known as Medicare.
The costs of these social insurance programs are paid through a combination of general revenues, payroll taxes, and insured premiums. These programs are discussed in detail in later chapters.

CREDITOR GROUPS

Creditor organizations, including banks and other lenders, may purchase group insurance coverage on those to whom they have lent funds. Coverages purchased typically include life and/or disability income coverage. The creditor organization is usually the policyholder, and charges the premium to the debtor. Should the insured become disabled or die, the insurance company would pay the benefits to the creditor organization to reduce the amount of the insured's outstanding debt.

DISCRETIONARY GROUPS

Groups are sometimes established primarily for the purpose of providing insurance or self-insured group benefits. The group may have to apply to the state insurance department for approval to be considered a discretionary group for this purpose. These plans may be either insured or self-insured and are generally issued to trusts. Discretionary groups are much more common in the United States than in Canada.

SELLERS OF GROUP INSURANCE PRODUCTS

Group insurance products are sold by a variety of entities. Some of the products are sold on a self-insured basis, by (1) insurance companies under ASO contracts, (2) third party administrators, or (3) health care service organizations.

INSURANCE COMPANIES

In both the United States and in Canada, group insurance products may be sold by life, health, or property and casualty companies. Insurance companies may offer the full range of group insurance products, including indemnity medical plans, PPO plans, POS plans, capitated or subcapitated medical plans, dental, disability, life, and long term care. As the management of health insurance has required more clinical expertise, many insurance companies no longer offer medical coverages, and the trend in the United States has been to withdraw from the medical market, leaving the market to a smaller number of companies who specialize in this coverage. The passing of the ACA has also led to some health insurers withdrawing from the market rather than accept the increased administrative burdens. Insurers also provide ASO contracts or provide services that offer some blend of insurance and administration to self-insured employers or multiple employer trusts. ASO is generally limited to medical and dental coverages, although some ASO disability plans may be found as well.

Insurance company ownership may be structured in stock or mutual form. Stock companies, the majority, are owned by stockholders. These companies are typically in the group insurance market to make a reasonable return on investment for their shareholders, and have some advantages over mutual companies and not-for-profit organizations in accessing capital in the financial markets. Mutual companies are owned by their policyholders, and allow for any positive financial experience to be returned to the participating policyholders. They are limited in their ability to raise capital and must rely on surplus and earnings to finance growth opportunities.

In the United States, insurers may have some advantages over other group sellers to the employer market, since they often have a national presence, are licensed in multiple states, and can offer policyholders a range of benefits from a single source.

HEALTH CARE SERVICE ORGANIZATIONS

Health care service organizations are not-for-profit entities, and are often exempt from state premium or income tax. The majority are Blue Cross / Blue Shield or Delta Dental plans, although not all Blue Cross / Blue Shield plans are health care service organizations.

Health care service organizations generally sell only medical and dental products, including indemnity, PPO, POS, or capitated plans, but many offer other coverages through affiliated

companies. They also typically offer ASO and other alternative funding contracts. They often have a strong local presence, and may only be licensed in a single state.

Health care service organizations sell to employers, union trusts, associations, and other groups. To the extent the buyer also provides other group products to its membership, such as disability or life, those products need to be purchased from another carrier.

A NOTE ABOUT BLUE CROSS/BLUE SHIELD ORGANIZATIONS

Blue Cross / Blue Shield plans are all independent organizations operating under a common trademark, but not a common organizational structure. While the origin of these plans was as health care service organizations, over the years many Blues organizations have explored alternative corporate arrangements. Some Blues organizations are now structured as stock or mutual companies, and they may be involved in other arrangements such as joint ventures as well.

HEALTH MAINTENANCE ORGANIZATIONS

Health maintenance organizations (HMOs) are typically licensed as different entities from insurance companies or health care service organizations. They have a variety of types of owners, including the public, insurance companies, Blue Cross/Blue Shield organizations, and provider groups. They may be organized as for-profit or not-for-profit, although for-profit is more common.

HMOs contract with providers of care, such as hospitals and physicians or physician groups, to form networks. HMOs are also directly involved in the management of health care. HMOs tend to be local. They typically provide only medical benefits, although some dental and vision benefits may also be provided. Benefits provided to participants are generally comprehensive, but the participants are often limited to receiving care from only the providers with whom the HMO has contracted, except in the case of emergencies. In the late 1990s, the public's level of satisfaction with HMOs received considerable media attention. Concerns about cost savings at the expense of quality of care, choice of provider, and selection of treatment plans, led to the movement away from restrictive HMO plans to those providing more choice.

