Professional Series

Individual Health Insurance

Second Edition

Hans K. Leida *William F. Bluhm*

TABLE OF CONTENTS

Acknowledgments		v
Preface to the Second Edition		vii
About the Authors		ix
Chapter 1	Introduction	1
Chapter 2	The Products	29
Chapter 3	Policy Forms	85
Chapter 4	Managing Antiselection	109
Chapter 5	Setting Premium Rates	161
Chapter 6	Reserves and Liabilities	213
Chapter 7	Financial Reporting and Solvency	263
Chapter 8	Forecasting and Modeling	293
Chapter 9	Regulation	323
Chapter 10	Other Insurer Functions	373
Chapter 11	Managing the Business	391
Index		419
Appendix A	Section 52.7 of New York's Regulation 62	A-1
Appendix B	Report to the NAIC's A&H Working Group of the Life and Health Actuarial Task Force	B-1
Appendix C	Rate Filing Task Force Model User Hints	C-1
Appendix D	Health Insurance Reserves Model Regulation	D-1
Appendix E	Guidelines for Filing of Rates for Individual Health Insurance Forms	E-1

CHAPTER 2

THE PRODUCTS

There is a wide array of products being sold in the individual health insurance market. Each of them has its own characteristics, varying from other products in many different ways. This chapter describes those characteristics, and is organized by product type. Sections 2.1 through 2.5 describe medical-type coverages, 2.6 and 2.7 describe income protection coverages, 2.8 describes long term care coverage, and 2.9 describes dental coverages.

2.1 MAJOR MEDICAL COVERAGE

The precursor of **major medical** coverage was available in the early 20th century, when a disability coverage added a provision to increase payments while someone was hospitalized. The most major changes to liberalize medical care insurance occurred in the 1930s (initially accident only) and 1940s. Major medical coverage was introduced about 1950,[1] as medical care costs became much more significant than they were previously, and it became obvious that simple coverage of only hospital costs, or only physician costs, did not adequately protect the policyholder. Major medical is distinguished from earlier coverages in that it was the first time the disparate sources of health care costs (hospital, physician, and ancillary) were combined into a common policy.

The list of health care expenditures that a policy covers are commonly called **covered services**, or **covered expenses**, and this term is typically well defined in the policy form itself. Regulators felt the need to require that a certain minimum combination of covered services should be provided if a policy was to be called "major medical," presumably under public policy aimed at either (1) preventing insurers from misleading consumers by

[1] *Health Insurance Provided Through Individual Policies,* Edwin L. Bartleson. Published by the Society of Actuaries, 1968.

using the name for a policy with lesser benefits, or (2) prohibiting policies which have unexpected (at least for the policyholder) holes in the benefit plan.

New York's Regulation 62, for example, requires a specific set of minimum benefit parameters that a policy must meet to be called major medical insurance.[2] (The exact wording of this part of the regulation, section 52.7, is contained in Appendix A to this text).

Once the covered services are defined for a policy, it is necessary to define how benefits are calculated from the covered services. These calculations reflect various ways in which the covered expenses are allocated between the insurer, the insured, and the provider.

Allocating some portion of the covered expense to the insured is often deemed to be good design, because it still provides some (albeit watered down) financial incentive to the insured to control costs. The portion of costs allocated to the insured is called **cost sharing**.

DEDUCTIBLES

A **deductible** is a dollar amount, specified in the policy, for which the insured is responsible before any benefits are payable. A plan with a 100% benefit after a $100 major medical deductible means that if (for example) $1,000 of covered services occurs, the first $100 of covered expense would automatically be the responsibility of the insured, and the $900 in excess would then go into the benefit calculation.

Deductibles can apply to all services under the contract, to major categories of services (like hospital inpatient charges), or to smaller categorizations. The categories might depend on where the service occurs (such as inpatient vs. outpatient vs. physician's office), whether the provider is part of the insurer's network (such as a separate deductible for inpatient stays in non-network hospitals), what kind of service it is (such as inpatient stays, ancillary services, or prescription drugs), or in other ways.

It is important to address how the deductible interacts with other aspects of the contract – in particular, provider discounts. Suppose, for example,

[2] 11 NYCRR 52.7

that the $1,000 claim in the previous example was for physician services, and is the retail, undiscounted charge the physician puts on the bill (commonly called **billed charges**.) If the physician is participating in the insurer's network, it is likely that the physician has agreed to abide by a payment schedule (or other discount mechanism) which might reduce that $1,000 to, for example, $700. (This figure of $700 would be called the **allowed charges** for that benefit, and is what the insurer will recognize in the benefit calculation.)

