ACTEX Professional Series

GROUP INSURANCE

EIGHTH EDITION

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8th

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About *Group Insurance*

Since its original publication in 1992, Group Insurance has become the resource of choice for experts as well as beginners. It is an essential tool for anyone who wishes to practice in the group benefits field.

This text is a comprehensive treatment of all aspects of group insurance in the United States and Canada. It addresses life and health insurance as well as government programs and more specialized forms of insurance. Emphasis is placed on the actuarial aspects of this important field of insurance including pricing, regulation, underwriting, financial reporting, and modeling.

The eighth edition of Group Insurance contains a number of important changes and enhancements. Every chapter in the book has been revised and updated to reflect the latest developments in the group insurance market. There are also new chapters on Group Insurance Reserves and Estimating Pharmacy Claim Costs, along with a greatly expanded treatment of the impact of the Affordable Care Act in the United States. Finally, improved organization should provide a logical guide to the detailed content of this text.

ISBN: 978-1-62542-682-6

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Greenland, NH

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Greenland, NH 03840

Manufactured in the United States of America

10 9 8 7 6 5 4 3 2 1

Cover Design by Rachel Maragnano

Library of Congress Cataloging-in-Publication Data

Names: Skwire, Daniel D., editor.
Title: Group insurance / principal editor, Daniel D. Skwire ; associate editors, Kristi M. Bohn, Margaret D. Cormier, Stephen J. Kaczmarek, Sara C. Teppema; founding editor, William F. Bluhm.
Description: Eighth edition. | Greenland, NH: ACTEX Learning, 2021. | Includes bibliographical references and index.
Identifiers: LCCN 2021932567 | ISBN 9781647563509 (alk. paper)
Subjects: LCSH: Group insurance--United States. | Group insurance--Law and legislation--United States.

ISBN: 978-1-64756-350-9

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PREFACE

When Bill Bluhm authored the first edition of this textbook in 1992, I don't know if he imagined that it would survive beyond his retirement and one day reach an eighth edition. I am certain, however, that he wanted the book to be both timely and timeless, and that is a vision we have attempted to fulfill with each new edition.

Most of the work on this edition occurred during 2020, the first year of the COVID-19 pandemic. Prior to COVID-19, many of us who worked with group insurance viewed the idea of a pandemic primarily as a thought experiment—an extreme but remote scenario to be considered in cashflow testing or enterprise risk management, but something we were unlikely to deal with firsthand. We have learned a lot since then.

In many ways, the pandemic has reinforced the importance of what we strive to achieve with group insurance. Indeed, it could serve a case study for the value of each of the primary subjects addressed in this text: benefit design, pricing, regulation, financial reporting, and data analytics. It also emphasizes the importance of health policy, meaning the vision for how a country or a health care system will provide for the delivery and financing of health care for its citizens or members. The connection between health insurance and employment in the United States has, for example, proven challenging in the face of a pandemic that has simultaneously increased unemployment and the need for health care.

This new edition makes frequent reference to COVID-19, but generally as an example of how the underlying principles of group insurance apply to this most challenging of health issues. The principles themselves haven't changed, however, and when it comes time to prepare the next edition of this book, it will be interesting to reflect on the pandemic and the responses of the group insurance world with a bit of historical perspective.

As always, I am deeply grateful for the efforts of the four associate editors who have done so much to help create this book: Kristi Bohn, Maggie Cormier, Steve Kaczmarek and Sara Teppema. They have been instrumental in every phase of the book, from planning the content, to working with the authors, to completing the editing. Thank you for your exceptional work!

Thank you also to the many authors who have brought their dedication and expertise to this project, always gratefully accepting suggestions and guidance from the editors, while educating us every step of the way. 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 their commitment.

The staff at ACTEX Learning has done much to make this book a reality. Kim Neuffer, in particular, has brought a firm but gentle hand to managing timelines for a very busy group of authors and editors. I would particularly like to thank Kim for finding a way to update the index that did not involve my cataloguing each key word used in the book!