PROVIDER OWNED ORGANIZATIONS

In the 1990s, provider owned organizations such as physician hospital organizations (PHOs), provider-sponsored organizations (PSOs), and provider-sponsored networks (PSNs) began to form. These organizations often emerged due to providers' increased interest in more control of their own delivery of medical care and in the reimbursement of provided services. These organizations consist of provider groups, usually a hospital or hospital system and the associated group of physicians with admitting privileges. The group accepts a scheduled payment, known as global capitation, in return for accepting the risk of providing specified health care services. They may contract directly with employers, government, insurance companies or managed care organizations.

The local focus of these organizations, as well as their direct affiliation with providers, may offer marketing advantages relative to other types of organizations. However, historically these groups did not appear to be as well prepared to accept risk (in terms of both capital and management

expertise) or perform administrative services as well as other types of organizations. For many of these reasons, the number of these organizations has declined significantly, with a few exceptions. The successful ones, such as the Kaiser Foundation Health Plan, Intermountain Healthcare and the Geisinger system in Danville PA, attracted considerable attention during the discussions leading to the 2010 health care reform legislation. Following the passage of the ACA, there is a renewed interest in these and other related organizational structures (such as Accountable Care Organizations, or ACOs). As the ACA puts an emphasis on paying providers based on value instead of volume, many provider groups are looking for ways in which they can share in the savings or otherwise benefit from the investments they are making in population health and other forms of value-based care.

SELF-INSURED EMPLOYERS

Self-insured employers do not provide group insurance coverage in the same way as insurance companies or Blue Cross/Blue Shield organizations, but they do accept risk. Self-insured benefits most often include medical, dental, and short-term disability. Due to the lower frequency and higher severity of life and long-term disability coverage, and also because of income tax considerations, these benefits are often insured. Employers may elect to self-insure for a variety of reasons. Self-insured plans are not generally subject to state premium tax or state mandated benefit provisions. Also, since the self-insured plan pays claims as they are submitted, the sponsor retains the use of the funds until they are paid and the benefit of the investment return. Finally and most importantly, the promises made by the employer are backed by the general assets of the employer or the trust, and (unlike insured benefits) self-insured plans are not subject to regulatory capital requirements (risk-based capital, or RBC). The combination of the exemptions from RBC, state premium taxes and mandated benefits can make a self-insured plan 5% - 6% less costly than an insured plan. Self-insured employers often contract with an insurance company or third-party administrator to provide for the administrative aspects of the plan.

In Canada, group insurance products and services are offered by insurance companies and Blue Cross plans, which tend to operate more like insurance companies than Blue Cross/Blue Shield plans found in the United States. Canadian Blue Cross plans may offer other group insurance products, such as disability plans, besides group medical coverages. Because the mix of public and private care is different than in the United States, managed care organizations such as HMOs and other provider owned organizations are rare in Canada. Self-insured employer plans are common in Canada as in the United States.

GOVERNMENT INSURANCE PROGRAMS

UNITED STATES MEDICARE

Established in 1965, Medicare provides health coverage to the eligible aged and disabled in the United States. Part A coverage provides for inpatient hospital, skilled nursing facility, and home health benefits. Providers of Part A services must accept the government's payment as payment in full, that is, cannot balance bill. Part B coverage provides for outpatient hospital benefits, physician services, durable medical equipment, ambulance, and other non-physician providers. There is generally a premium required to participate in Part B (some financial support may be available for those that qualify). In addition to the premium, beneficiaries are also subject to

some cost-sharing provisions for Part B services (there can be some limited cost sharing in Part A as well). Physicians are not required to accept the government's payment as payment in full, although many do, and there are limits to the amount they can charge in excess of the government's payment. Medicare Part D, providing prescription drug coverage, was added to Medicare in 2006. Participation in Part D is voluntary, although eligibles who do not enroll within certain timeframes may be subject to late enrollment penalties. Medicare Part D may be offered through a stand-alone prescription drug plan ("PDP") or a Medicare Advantage ("MA") plan (discussed below). The benefits and premiums vary by plan and plan sponsor. Eligible beneficiaries may have many options of stand-alone PDPs or MA plans from which to choose. Funding for Medicare is provided through payroll taxes, general revenues, and beneficiary premiums.