The benefit for this imaginary plan pays 100% above the deductible, so the benefit calculation subtracts the $100 deductible from the *discounted* $700 benefit, and pays the physician $600. In this case, the insurer gets the full value of the discount, and the insured must pay the undiscounted $100. This is the most common interpretation of deductibles.

Sometimes there are family deductibles that are expressed as a multiple of the individual deductible, such as 2, 2.5, or 3 times. This naturally adds somewhat to the claim cost of a major medical benefit, since there will be some families whose claims will exceed the family deductible even though the individual expenses may not exceed the individual deductible.

COINSURANCE

It is common in major medical plans that, once the deductible is satisfied, benefits above that amount are payable at a percentage (typically 75%-90%, the most common being 80%) of covered expenses. Perhaps counter-intuitively, the percentage payable by the insurer (80%) is called the **coinsurance**; the remaining portion (20%) is part of the insured's cost sharing. (This terminology is not used consistently. Some people call the 20% the coinsurance.)

In the previous example (with $1,000 of billed charges, $700 of allowed charges, and a $100 deductible), if the policy pays 80%, then the $600 of allowed charges in excess of the deductible would be payable at 80%, or $480, with the insured responsible for the remaining $120.

Most provider contracts require that the provider accept the allowed charge determination, and not seek the difference between billed and allowed charges from the insured. The practice of seeking payment from the insured for the excess of billed charges over allowed charges is known as **balance billing**.

OUT OF POCKET LIMITS

As mentioned earlier, it is generally considered a good idea to provide financial incentive to the insured to control costs, through cost sharing. Once a claim reaches a particularly large amount, however, there is usually a provision that relieves the insured of the cost of any additional covered expenses. This is often called an **out of pocket** provision, or a **stop loss** provision.

Out of pocket limits can also be considered 100% coverage once a claim trigger occurs. That trigger can be expressed either in terms of covered expense (such as $5,000) or out of pocket expenses (such as $2,000). They can also be expressed to include or exclude the deductible. If the contract is a family contract, there will often be one out of pocket limit for each individual, and a separate trigger for the family as a whole, in case no single person hits the trigger but there are numerous moderate sized claims.

MAXIMUM LIMITS

Sometimes a policy will have an overall maximum benefit payable on behalf of an individual. This limit can be expressed in terms of benefits per year (like $1 million of benefit per year), over the life of the individual (like a $2 million lifetime benefit), or both.

Overall benefit maximums were quite common early in the development of major medical policies. As time went on, the original maximums (some as low as $25,000, for example) sometimes seemed absurdly out of date, in light of modern health care costs. Those maximums continued to grow over time, to multiple millions of dollars in the 1980s and ’90s.

Over time, many policies eliminated maximums. Ironically, some companies then reintroduced maximums for marketing purposes. Some marketers found that the public views a “$5 million maximum” more favorably than an “unlimited maximum.” It turns out that the premium cost for such differences is quite minor, although the risk can be significant for the small insurer who happens to find the rare multi-million dollar chronic claim. (Such an insurer might have stop loss reinsurance – that is, enter into its own insurance contract with another insurer – to cover the risk of such a claim.)

Some policies that have limited lifetime maximums will have a provision that will gradually reinstate eligibility for benefits, even though the maximum had been reached. A policy might, for example, reinstate $50,000 of benefit eligibility each year, after (and despite) the lifetime maximum having been reached. This allows an insured who has previously had a catastrophic event to maintain modest amounts of coverage.

Under the ACA, major medical policies (grandfathered or not) can no longer have lifetime dollar limits on covered services deemed to be "essential health benefits." In addition, annual dollar limits on essential health benefits that previously existed had to be phased out for non-grandfathered plans by 2014.

INTERNAL LIMITS

Sometimes there are benefit limits defined in a policy that apply only to specific subsets of benefits. Today, the most common internal limits on charges for all services (rather than a single service) relate to mental and nervous benefits, substance abuse benefits, and chiropractic benefits. In addition, these benefits can also have per service limits. An outpatient mental and nervous benefit might, for example, be limited to $40 per visit, and 20 visits in a year. As in this example, the overall limit can be expressed either in dollars or in number of services.

The ACA prohibits annual dollar limits on essential health benefits; this also prohibits internal limits on those benefits that are based on a dollar value. Because the law does not prohibit limits on the number of services of a given type that are covered, however, in many cases plans replaced annual dollar limits on particular services with annual limits on the number of the services instead.