The COVID-19 pandemic has given me a newfound appreciation for the importance of family and for the many types of family I have. With restrictions on business travel and other activities, I have seen more of my immediate family, and they have seen more of my disappearing into my study during what otherwise would have been family time to work on this textbook. Thank you to Denise, Adam, and Luke for the many ways in which you have helped and supported me with this project.

I have spent less time this year than in the past with other family members, including my parents and in-laws, but that has only emphasized how much I miss them and how important they are to me. Much love to all of you! (Once you've read this preface, I will not be offended if you do only a brief skim of the following 900 or so pages…)

Lastly, I have come to understand how much I consider my clients and coworkers to be family as well. I have missed seeing you in person this past year, but I am continually thrilled and amazed by the many ways in which we have been able to help and support each other during this difficult time, exactly as family members should.

Group insurance serves many purposes, but at its core it provides a means for all of us to protect ourselves and our families from a world of risks, both known and unknown. This book is dedicated to all of our families, with best wishes for health and security in the years ahead.

Portland, Maine
February, 2021

Daniel D. Skwire, FSA, MAAA
Principal Editor

1 SECTION ONE

INTRODUCTION

2 OVERVIEW OF MARKETING AND SALES

by Nick Ortner

INTRODUCTION

The best-designed and priced group insurance product would be of little use without an efficient sales and marketing program to promote that product to its intended purchasers. A company can have state-of-the-art systems, efficient administration, and actuarially sound and competitive premium rates (or funding alternatives), but nothing happens until that company has properly marketed, sold, and implemented its products.

The American Marketing Association defines marketing as "the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large."[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 (i.e., the sale to the customer).

It is often common in practice to separate the marketing and sales functions. The separation occurs not because the functions are unrelated, but rather because there are such dependencies between the two. In fact, it could be said that marketing is to sales as strategy is to tactics. This frame of reference shows marketing as an overall process, with sales and distribution as the implementing components.

In the context of group insurance, the relationship between marketing and sales may vary depending on the employer size, intermediaries (i.e., brokers/agents and other advisors), and product.

MARKETING

Some marketing functions are common to all types of organizations, but others require special attention in the context of group insurance.

MARKETING FUNCTIONS

Marketing is the process that prepares the way for sales. Strategy is conventionally viewed as the overall blueprint that guides the company toward achieving its stated goals and objectives. The marketing area plays a key role in planning by providing important information about the company's current position in the market and possible future opportunities, while developing strategies and tactics for specific customers, products, and distribution channels.

[1] https://www.ama.org/the-definition-of-marketing-what-is-marketing/ , accessed 31 Oct 2020

Marketing research is an important part of this overall planning process. Defined by the American Marketing Association as "the function that links the consumer, customer, and public to the marketer through information – information used to identify and define marketing opportunities and problems; generate, refine, and evaluate marketing actions; monitor marketing performance; and improve understanding of marketing as a process,"[2] the role of research is to focus on understanding customers and defining the intended market (by geographic, demographic, or other population characteristics) to answer questions such as:

- Who are the potential customers for our products?
- What features or capabilities do customers desire in the products they purchase?
- Where are customers located?
- How much are our potential customers willing to pay?
- From what types of distribution arrangements do customers prefer to buy?
- Who are our competitors and what are they doing?

Market research employs scientific survey techniques and sophisticated statistical analyses. Larger companies may primarily rely on their own internal research staff along with feedback from their product managers and sales and distribution experts. Smaller companies may have resource and funding constraints that limit their research and force reliance on external research firms when there is a critical need.

Market research is commonplace in the consumer product industry and continues to gain ground in insurance and financial services. Historically, group insurance companies may have lagged durable goods companies in implementing research-based approaches due, at least in part, to insurers' focus on product and distribution.