Many Medicare eligible beneficiaries also have the opportunity to forego traditional Medicare coverage and participate in a Medicare Advantage ("MA") plan (sometimes called Medicare Part C). The majority of MA plans are managed care plans, such as HMOs or PPOs. The government provides a payment to the MA plan for each enrolled beneficiary, risk-adjusted to recognize the relative condition-related risk of different enrollees. The MA plan then assumes the risk of providing services for the covered insured. Some MA plans may offer additional benefits beyond those normally provided by Medicare Parts A, B, and D. Insureds covered by an MA plan pay Part B premiums to Medicare, and may pay additional monthly premiums to the MA plan.

The significant cost-sharing and gaps in coverage that exist in Parts A and B of Medicare led to the growth of a large market in Medicare Supplemental or "Medigap" insurance which is sometimes purchased by traditional Medicare beneficiaries to cover large and unplanned out-of-pocket expenses associated with some services. Retirees are sometimes provided with group Medicare supplement plan coverage by their former employer, though this has become less common over time because of the rising cost.

UNITED STATES MEDICAID

Medicaid provides health coverage for certain individuals with limited income and financial resources in the United States. Prior to the ACA, eligibility criteria generally included children; parents or caregivers of children; disabled children or adults; and aged adults. The ACA established an expansion of Medicaid eligibility to nearly all Americans under age 65 with income up to 138% of the federal poverty level. However, a Supreme Court ruling in 2012 effectively made the expansion of Medicaid eligibility optional for the states. Implementation by state varies and by the end of 2015, 30 states had adopted the higher income threshold for coverage and expanded the program. Medicaid coverage is comprehensive, with many benefits covered at 100%. Medicaid provides broad coverage, including benefits such as dental, vision, and custodial nursing care, in addition to traditional health benefits. Cost-sharing levels for beneficiaries are very low. Medicaid reimburses providers at rates that often represent deep discounts from standard charges, which must be accepted as payment in full. Physicians are not required to participate in Medicaid, although hospitals frequently must participate. Medicaid programs are administered by state governments and are funded by state revenues with matching Federal funds. States may pay providers on a fee-for-service basis, or may provide for services through prepaid programs such as HMOs (called "MCOs" in state Medicaid). The number of

Medicaid beneficiaries in managed care plans has grown from 14% of enrollees in 1993 to 59% in 2003 to 74% in 2011.[6]

CANADIAN MEDICARE

Provincial government sponsored health care programs known as Medicare cover the majority of the population of Canada. Medicare provides coverage for a variety of medical services, such as hospital services, inpatient and outpatient physician services, as well as extended health care services, which include long-term residential care. Benefits are on a service basis, meaning that patients do not need to pay first and then submit a claim. Federal standards for provincial programs discourage user fees. Although they are not required to do so, a vast majority of physicians participate in the Medicare program. Under Medicare, physicians are generally compensated on a fee-for-service basis. Medicare is funded by the provinces through general revenues, and in some provinces, payroll taxes and premiums. Provincially sponsored Medicare plans that meet federally established criteria for portability, universality, comprehensiveness, accessibility, and public non-profit management are eligible for a federal funds transfer to offset some of the costs of the provincial program. Private health insurance plans are also available as supplements to the public program, and many Canadians have this additional coverage through their employers.

[6] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf

2 OVERVIEW OF SALES AND MARKETING

John Elliott
William A. Raab
Updated by Brian Marsella

INTRODUCTION

A textbook on group insurance would not be complete without a description of how sales and marketing fits with the other group functions. A company can have state-of-the-art systems and efficient administration, and actuaries can develop competitive rates and funding alternatives, but nothing will happen until products have been properly developed, marketed, and sold.

The American Marketing Association defines marketing as "the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives."[1] This is a broad description of the process that begins with the original product or service concept and concludes with an exchange of something of value for the product or service – the "sale" to the customer.

It is more common in practice to separate the marketing and sales functions. The separation occurs not because there is a dichotomy between marketing and sales, but rather because there is a close relationship that can be explained with the analogy, "marketing is to sales as strategy is to tactics." This frame of reference shows marketing as an overall process, with distribution and sales as the implementing component.

In the context of group insurance, the relationship between marketing and sales will vary depending on the insurance product, employer size, and intermediaries.

MARKETING

This chapter on marketing and sales includes an overview of some basic marketing concepts. When necessary, it also includes explanations relating these concepts to group insurance.

MARKETING FUNCTIONS

Marketing is the process of preparing the way for sales. The following sections consider some of the marketing functions and how they fit into the overall strategic planning process.