Starting in 2014 individual health insurance plans must also comply with parity requirements in the **Mental Health Parity and Addiction Equity Act of 2008** (**MHPAEA**). The details are complex, but in general the inside limits applied for mental health and substance abuse services cannot be more stringent than those applied to other services.

Some Blue Cross plans have had limits on the number of inpatient days covered per spell of illness. In the past, this was often considered equivalent to an overall maximum, since the bulk of covered charges (for very large claims) was almost inevitably due to inpatient costs. With the growing number of transplants (and their associated surgical costs), and

the sometimes major costs associated with new drugs, a limit on covered inpatient days starts to look more like an internal limit.

Early in the development of major medical benefits, internal benefit limits were commonly used to limit exposure to broad categories of benefits deemed to be the greatest risk for cost, such as inpatient and outpatient hospital benefits. Such benefit designs were made without benefit of foresight of what would happen to benefit costs over time. In such cases, the hospital inpatient benefits might have been contained to a fraction of inflationary trends (with hospital inpatient benefits maxing out), while ancillary services might continue to grow because there are no internal maximums. In many cases the non-limited benefits (like ancillary services) have eventually become the major portion of benefits for the persisting book of business.

COPAYS

Cost sharing that occurs each time a service is provided is called a **copay**. Commonly, when they are used, copays apply to physician office visits (perhaps $20 per visit, for example), prescription drugs (often **tiered**, with copays varying depending on the drug prescribed, such as: $10 for generic drugs, $20 for brand name drugs on the insurer's formulary, $40 for non-formulary drugs, and $100 for high-cost specialty drugs), emergency room (such as $50 per visit), or other specific benefits. (A **formulary** is a list of drugs, promulgated by a health plan or a pharmacy benefits manager, that has member cost sharing that differs depending on how each drug is included on the formulary.)[3]

Copays came into vogue in the '70s and '80s, when HMOs first became popular.[4] HMOs tend to use copays rather than deductibles for cost sharing purposes. There are two types of services which most often use copays for cost sharing. The first type is the category of services which might be subject to over-utilization, where the insureds themselves have significant control over the usage. Examples of this include physician office visits and emergency room visits.

---

[3] *Group Insurance, Sixth Edition*, Bluhm, et al,, ACTEX Publications, 2013. Chapter 9.

[4] An **HMO** is a **Health Maintenance Organization**, a type of health insurance company, typically licensed either under a specific federal law or under a unique part of the insurance or health laws of a state, characterized by hiring or contracting with the providers needed to provide comprehensive care to their members.

Another common situation where copays are used is when the administration of a benefit (most frequently the prescription drug benefit) is done separately. The administration of prescription drug benefits are typically outsourced to a **pharmacy benefits manager** (**PBM**). Because the administration is done by the PBM, who doesn't have easy access to the insurer's claim records, it is difficult to coordinate claim payment calculations with other benefits, paid under other parts of the contract.

Eligibility for prescription benefits and the determination of benefits typically occur at the time the prescription is filled, and requires access to benefit information to determine cost sharing, so that the pharmacy can collect it at that time. Copay administration does not require knowledge of other benefits paid (unless they accumulate towards an out of pocket maximum); deductibles do. Since PBMs have historically been unable to access insurer benefit and claim information, there had been a compelling argument to use copays with prescription drugs, rather than deductibles that are integrated with medical coverage. Some plans, particularly high deductible plans, still have integrated deductibles today. Integrated plan designs may become more common under the ACA, since all cost sharing for essential health benefits, including prescription drugs, is required to accumulate towards an out of pocket maximum.

VARIATIONS ON A THEME – RELATED PRODUCTS

Comprehensive Major Medical Coverage

Major medical coverage originally had substantial deductibles which were intended to cause self-insurance of smaller health care costs. This was consistent with the original intent of major medical coverage to be insurance against "major" costs, rather than more frequent lower cost expenses. When adjusted to today's dollars, these sizeable deductibles were quite similar to today's high deductible, "consumer directed" policies.

Over time, a version of major medical coverage developed which was intended to cover more of the smaller expenses, and therefore had relatively small deductibles. Such deductibles were originally as small as $50 or $100. This coverage is sometimes referred to as **comprehensive major medical** (**CMM**) coverage.

Some carriers (particularly commercial carriers) may allow for widely customizable major medical plans, varying deductibles, coinsurance, co-

pays, optional benefits (like maternity, accident, and critical illness), prescription drug options and copays, and so forth. These carriers try to make coverage more affordable to prospects, by allowing them to pick and choose the benefits they find most valuable in relation to cost. (Such variation will, of course, also tend to generate more antiselection, as the insureds are most likely to choose the benefits that they are most likely to actually *use.*)

Catastrophic Medical

Another variation of major medical is the **catastrophic major medical product**.[5] This product's purpose is to protect from the opposite risk addressed by CMM coverage. It is major medical coverage with very high deductibles, typically on the order of $25,000-100,000.