In today's environment, that narrow focus on product and distribution has expanded. Group insurance providers now recognize the critical role research plays in achieving their goals, particularly as they work to understand and change the behaviors of consumers. Increased and focused commitments to research and development, enhanced by emerging consumer survey technology, are helping to scale and facilitate effective and efficient research and consumer understanding.

The creation of competitive products is one of the processes identified in the definition of marketing. How are new products created or developed? Although there is a general pattern to the process, the specifics may be different at every company.

Marketing in the Group Insurance Marketplace

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

Group insurers can employ many methods and strategies for marketing products. One decision that group insurance marketing professionals must make is the audience for their campaign. A need for multiple marketing campaigns may exist due to the complexity of the distribution

[2] Ibid, pp. 103-108.

model for group insurance. Insurers often create marketing strategies targeted to three sets of consumers: intermediaries that advise their clients, group policyholders (such as employers, unions and associations), and individuals. Insurance companies may have separate marketing plans for all three of these consumers of their products and services. The level of focus on these different consumers may change by company and product.

Group Insurance Regulation and Exchanges

Another consideration for the group insurance marketing process is regulation, both federal and state. Group insurance is primarily regulated at the state level, meaning insurers' marketing efforts and product offerings must be compliant on a state-by-state basis. State variations create complexity for group insurers installing a single, cohesive strategy across states. At the federal regulatory level, the Affordable Care Act (ACA) of 2010 created and facilitated the operations of public exchanges by the states to assist small employers and individuals with purchasing individual health insurance. These public exchanges included navigators (personnel assigned to help people obtain coverage) and other awareness campaigns that overlapped with certain marketing and sales functions that insurers already had in place. Moreover, since the ACA includes numerous regulations governing group insurance coverage, employers and insurers continue to work to be compliant with the law as its rules have evolved.

In addition to public exchanges, new options such as private exchanges have grown in popularity, particularly with larger employers. Private exchanges provide a range of information to facilitate health and other insurance product selections and include employer contributions toward enrollees' insurance costs. New rules offering potential alternatives such as health reimbursement arrangements (HRAs) may lead health insurers to reexamine their marketing strategies for brokers and agents, employers, and consumers.

Once a company has developed its marketing strategy, researched the market, created products to meet the demands of that market, implemented an advertising and promotional campaign, and considered the relevant regulations, it can turn its attention to sales.

SALES

Sales is often seen as the culmination of the marketing process, although this is a somewhat simplified and incomplete view. Ongoing customer service after the sale is needed to complete the marketing and sales process. Organizations cannot survive if they must continually focus their sales efforts on replacing dissatisfied customers who have terminated their relationship with the company. For market-driven organizations, marketing, sales, and ongoing service should be viewed as one continuous process.

Group insurance often has two levels of sale. The first sale is made to the plan sponsor. This initial process entails selecting plans to be offered and understanding their cost, and it includes discussing and confirming the financial management, administration, and services available to the sponsor.

Later in the process, a second sale is often made to the individual participants. Activities in this step of the process include educating eligible participants on the offering and helping them select plans from among options offered by the plan sponsor. This second sales process is discussed

in more detail later in the chapter.

Group insurers tend to organize their sales efforts according to targeted market segments. For a given market segment, the distribution model may depend on plan sponsors' size and industry, as well as the sophistication of the plan sponsors and their benefit plans. This section examines the most common market segments and distribution models, the role of intermediaries in the sales process, and emerging strategies in the group distribution process.

MARKET SEGMENTATION

Group insurers often assess sales at a target market segment level. Segmentation analysis is not designed to minimize the importance of distribution channels. Rather, such analysis enables the company to understand its potential customers and focus its distribution efforts. As a result of segmentation analysis, management can make specific decisions regarding which market segments to pursue, which products to emphasize, and which distribution channels to use.