Strategy is conventionally viewed as the overall game plan or blueprint that guides the company toward achieving its stated goals and objectives. The marketing area plays a key

[1] E.N. Berkowitz, *Essentials of Health Care Marketing,* (Gaithersburg, Md., Aspen Publications, 1996) p. 4.

role in this strategic plan by providing important information about the company's current position in the market as well as possible future opportunities. The marketing area can also participate in the overall planning process by developing strategies and tactics for specific products, customers, and distribution channels.[2]

Market research is an important part of this overall planning process. The role of research is, quite simply, to focus on understanding customers. Who are the potential customers for our products, what features do they wish to purchase, where are they located, how much are they willing to pay, and from what types of distribution arrangements do they wish to buy? Who are our competitors and what are they doing?[3] Scientific survey techniques and sophisticated statistical analysis are employed. In fact, market research is a profession in itself, with its own trade organization. It is not unusual for a company to supplement the efforts of its own research department by using an outside specialty firm.[4]

Market research is commonplace in the consumer product industry and is gaining ground in financial services. The traditional group insurance companies may have lagged behind durable goods companies in implementing a research-based approach. This is probably due, at least in part, to their focus on product and distribution. In today's environment that has changed. Insurers and managed care organizations recognize the role research plays in the marketplace, particularly as insurers work to try and change the behaviors of the consumers.

The development of competitive products is one of the processes identified in the marketing planning process. Common sense tells us that companies need products and services to sell to make a profit. How are new products developed? Although there is a general pattern to the process, the specifics are different at every company. Two different approaches are summarized below. The first might be called a traditional product-driven process; the second is market-driven.

The Traditional Product Development Process:[5]

The product development process under a traditional, product-driven approach can be conceptualized into seven steps:

- Idea Generation: Ideas can come from a number of sources, such as product managers, a product committee, customers, competitors, or employees.
- Idea Screening: The product ideas are screened to determine which are compatible with the company's strategy, resources, and skills.
- Concept Development and Testing: A team refines the concept into a product, and questions such as "What are the benefits?" and "Who will buy this?" are answered.
- Business Analysis: Costs are projected, and a return on investment (or return on equity) analysis is done.
- Product Development: The actual product is given concrete form.

---

[2] A. Hiam and C.D. Schewe, *The Portable MBA in Marketing*, (New York, NY, John Wiley and Sons, Inc., 1992) p. 24.
[3] Ibid, pp. 103-108.
[4] Ibid, pp. 108-110.
[5] Ibid, pp. 244-253.

- Test Marketing: The product is tested in limited real-world markets.
- Commercialization: Full-scale manufacture and distribution.

The Market-Driven Product Process:[6]

The market-driven process can be thought of as having three major steps:

- Assessment of Target Market Needs: A target market is chosen, and market research is done to assess the needs of that market. Competitive analysis is a critical part of this research.
- Identification of Differential Advantage: Since the needs of the buyer and the competition's approach are known, a determination is made of how to differentiate one's own product or service from the competition, to better serve the customer's need.
- Strategy Formulation: A strategy is developed to build and deliver the product, based upon the differential advantage. This is then followed by either a pre-test (a limited market test), or full implementation.

Marketing in the Group Insurance Marketplace

Although there may be subtle differences from industry to industry, this overall marketing process applies to a broad range of products and services, from laundry detergent, to mutual funds, to group insurance. The application of the marketing process for the group insurance industry has its own particular considerations.

As described previously, organizations can employ many methods and strategies for marketing products, and group insurance is no different. One issue that group insurance marketing professionals must decide on is the audience for their campaign. The need for multiple marketing campaigns is due to the complexity of the distribution model for group insurance. Insurers create marketing strategies targeted to intermediaries that advise their clients, to group policyholders (most often employers), and to individual consumers. In general, most insurance companies will have marketing plans for all three of these consumers of their products and services. The level of focus on these different consumers will change by company and by insurance product.

Another consideration for the marketing process in the group insurance environment is state and federal regulation. Group insurance is primarily regulated at the state level, meaning insurers' marketing efforts and new product offerings must be compliant on a state-by-state basis (even if a single strategy across states.) In March 2010, President Obama signed into law the Affordable Care Act (ACA), which defined public exchanges, intended to assist the uninsured to purchase individual health. Since the ACA has taken effect, employers are looking for new ways to be compliant with the law and avoid future taxes. There are also new options such as private exchanges that are causing health insurers to reexamine their marketing strategies for brokers, employers and consumers. The ACA has also added federal regulations that require compliance.