Catastrophic coverage is consistent with the original intent of insurance: to protect assets against infrequent, large expenses. It was sometimes purchased to roughly wrap around older policies that might have outdated overall maximums. In addition, there are some purchasers who have sufficient financial means and the desire to self-insure costs to a much higher level than is typical for others.

The ACA caps out of pocket maximums for non-grandfathered major medical policies, which will effectively prohibit catastrophic major medical products as described in this section. The highest out of pocket maximum allowed in 2014 was $6,350 for a single policy, or $12,700 for a family.

Short Term Medical

Some major medical insurers found in the past that a sizeable proportion of newly issued individual major medical policies were sold to insureds who only intended to keep their coverage in force for short periods. This led to substantial lapse rates in the first duration of policies. Each of those issued policies had a substantial investment by the insurer associated with them, due to the cost of sales, underwriting, and issuing the policy. The insurer often did not recover this investment until the policy had been in force for

[5] The catastrophic major medical products in this section should not be confused with the "catastrophic" plans created under the ACA, which actually provide richer coverage than the plans described here.

CHAPTER 5

SETTING PREMIUM RATES

Before discussing the details of how premium rates are set, it is important to first understand the context and the overall rate setting process. In addition to the information in this chapter, there are valuable guides in the U.S. *Actuarial Standards of Practice*.[1]

5.1 THE RATE SETTING PROCESS

Rate setting generally involves two different approaches, depending on whether rates are being set: (1) based on direct, existing experience (such as the experience of an existing block of policies), sometimes called **rerating**, or (2) based on **fundamental pricing** – rating from other data sources (used as benchmarks), which are adjusted to apply to the current situation. All pricing processes use one or both of these approaches in setting rates. These two methods are discussed in detail later in this chapter.

In all methods of rate setting, the fundamental nature of the process is the same: (1) measuring the past, (2) evaluating and adapting it to the future, and (3) using the results of (1) and (2) to project the future in order to determine needed rate levels. How each of these is accomplished, however, often is challenging in many ways.

Rate setting occurs in multiple contexts, each of which will impact the rate setting process. Some of the major considerations are:

- *The market:* The marketplace itself is a major factor. How the product is priced by competitors sets expectations for consumers, and thereby limits insurers' pricing options. This can apply to rate guarantees, margins, rate structures, and the level and type of prefunding, if any.

[1] See www.actuarialstandardsboard.org/asops.asp.

- *Existing products:* If a company is already in the given marketplace, expectations by producers and the market will have an impact. If, for example, a company's strategy is to have a low initial rate for a product, but then apply large rate increases later, this will draw producers and policyholders who prefer that approach. Changing strategies will cause a disruption to the expectation of the groups, and could impact sales. As with all changes in direction, such changes in strategy should be made considering any potential impacts.
- *Distribution system:* The structure, compensation system, and level of control by the company are all relevant to the pricing process, as are expectations and understanding by the producers as to how rates are set and revised. Sudden changes can cause disruption and loss of business.
- *Regulatory situation:* How likely is it that the full needed rate increase will be allowed by the regulatory process? This is an important factor, as are more straightforward concerns, such as explicit limitations on how rates can be set. As an example, the ACA imposed new scrutiny on rate changes in the individual major medical market above certain thresholds (generally 10%).
- *Strategic plan and profit goals:* Pricing is, to borrow a phrase, "where the rubber hits the road" for many individual health (IH) coverages. The ability to price competitively yet profitably is an ongoing (sometimes, seemingly insurmountable) challenge, especially for companies active in the commercial market. Pricing practices and methods should reflect and contribute to achieving the company's strategic goals.

Once the context is understood, it will generally define most aspects of how rates will be structured for a product.

5.2 RATE STRUCTURES USED TODAY

Premium rates could theoretically be set to vary by any factor discovered to have a material correlation to claim costs. In practice, rating variables are generally limited to those that have both a rational causal relationship and such a correlation.[2] Such variables, depending on the coverage, might include: age, gender, occupation, geographic area at time of issue, geographic area at time of renewal, income level, current health status,

[2] For a thoughtful discussion of this topic, see the 2011 American Academy of Actuaries monograph "On Risk Classification," available at http://www.actuary.org/files/publications/RCWG_RiskMonograph_Nov2011.pdf

past claim history, duration of the policy since issue, benefit plan (more on this in a minute), tobacco use status, marital and parental status, presence and nature of other coverage, and sometimes situation-specific factors, such as whether the policyholder converted from another plan of the same insurer.