For example, an insurer could segment employers by industry, the manner in which employers purchase benefits (i.e., paternalistic, procurement-driven, etc.), or geographic area. Insurers might focus on the public sector and dedicate resources to the specific needs of that market or subsets of that market (e.g., educators). Meanwhile, other insurers might limit distribution to certain geographic areas where they have greater physical presence or brand recognition. With the advent of private exchanges, group insurers may focus on employers that are either more prone to pursuing a defined contribution approach within such an exchange, or to those who prefer to stay the course in the traditional market.

Another common market segmentation approach for group insurers is by employer size, as described in the next section. This approach is often an efficient and convenient way for insurers to assess market segments and focus their distribution channels. Certain distribution models tend to serve specific size segments, as described later in this chapter. Size segmentation often varies by insurer.

SIZE SEGMENTS

Smallest Groups (2 to 50 Employees)

In the United States, the fully insured small group segment is heavily regulated by the ACA, with small group coverage offered on state public exchanges. Other products sold in this space (e.g., self-insured or level-funded products) tend to face less regulatory scrutiny.

Insurers are required to comply with benefit coverage, plan design actuarial value, and premium rating restrictions. Insurers offering products in this size segment primarily use brokerage or general agency distribution methods, with agents and brokers operating in this market usually specializing in small groups. The clientele may be less sophisticated regarding group insurance and often does not have the resources to maintain full-time benefit managers or human resource departments for support, and so relies on brokers for guidance on benefit plan management.

Mid-Market Groups (51 to 500 Employees)

In this size segment, a group's own claim experience is usually available to assess and consider for a variety of insurance products and can have an influence on product pricing. Flexibility of plan design is often necessary because employers in this size category, particularly on the larger end of the segment, tend to be relatively sophisticated and typically have benefit managers monitoring their benefit offerings. Mid-market groups commonly require benefits customized to the needs of their business and employees.

This market group typically uses specialized brokers and large local or regional brokerage firms. The process of obtaining and analyzing the information needed to prepare a proposal or respond to a Request for Proposal (RFP) process tends to require a skilled group benefit specialist on both the broker and insurer sides of any negotiation. Consequently, a group field force model (agents and supervisors operating away from the home office) may be favored by insurers to engage and sustain relationships with employers in this size segment. Insurers may also have account managers who focus on servicing and renewing these groups. The account management team is often critical to group retention and the overall success of the segment.

Large Groups (500 Employees and Larger)

The large group segment has the greatest variety of solutions and distribution models to match the complexity and often diverse needs and geography of these employers. Very large groups (sometimes known as "jumbo groups" or "national accounts") may be multi-site and multi-state, staffed with full-time benefit and risk management departments that manage a complex array of benefit plans. Employees may have many plan options and possibly multiple insurers from which to choose. Large group customers usually deal primarily with large employee benefits consulting firms or skilled local brokers familiar with the unique needs and demands of large employers. Insurers tend to employ national account field forces that are specifically dedicated to this size segment. The larger the group, and particularly the greater geographic dispersion of the group, the less likely local or regional health insurers may be able to provide adequate coverage or services.

ROLE OF INTERMEDIARIES

Employers tend to rely on intermediaries (i.e., third-party advisors) to assist them with their employee benefit plans. Such assistance may include guidance on issues such as plan design, pricing, comparative analysis of competing insurers' products and services, and emerging market information and competitive intelligence. The intermediary may also get involved in ongoing customer service issues and serve as the employer's representative to help resolve billing and claim disputes. At renewal, the advisor may survey the marketplace to assess whether the employer would be better served by renewing the plan with the current insurer or by changing insurers (or at least considering such a change). Renewal analyses may include a discussion of plan design options and emerging alternatives with the current insurer and, possibly, one or more competitors.

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

A broker is an individual who represents the insurance buyer and is licensed to sell products for

more than one insurer. Broker compensation is usually based on sales commissions for products sold, with commissions usually calculated as 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" (sometimes interchangeably referred to as producers) are similar to brokers, except agents are typically associated with representation of insurers. The term "independent agent" describes an agent who is authorized or appointed, to sell products from different insurance carriers, whereas some larger insurance companies may have "career agents" or "captive agents" who are required to exclusively sell that company's products. Agent compensation, like brokers, is also based on commissions.