[6] Berkowitz, pp. 17-19.

At this point, the company has developed its strategy and done necessary planning, researched the market, developed products to meet the demands of that market, and implemented an advertising and promotional campaign to build awareness of its products and services. Let's now turn our attention to sales.

SALES

In a sense, sales can be seen as the culmination of the marketing process, although this is a somewhat oversimplified view. Ongoing customer service after the sale completes the marketing and sales process. Organizations cannot survive if they must focus their sales efforts on replacing dissatisfied customers who have terminated their relationship. In the context of market-driven organizations, marketing, sales, and ongoing service are all one continuous process.

Group insurance often has two levels of sale. The initial sale is made to the plan sponsor. This entails selection of plans to be offered and their cost, and includes a discussion of financial management, administration, and services offered to the sponsor. Later, a "second sale" is often made to the participants. This can include selection of a particular plan from among those offered by the sponsor, and for certain products, such as group universal life and long-term care, may be similar to the sale of an individual insurance product. The second sale is discussed in more detail later in the chapter.

Historically, group insurers have organized their sales efforts to targeted market segments. For a given market segment, the distribution model is dependent on plan sponsors' size and industry, as well as the sophistication of their employee benefit plans. This section examines the most common market segmentations and distribution models along with the role of the intermediaries in the sales process. It also discusses emerging strategies in the group distribution process.

MARKETING SEGMENTATION

Group insurers often look at sales (and, more generally, distribution) from the perspective of target market segments. Segmentation analysis is not designed to replace emphasis on distribution channels. Rather, it enables the company to understand its potential customers and focus its distribution efforts appropriately. As a result of the analysis, management can make specific decisions as to which market segments to pursue, with which products, and through which distribution channels.

For example, an insurer could segment employers by industry, manner in which they purchase benefits (i.e. paternalistic, procurement driven etc.) or geographic area. An insurer might focus on public sector employees and dedicate its resources to the specific needs of that market. Certain group long-term disability insurers, for example, have focused on educators as a sub-segment of the public sector market. Meanwhile, another insurer might choose to limit distribution to certain geographic areas where it has greater physical presence or brand recognition. Additionally, with the advent of private exchanges, some groups may focus on whether an employer may be more prone to looking at a defined contribution approach or staying the course of the standard market.

One common way for group insurers to segment business is by employer size. This is a convenient way for insurers to look at market segments and focus its distribution channels. Certain size segments tend to be serviced by specific distribution models, described later in this chapter.

SIZE SEGMENTS

Smallest Groups (2 to 100 Employees)

In the U.S., the small group segment is heavily regulated by the ACA. Insurers are required to comply with benefit coverage, plan design actuarial value and premium rating restrictions. Insurers offering products in this size segment often use the brokerage or general agency distribution methods, with little or no group field force involvement. Agents and brokers who operate in this market usually specialize in small groups. The clientele tends to be less sophisticated regarding group insurance and does not have the resources to maintain full-time benefit managers or human resource departments and so relies on brokers for advice on benefit plan management. Small group coverage is also offered on state exchanges and the definition of small group expands to cover 2-100 employees in 2016.

Mid-Market Groups (100 to 1,000 Employees)

In this size segment, a group's own claim experience is usually available for a variety of insurance products, which has a major impact on product pricing. Flexibility of plan design is necessary because employers in this size category are relatively sophisticated and have benefit managers who closely monitor their benefit offerings. They require benefits customized to the needs of their business and the type of employees they hire. For certain benefits, self-insurance is a major consideration. These customers typically use specialized brokers and large local or regional brokerage firms. The process of obtaining and analyzing information needed to prepare a proposal requires a highly skilled group benefit specialist, both on the broker and the insurer side of the negotiation. Consequently, a group field force model is usually favored by insurers in this size segment. In addition, insurers often have account managers who focus on servicing and renewing these groups. The account management team can be key to the overall success of retention and will be discussed later.

Large Groups (1,000 Employees and Up)

The large group segment has the greatest variety of solutions and distribution models to match the complexity and geography of these employers. Very large groups are usually multi-site and multi-state and have full-time benefit and risk management departments that manage a complex array of benefit plans. Employees typically have a number of plan options – and possibly multiple insurers – from which to choose. These customers usually deal only with large employee benefits consulting firms or highly skilled local brokers. Many insurers have "national account" or "special account" field forces dedicated to this size segment. The larger the group and the more geographically dispersed, the less likely local or regional health insurers are able to provide adequate coverage or services.