The term **community rating** is one often used to describe medical insurance rating schemes, and occurs in various forms – "modified community rating," "adjusted community rating," and so forth. The term is a popular one, particularly for public policy purposes, and refers in general to a scheme where many rating variables, which might otherwise be used, are knowingly ignored. Which variables those are will vary from situation to situation, making "community rating" a slippery term to define. Community rates will typically not vary by age, gender, occupation, income level, health status, past claim history, duration, tobacco use status, or the presence or absence of other coverages. It usually allows rates to vary by geographic area (although this variable may often be limited), marital and parental status, and benefit plan. In addition, in various regulatory settings, regulators have redefined the term for their specific use in particular situations. ("Community rating by class" is one such, used by federal regulators in HMO contexts.) The bottom line is: it is important to make sure the term is well defined when using it or relying on it.

For example, the ACA imposed a form of modified community rating for individual and small group major medical coverage starting in 2014 (grandfathered and transitional plans are exempted). The allowable rating variables are:

- Age (carriers must use standard age rating factors which vary by no more than 3:1 from the oldest to the youngest adult ages);
- Tobacco (limited to no more than a 50% surcharge for users);
- Area (rating areas are prescribed by the state, but factors are unlimited unless limited by state law);
- Family tiering/structure (family rates must generally equal the sum of member level rates, with the number of child dependents capped at three); and
- Plan (including benefits, cost sharing, and network).

Health status may not be included in any of the rating factors. States are free to impose more restrictive requirements if they like, and some do.

There is much work being done today on **predictive models**, used to predict future claim costs for individuals and groups based on past claim history, prescription drug use, or other information. These investigations are likely to become an integral part of the underwriting process for most carriers (at least those allowed to underwrite risks), and will likely affect the rate structures.

In the P&C insurance market, there is a controversial issue regarding whether P&C rates should be able to vary based on the insured's credit score. This is an example of consumer data used in underwriting. This is a newly developing area of underwriting in individual and small group health insurance. Its ultimate usefulness has not yet been tested in the market. With the prohibition of underwriting for individual major medical starting in 2014, these tools may instead find their applications in care management or other programs where one needs to stratify the population by health status.

Descriptions of the major rating structure elements follow. In these descriptions, the rating structure variables are related to the corresponding characteristics of the underlying data. In some cases, however, the premium rate relativities chosen may not follow the claim cost relativities for the rating cells, either because of regulatory restrictions or as a business decision by the insurer. To the extent the chosen rate relativities deviate from the underlying claim relativities, subsidies are being created from one rate cell to another. Subsidies can create antiselective situations, and increase the insurer's risk.

AGE

There are three major categories by which rate structures treat the age of policyholders. First, there is **attained age rating**. Under this approach, a policyholder's rate is a function of his age at renewal. Someone age 25 who buys a policy, and pays the age 25 rate, will next year pay the (then current) age 26 rate. If the attained age rates are grouped into rate categories larger than a single age, such as in 5 year (quinquennial) age groupings, this is called **step rating** or **age banding**.

If the rates reflect the age at issue, but not the age at renewal, then the rating scheme is called **entry age** or **issue age rating**. This rating scheme is usually accompanied by a corresponding reserve to offset the increasing costs in future years (called the "active life reserve," "policy re-

serve," or "contract reserve"). These are described more fully in the chapter on reserves.

In some circumstances, age structures do not recognize age at all, which might be called a **uni-age rating** scheme. Most community rate structures are uni-age. Since age-based rates might vary by a factor as much as 3:1 or 4:1 (for adults under age 65 – if children are included the ratio would be even higher), charging an average rate over all ages creates a significant disparity between the actual cost and the price charged. This leads to a situation ripe for antiselection. (Antiselection, and the art of dealing with it, is discussed further in Chapter 4.) Unless all carriers use similar rate structures in a given market, a company using uni-age rating can experience severe antiselection. One such example occurred with an insurer that determined, while it issued policies from ages 18 to 64 with a common rate, its average policyholder age was 57. (These later ages were the only ones with a premium rate that was competitive with carriers using age-based rating.) Under the ACA, all carriers selling individual major medical must use the same age rating factors in each state. We will discuss this in more detail later.