Consultants are the third group of intermediaries and tend to work primarily with large employers. Compensation for consultants is typically based on a fee for services rendered, as opposed to commissions, with that compensation paid by the employer, rather than the insurer. The consultant could be paid an annual retainer or an hourly fee for consulting services. Fees could also be negotiated for specific projects, such as a vendor selection process or creation of customized communications explaining the various benefit packages available at open enrollment. Some firms may operate as consultants in certain instances and as brokers in others.

Critical components of intermediary services are independence and disclosure. Companies must be able to trust their advisors are working without conflict to independently guide client benefit decisions and be aware of any potential conflicting relationships for their advisors before decisions are made. As one high-profile example from 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. Allegations included "bid-rigging" where business was placed with preferred insurers while other participating bidders submitted intentionally uncompetitive bids, and "pay-to-play" arrangements where brokers received undisclosed contingent commissions as incentives for placing business with certain insurers. The National Association of Insurance Commissioners (NAIC) got involved, as did several other state insurance departments and attorneys general. Even though the original allegations involved property and casualty coverage, the inquiries expanded to include other insurance lines, including group insurance. There were numerous civil actions and settlements divided among several states, while also resulting in the NAIC strengthening commission disclosure requirements in its Producer Licensing Model Act.[3]

With the advent of consultant-owned or consultant-driven private exchanges, the importance of intermediary independence may increase if employers question the ability of those same consultants to remain unbiased regarding employers' options. How private, consultant-led exchanges may change the landscape moving forward remains a question, but there is an expectation that boutique vendors may enter and remain in the arena to provide the independent guidance employers may demand when choosing between multiple consultant-led exchanges and then making decisions within the selected exchange.

[3] 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).

DISTRIBUTION MODELS

INDEPENDENT BROKERAGE/AGENCY

Under the independent brokerage or agency distribution model, the insurer relies on independent brokers or agents to sell products. These experts are traditionally self-employed entrepreneurs, who are primarily responsible for their own overhead costs and maintaining their own office space and clerical staff. This model is attractive to some companies, especially those with limited resources, because it does not require the commitment of capital and staff resources insurers might otherwise need to house, train, supervise, and maintain their own branch-office field force. Companies using such a model may allocate a portion of these savings back to the brokers in the form of higher commission rates, override payments, or expense allowances, with such support often contingent on achieving and sustaining certain minimum sales volumes.

Brokers and agents in this model do not sell any one company's products as their sole responsibility, and instead sell multiple companies' products. This arrangement may make any insurer in brokers' portfolios vulnerable to price competition or commission escalation, since the business may often flow to the insurer with the lowest premium rate or the highest commission rate.

As independent entities, brokers may specialize in specific product lines, such as property and casualty insurance or financial planning. Even if brokers specialize in a company's desired product, distribution may be limited to a specific geographic area or client base. Insurers must often support a broad variety of products for many market niches to maintain sufficient growth and revenue flow.

The independent brokerage or agency distribution method may be most frequently used to distribute small group and individual insurance products, including various types of life insurance, annuities, Medicare supplement insurance, critical illness coverage, and long-term care insurance, all examples where the agent relationship is an important element of the sale. On the other hand, products for larger groups tend to be sold based on price and value, and as a result, the independent brokerage or agency model has not been widely used by group insurers.

GROUP FIELD FORCE

The group field force model is the traditional model that large group insurers often use. Under this distribution model, the insurer employs a full-time salaried field force of representatives that exclusively sell products developed by the insurer they represent (i.e., "captive" or "career" representatives). Insurers usually pay incentives to group representatives for sales above certain targets, in addition to base salaries. This distribution method is typically a wholesale model, meaning the insurer's representatives may sell through both brokers and consultants and, in certain situations, directly to employers.