ROLE OF INTERMEDIARIES

Employers tend to rely on third-party advisors to assist them with their employee benefit plans. This assistance includes advice on issues such as plan design, pricing, and comparative analysis of competing insurers' products and services. The advisor usually gets involved in ongoing customer service and often acts as the employer's representative in resolving disputed billing and claims issues. At renewal, the advisor surveys the marketplace to see if the client would be better served by renewing the plan with the current insurer or by changing insurers. This analysis includes a discussion of plan design alternatives, either with the current insurer or a competitor.

These advisors fall into three general categories: brokers, agents, and consultants.

A "broker" is a somewhat generic term for an individual who represents more than one insurers. The broker's compensation is usually based on sales commissions for products sold. The commissions are a percentage of premium paid or a fee per covered employee. In either case, the commission is built into the price of the product.

"Agents" are similar to brokers, except that they are typically associated with a single insurer. Their compensation is also based on commissions.

"Consultants" work primarily with large employers. Compensation is typically based on a fee for services rendered, as opposed to commissions, and is paid by the employer rather than by the insurer. The consultant could be paid an annual retainer, and/or could be paid an hourly fee for consulting services. There could also be fees negotiated for specific projects, such as a vendor selection project or creating customized communication materials explaining the various benefit packages available at open enrollment. In many cases, products are usually quoted net of commissions. Some brokerage firms operate as consultants in certain instances and as brokers in others.

In late 2004, the Attorney General of the State of New York announced an investigation into the business practices of several large property and casualty insurance brokerage firms. Among the allegations was bid-rigging, in order to place business with preferred insurers, thus earning higher contingent commissions (which are additional commissions granted to brokers who meet a new or continuing enrollment goal with a insurer). The National Association of Insurance Commissioners (NAIC) got involved as did several other state insurance departments and attorney generals. Even though the original allegations involved property and casualty coverage, the inquiries were expanded to include other lines, including group insurance. There were numerous civil actions, and the NAIC strengthened commission disclosure requirements in its Producer Licensing Model Act.[7]

It is also important to point out that with the advent of consultant-driven private exchanges, some employers are beginning to question the ability for such consultants to be unbiased as they have been in the past with regard to an employers' options. It remains to be seen as to how this will change the landscape moving forward, but there is an expectation that some

[7] The NAIC website (www.naic.org) provides archival material on this subject, as does the website of the New York Attorney General (www.oag.state.ny.us).

boutique vendors will enter the arena to help employers choose between multiple consultant-led exchanges.

DISTRIBUTION MODELS

BROKERAGE

Under the brokerage distribution model, the insurer relies on independent brokers to distribute products. These brokers are self-employed entrepreneurs, who are responsible for maintaining their own office space and clerical staff. This method can be used for wholesale distribution (such brokers are often called general agents), retailing, or a combination of both. This model is attractive to some companies, especially those with limited resources, because it does not require the large commitment of capital and staff resources necessary to house, train, supervise, and maintain a branch-office field force. A portion of these savings may be given back in the form of higher commission rates, overrides, and expense allowances to the brokers.

This model is characterized by a single, narrow distribution channel. The broker does not have the sale of the company's products as his or her sole responsibility. Other companies' products are also sold. This makes the insurer vulnerable to price competition, since the business will often flow to the insurer with the lowest rate.

As an independent, the broker may choose to specialize in other product lines, such as property and casualty or financial planning. Even if the broker is specializing in the desired product, distribution can be limited to a local area or a specific client base. In order to maintain sufficient revenue flow, the insurer must support a broad variety of products for many market niches.

This method is most frequently used to distribute individual and small group insurance products, including various types of life insurance, annuities, Medicare supplement coverage, critical illness coverage, and long-term care policies, where the agent relationship is an important element of the sale. Group products tend to be sold based on price and value, and this model has not been widely used by group insurers.

GROUP FIELD FORCE

The group field force model is the traditional model used for years by most large group insurers. Under this distribution system, the insurer employs a full-time salaried field force of captive group representatives. The group representatives are usually paid an incentive for sales in addition to a base salary. This distribution method is typically a wholesale model, where the insurer representatives call on and sell through brokers and consultants, and in certain situations directly to the employer.