Medical and Med Supp coverages tend to use attained age rates, or, when regulated to do so, issue age or uni-age rates. These products are most easily characterized as "inflation sensitive" coverages – the claim costs tend to go up each year with increasing health care costs. The impact of claim trend (sometimes 10% to 20% per year, or even more) tends to overshadow the impact of year-to-year age increases (typically 2% to 3% per year), so rate structures intended to level the age increases, such as issue age rate structures, can become fairly ineffective for these types of policies if claim trends remain high.

Non-inflation sensitive coverages, particularly those with relatively fixed benefits, are more prone to use age-leveling premium structures. For this reason, DI, LTC, and HIP coverages all tend to be sold on an issue age basis. In this case, leveling of age increases in the premium structure can be quite effective. In fact, for non-cancelable policies, the premium rates are actually guaranteed not to increase.

Claim costs do vary significantly by age for virtually all coverages. People at older ages tend to generate higher claim costs than people at younger ages for most coverages. (Two counterexamples are maternity coverage and accidental death coverage, but there are not many such examples.)

Underwriting has a particular impact on the age curve. This is because the age curve describes the relative claim costs of *average* insureds at each age. For some products, the average insureds at higher ages have significantly higher expected claim costs than the average younger insured. To the extent underwriting is effective, it has the impact of weeding out those at higher ages with chronic diseases or predictably high claim costs, having a relatively greater impact at the higher ages. This is one reason why the morbidity by age curve for individual insurance has historically tended to be substantially flatter than that of large group insurance, where there was no individual underwriting.

Typical age curves for different coverages are illustrated in Figure 5.1. The relativities have been multiplied by a factor so that the average factor for each coverage, over an assumed typical population, averages to 1.00. (This process is called *normalization* of the factors over that population.) Note that the Accidental Death coverage has factors that *decrease* above the younger ages (and would be even more pronounced if the graph extended to still younger ages); this is one of the few coverages which does so. The slope of most coverages varies by duration; the slope in this graph represents an average slope over all durations.

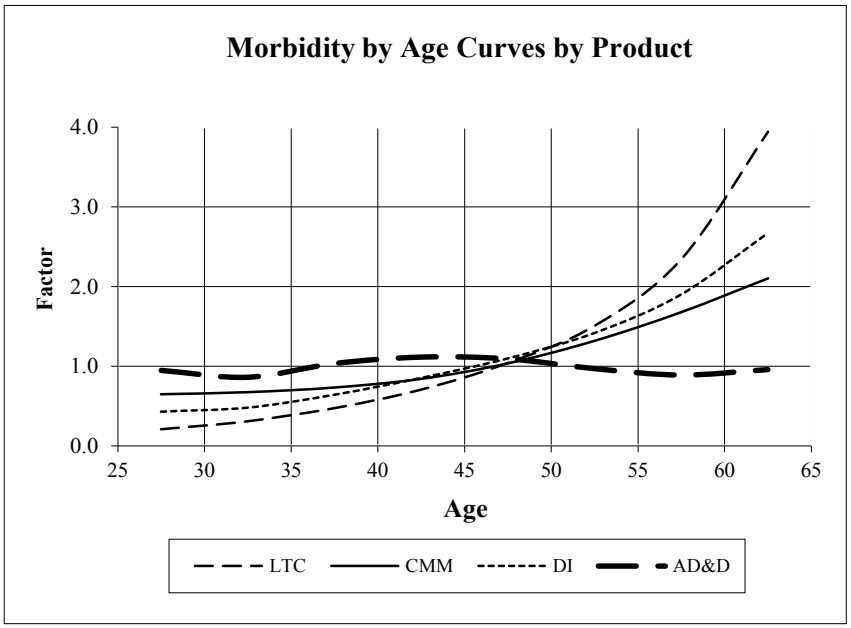

Figure 5.1

CHAPTER 10

OTHER INSURER FUNCTIONS

This chapter describes a number of the professional functions that an insurer must perform in order to successfully sell and administer its individual health business. The chapter begins by describing the many ways in which individual health insurance is marketed. It then describes the underwriting, claim administration, and policy administration and service functions.

Perhaps one way to think of the functions performed at an insurer is to examine the roles played by various insurer personnel over the life of a policy. Initial contact is made through the sales function. Then the underwriting area comes into play, determining whether and on what terms coverage will be offered. (Underwriting is discussed in Chapter 4, Managing Antiselection.) If the policy is offered and accepted, policyholder services enter the picture, to issue and maintain the policy. Later, claim administration will become involved if and when there is a claim.

10.1 SALES AND MARKETING

As you have probably noticed throughout this text, in many ways the individual health insurance market is not a single market, but rather a collection of small market segments, varying by product and type of insurer. Sales and marketing is no different, and the characteristics of the market will depend on the market segment being studied.

At the same time, there are a limited number of production conduits available. Products are sold via personal sales by agents, by telephone (telemarketing), or by mass marketing methods. Mass marketing can occur through various media (including television, radio, the internet, billboard advertising, or flyers), or brochures provided through and with other media (such as a credit card bill or a paycheck). Sometimes leads produced through mass marketing methods are handed off to agents or telemarketers for follow-up.

In the commercial major medical, disability income, and long term care markets, most products are sold by independent brokers, although there are a small number of insurers with captive agency forces of their own, usually managed through a general agency system. Most brokers who are active in these markets specialize in the coverage being sold, as success demands specialized knowledge about the current conditions in these quickly-changing marketplaces. Brokers will sometimes "spreadsheet" rates – comparing the rates of a variety of insurers, in order to obtain the lowest rate for a particular prospect.

Captive agents are usually not as specialized as brokers, and instead are focused on providing a spectrum of products from the same company to their customers. In some schemes, with general agencies of sufficient size, and products that require specialized knowledge (such as DI or LTC), a general agency might have a product specialist who supports the non-specialized agents in the agency.

Blue Cross and Blue Shield plans are no longer homogeneous in their approach to sales. Some rely on their own employees to produce sales, either directly or through telemarketing, some rely on the broker community, and some do both.

Insurers are constantly re-evaluating their products. In the major medical market, this is most notable with respect to premium rates. Seemingly minor changes in rate relativities between areas can cause significant shifts in production volume. Often the difference between selling a high volume of business and selling a little can revolve on a rate difference as little as 5%. The DI and LTC markets are often more driven by product design, although premium levels are never absent from the list of important issues.

Except for telemarketing or mass marketing, selling in these markets usually occurs through personal contact between an agent (whether employed directly by the insurer, a general agent, or a broker) and the prospect. The agent often helps the prospect fill out the application, and creates a personal connection with him or her. (For some coverages, agents are sometimes asked by the company to also perform some field underwriting, by doing a limited amount of simplified underwriting while interfacing with the client.) Some products, particularly those covering basic needs, require more sales effort to sell than does a lower cost supplemental policy.

General agents (**GAs**) are typically (but not always) appointed by an insurer to be responsible for all business provided in a given geographic ar-

ea. They will hire sub agents, on behalf of the insurer, to be the actual business producers, and will manage those agents. A **brokerage** is an entity formed of a group of agents, not affiliated with any particular insurer, although they may form exclusive working arrangements with them from time to time.

Within every product type, some products are designed to cover basic needs, while others are more supplemental. Most typically, it is supplemental products that are more easily sold using mass marketing methods, while basic coverages are less often sold that way. There are several reasons for this, but it seems mostly driven by the cost of underwriting. Basic coverages typically have much larger claims, and therefore constitute a much bigger risk to the insurer. Antiselection under supplemental coverages can more often be controlled by other means, such as contract language and product design.

The market for basic medical coverage (major medical) is most often self-employed persons, and individuals who are not covered (for whatever reason) by a group contract. Sometimes that lack of coverage arises because an employee is temporarily between jobs, or is a college graduate looking for a first post-graduate job. This short term need is usually met with a short term medical contract.

Another common situation (not met by short term coverage) is when individuals are employed by a small business without group health insurance. This situation is becoming more frequent, as small employers are less able to afford the cost of health insurance as an employee benefit.

A somewhat less comprehensive medical coverage, addressing hospitalization only, is sometimes used to provide a lower cost alternative to major medical coverage, while still protecting against major illnesses or injuries. Such limited coverage will generally not satisfy the requirement to purchase health insurance mandated by the ACA.

There are similar comparisons that can be made between basic and supplemental DI coverages. Because U.S. Social Security provides a significant disability benefit, DI products tend to be built around this. When looking at the market in total, companies will tend to disproportionately focus on higher income individuals, because those are the prospects who

have the most meaningful need (if defined as the portion of earnings being replaced) for coverage above Social Security.

As discussed in Chapter 1 and throughout this text, the ACA introduced a new distribution channel for individual major medical coverage starting in 2014: the public insurance exchange. While brokers and agents can still assist individuals in obtaining coverage, there are also new options for those seeking assistance in purchasing coverage: navigators, in-person assisters, and certified application counselors.