This distribution channel is wider than in the pure brokerage model. The sales force is totally dedicated to the sale of the insurer's products. There is no specialization in outside product lines, no distribution of other companies' products, and distribution is not limited to a small local area. Rather, the group sales force tends to operate in as many market niches as

possible. Relationships are developed with a large variety of brokers, thereby gaining access to a large, diverse base of prospects. This enables the insurer to generate sufficient sales volume while serving a narrower market with a more focused portfolio of products.

Overhead expenses are higher than in the brokerage model. However, this may be partially compensated for by the loyalty of the field force, which will sell value instead of low price. This permits pricing at levels sufficient to cover expenses while maintaining profit margins. Company growth can be managed by increasing the size of the sales force. Although overhead increases as sales representatives are added, economies of scale are possible. Revenue increases as a result of expansion are more predictable because the sales people are employees, not independent brokers.

Within this model, there are often separate teams that work to manage employers once they become customers. The account management team is responsible for making sure the service to the employees and the employers is sound as well as working in a consultative capacity to determine what other products or services might be useful to the employer. The team is also involved in cross-selling to gain additional work from the employer, which should have a positive impact on retention.

MULTIPLE LEVEL

The multiple level distribution model is the most advanced model currently in use for distribution of group insurance and is more complex than the others. Under this model, the insurer uses different types of distribution, layered one on top of the other, to sell its products. The layers include a mix of wholesalers, retailers, brokers, life agents, general agents, salaried representatives, telemarketers, and direct sellers.

The distribution channels are extremely broad and enable the insurer to focus specific products into different channels. There is a mixture of low-expense models (like brokers) with higher expense models (like salaried representatives compensated on a sales incentive plan). This permits the insurer to have the advantages of a dedicated field force without the severe impact on pricing. The expense loads of the field force are blended with the lower expense methods. Because of the complexity of this system, sophisticated sales management and marketing support are critical to success. This model is widely employed by insurers with a national presence. It gives the insurer the flexibility to exploit whichever channel or channels work in specific marketing areas.

SALES TO PARTICIPANTS

Some group sponsors offer multiple choices of plans and insurers that require the insurer to sell their product to individual employees, after the initial sale has been made to the employer (this is the “second sale” mentioned above.) These sales are usually made by specialized enrollment staff (who may be paid through commissions), or by salaried enrollment specialists. The employees may meet with these specialists in the workplace, or respond to printed or website information at their own convenience. This second sale is often needed where plan sponsors offer multiple different models such as HMO, PPO or consumer-driven plans. In situations like these, the person doing the enrollment is attempting to “sell” his or her product.

Second-sale events are typically called "benefit fairs" and organized by the employer. At a benefit fair, representatives from all of the insurers whose products the employer is sponsoring, including group life, disability, dental, medical, and pharmacy, are available in a conference room or near the cafeteria. The insurers use tabletop displays and give away inexpensive promotional items. Employees visit the insurers they choose, asking questions, and obtaining marketing materials, plan information, and enrollment forms. The enrollment forms are usually completed and submitted at a later date.

In recent years, technology has played a larger role in helping employees make a decision on their benefits with the advent of interactive programs, particularly among larger employers. Technology helps the employee think through a number of decisions they need to make and helps to frame those choices about the tradeoff between premium rates and benefit levels. The ultimate approach to such technology would be the private exchange programs that some employers are implementing that help employees make choices from a large number of products.

LICENSING REQUIREMENTS

With the exception of second-sale activities, brokers, general agents, and field sales require licensing to sell insurance products. Each state, through its Department of Insurance, has its own state licensing and continuing education requirements. For sales professionals operating in multiple states, non-resident licenses are available and the National Insurance Producer Registry is dedicated to making licensing cost-effective and streamlined for the industry across all states.

ADDITIONAL DISTRIBUTION METHODS

Thus far, the discussion of distribution methods has focused on traditional models. However, there are other methods of distributing group insurance, often referred to as "alternative distribution." Alternative distribution methods involve mass-marketing techniques, such as television, radio, newspaper advertising, direct mail solicitation, internet website sales, and worksite marketing.

With the exception of internet and worksite marketing, the products distributed through these alternative methods are generally not the same as the employee benefits that have been the focus of this chapter. Among the products sold this way are critical illness coverage (such as cancer-only coverage), hospital confinement benefits, accidental death benefits, and term life insurance. Television, radio, and newspaper advertising often include a celebrity endorsement or an entertaining theme or mascot to gain attention. Direct mail solicitations are usually linked to a credit card or to membership in an association. Since the insurer is marketing the coverage directly to the consumer, there is no broker or group field force compensation. However, there are significant marketing expenses involved, and insurers often retain specialty marketing firms.