Participating in exchanges can involve significant administrative hurdles for an insurer. For instance, the insurer must interact with the exchange to verify eligibility and coverage, and must also complete the complex certification process for qualified health plans outlined in Chapter 9. Brokers generally have to be registered with the exchange to be compensated for exchange policies. Some carriers may question whether they need brokers involved at all, or whether they should instead focus on signing up consumers directly through the exchange. The impact of the exchanges on existing distribution channels will likely take some years to play out, and will be interesting to watch.

Even outside of the exchanges, internet sales are becoming more and more common. These occur both directly through the insurer's own website, and also through web brokers that offer multiple insurers' products.

COMPENSATION

Sales personnel are typically compensated by means of commissions payable on business they sell and have in force. Many times, a company with a captive agency force will provide a stipend in the first year or two of agents' careers (typically grading down over time, often to zero), in order to provide them with income while they learn their trade and build their portfolios of customers.

Commission rates are usually expressed as percentages of premium, and can vary by product, by duration (most commonly first year vs. renewal), by persistency of the agent's business, by volume of business placed, or by other factors. Schedules with higher first year (and possibly for a few subsequent years) commissions are said to be *heaped,* or *graded*, although "graded" sometimes refers to differences by other variables such as vol-

ume. Heaped commissions occur in both broker-driven markets and captive agencies, although more frequently in the broker market. They also are more often used by companies that have a life insurance focus, and are less prevalent among P&C companies, because the comparable scales for those other coverages are more heaped (life) or less heaped (P&C). One school of thought is that heaped commissions tend to attract brokers that are more likely to replace the business elsewhere (and thereby earn yet another first year commission), which argues that insurers' best interests lie with flat commission scales. Another consideration is that levelized commissions tend to generate better returns on investment (or equity) in pricing models. Prevailing practice in the marketplace will generally dictate whether a heaped commission scale is needed.

For coverages that are not inflation-sensitive, such as DI, non-scheduled increases in coverage are often treated as though they are first year premium for commission purposes, under the rationale that such an upgrade in coverage required selling comparable to a new policy of that premium size, and avoids the cost of issuing a new policy.

Sometimes a company will change its commission schedule in order to achieve a sales or tactical goal, such as a year-end push for new policies, or intentionally converting an existing policy to a new one.

It is important to understand that the more independent a producer is (i.e, they can go to competitors' products at will), the more competitive the compensation scheme needs to be. While we would like to think that an agent will always put their customer's needs first, the value of the commission to the agent will always have an impact on the success of the product.

For coverages that are inflation sensitive, it has long been a practice not to consider regular rate increases as first year premium. In recent years, there has also been a movement among some carriers to not consider the premium from rate increases even as renewal premium for commission purposes. This is particularly true for major medical and Medicare supplement coverages, where premium increases can consistently outpace actual cost trends by a sizeable margin. Some argue that salesmanship is needed to keep policies in force in the light of such increases. A middle ground between these arguments is to allow the increases to be commissioned, but at a lower rate. Over the past decade or so, there has been a growing movement toward paying flat commissions per policy or per member, rather than commissions based on a percentage of premium.

Sometimes service fees are paid to agents, to compensate for services provided through the renewal process. Renewal commissions might be composed partly of an element intended to compensate for ongoing service (service fees) and partly a payment of commission in renewal years for the original sale.

Another element of commission scales is the vesting schedule. Commissions generally become **vested** at the point when commissions become due to an agent regardless of whether the agent continues to be employed by the agency or the insurer.

General agents and brokerages are sometimes paid a commission override. This is an additional commission payable to the GA or broker, typically significantly smaller than the commission itself. Sometimes the combined commission and override is paid to the GA or broker, who then distributes the commission out of the total.

Group conversion policies generally exist in order to comply with the law, rather than as a source of profits. They are usually marketed through the employer, or directly with the insurer. Even when there are agents involved, there may not be any commissions payable.

The ACA requires insurers to pay the same commissions for major medical products sold in and out of the public exchanges. At the same time, minimum medical loss ratio requirements are putting significant pressure on administrative costs, of which commissions make up a large part. It is unclear how these changes will affect the traditional roles of brokers and agents in the individual health market in the long term.

Since OBRA 1990 became law, first year commissions on Medicare Supplement policies have been limited to two times renewal (defined as years 2-6) commission rates, presumably to help limit potential **churning** (intentional, unnecessary replacement of coverage by another carrier). This 2:1 limitation can be applied either on a dollar basis or a percentage basis.

Marketing's literal meaning is defined as "the act or process of buying and selling in a market.[1]" In an insurance company context, marketing typically involves developing all the sales material, (including research), addressing

[1] *The American Heritage Dictionary of the English Language,* Fourth Edition, Houghton Mifflin Co., 2000.