WORKSITE MARKETING

Worksite marketing of voluntary programs is more closely related to traditional distribution methods. There is usually a broker involved, and sometimes the group field force is involved as well. Employees are solicited at the jobsite in group meetings, which are often followed by individual one-on-one meetings where the final sale is made and the application taken. In addition to traditional enrollment materials, the enrollment specialist often uses a laptop computer that includes an electronic application for coverage, policy illustrations, and other marketing material.

The coverage is typically 100% paid by the employee through payroll deductions. Sales commissions are higher than under the employer's base plan due to the expense of an enrollment team. Products distributed in this manner often include dental, vision, short and long-term disability, supplemental term life insurance, accidental death, and critical illness coverage. Another product that may be solicited at the worksite is "Gap" insurance, designed to reimburse the deductible and coinsurance under the employer-provided health plan.

Certain products that accumulate benefits over an extended period of time, such as group universal life and long-term care, are also effectively marketed through these enrollment specialists.

INTERNET MARKETING

Another alternative distribution method is internet marketing, often referred to as e-commerce. E-commerce goes beyond simple product distribution. Companies are using this non-traditional tool for some of the traditional marketing functions that pave the way for sales, including advertising, public relations, product promotion, image building, and brand management. For example, most major insurers have websites where individuals can obtain information about the company, its products and services, local sales offices, charitable and community activities, the current stock price, employment opportunities, and so on. Recent research (primarily focusing on insurers marketing individual products) indicates that insurers specifically view the Internet as a strategic vehicle for effective communications and for enhancing service to agents, brokers, and customers.[8] It is reasonable to conclude that results would be similar for group products.

Many insurers are using the Internet for transaction management by giving their customers access to secure websites for plan administration purposes. Plan sponsors can do additions and deletions to their group bill, and participants can obtain information on policy and account values, find primary care physicians, download important forms, and check on the status of claims. The insurer is in effect using the Internet as a tool to manage the ongoing customer relationship. The cost per transaction using the Internet can be significantly lower than toll-free telephone lines and email.[9]

In addition to communication and transaction management, insurers also use e-commerce for product sales. Through the insurer website, consumers can obtain quotes for various forms of insurance coverage. Unless the insurer is a direct writer, the consumer is usually referred to a

[8] MarketTrends, *LIMRA's Factbook: 2005 Trends in the United States*; p. 64; LIMRA International, Windsor, CT, 2005.
[9] Ibid, p. 62.

local sales office for assistance, generating leads for the insurer's agents and brokers. This is particularly true for group insurance coverage.

A recent innovation is group internet enrollment. The employee enrolls for benefits directly through the Internet, making paper communication and forms unnecessary.

Internet enrollment can be done through the employer's website, through a third-party vendor, or through a link to the insurer website. This creates yet another opportunity to sell voluntary products such as accidental death benefits, supplemental group term life, and universal life. Because of the additional expenses involved, Internet enrollment is more practical for large employers.

Insurers are not the only ones using the internet for product sales. There are websites operated by insurance brokerage firms where consumers can obtain proposals for various insurance products, including group insurance. This is a variation of the brokerage and general agency distribution methods described above. The consumer would have access to the products of several insurers, and could obtain comparative pricing and benefit information. The brokerage firm would be required to maintain appropriate licensure for the various states where proposals would be delivered. This channel is usually viewed as a supplement to, but not a replacement for, the traditional broker intermediary favored by employers for purchasing group insurance. However, brokers who do not adapt to this new environment risk losing a portion of their customer base.

CONCLUSION

The group insurance landscape is dynamic, as employers continuously strive to manage the cost of a competitive benefits program. The passage of ACA has caused all employers to re-evaluate their benefit strategy with the social contract they have with their employees. They need to weigh the additional taxes and benefits against their ability to deliver such benefits in a cost-effective manner. The ACA has also given many employers the platform to have a dialogue with their employees about these costs that they previously felt they could not have in a constructive manner. In particular, this conversation has begun with unions and could cause some major changes in the union benefit world. Economic performance, evolving regulation, competition for labor, and demographic changes will all play a role in the evolution of the insurance industry.

As the group insurance landscape evolves, each organization will define its future by developing and executing its marketing strategies. Regardless of the size, scope or scale of the organization, all group companies will identify their primary markets, develop products, strive for sales targets, and work to satisfy their customers. The thrill and the challenge are in the execution of the marketing and sales process and the corresponding account management.