This distribution channel is different than the independent brokerage or agency model. The sales force is totally dedicated to the sale of the insurer's products. This dedication means there is no specialization in other outside product lines, no distribution of other companies' products, and distribution tends to not be limited to small local areas. Group sales forces instead typically operate in as many market niches as possible and develop relationships with a variety of brokers

and consultants to access a large, diverse base of prospects. Such an approach may enable insurers to generate sufficient sales volume while offering a more focused portfolio of products to a narrower market. A key tradeoff for the limitation to one carrier is that carriers tend to provide substantially greater support in the form of shared staff, office space, advertising, marketing materials, training, and other assistance.

As a result of that support, overhead expenses tend to be higher in the group field force model. However, such higher expenses may be partially compensated for by the loyalty of the group field force, which may sell according to value instead of focusing on the lowest price or highest commission. The group field force's heightened focus on value may permit pricing at levels that cover expenses and achieve target profit margins. Company growth can be maintained and managed by adjusting the size of the group sales force. Although overhead expenses increase as sales representatives are added, economies of scale may also accompany such growth. Revenue increases as a result of expansion may be more predictable because the salespeople in the group field force model are the insurer's employees, not independent brokers or agents.

Within this model, separate teams often have responsibility for managing the employer customers. Account management teams are responsible for providing sound and timely service to employers and their employees while working in a consultative capacity to understand the employers' needs and guide employers to other products or services that might be useful. Sales leaders and account management teams may also collaborate in cross-selling to gain additional work from the employer and influence account retention.

MULTIPLE LEVEL

The multiple level distribution model is probably the most complex model used for the sale of group insurance, relying on various models and personnel, layered one on top of the other, to sell insurers' products. The layers may include a mix of wholesalers, retailers, brokers, captive agents, and salaried representatives, along with telemarketing and other support.

The distribution channels are extremely broad, enabling insurers to place specific products into different channels. The mix of models may include a combination of low-expense models (like independent brokers) and higher expense models (like salaried representatives compensated on a sales incentive plan). Such a hybrid model may permit insurers to realize the advantages of a dedicated field force without a significant effect on pricing, as the expense loads of the field force are blended with the loads of lower expense methods also used. The complexity of this system requires robust and sophisticated sales management and marketing support for success. Insurers with a national presence and reach most often employ this model to give themselves the flexibility to leverage the channels that are most effective for specific markets and marketing targets.

SALES TO INDIVIDUAL PARTICIPANTS

Some group sponsors may offer multiple choices of plans or may allow the offering insurers to present and sell their products to individual employees or enrollees, following the initial sale to the plan sponsor or employer. Specialized enrollment staff (who may be paid through commissions) or salaried enrollment specialists may be responsible for such "second sales" activity. The employees may meet with these specialists or respond to website information or printed documents made available for employees' review. Second sales may be particularly

important where plan sponsors offer multiple different alternatives such as HMO, PPO, or consumer-driven health plans, with specialists providing clarity and support related to the marketed products.

Second sales events may include webinars, conference calls, or dedicated websites or phone numbers for representatives from the insurers whose products the employer is sponsoring (e.g., medical and pharmacy, dental, group life, and disability) to answer questions, obtain marketing materials and plan information, receive enrollment forms for completion and submittal.

LICENSING REQUIREMENTS

Brokers, agents, and field sales representatives all require licensing to sell insurance products. Each state's Department of Insurance has its own licensing and continuing education requirements. For sales professionals operating in multiple states, non-resident licenses may be available and the National Insurance Producer Registry (NIPR, nipr.com) is among the resources dedicated to making licensing cost-effective, streamlined, and uniform for the insurance industry across all states.

ALTERNATIVE DISTRIBUTION METHODS

This discussion of distribution methods has focused on what may be called traditional models. Alternative distribution methods for group insurance may involve mass-marketing techniques such as internet or website sales, worksite marketing, and mass media communications (television, radio, newspaper advertising, and direct mail solicitation). Though perhaps not historically traditional, internet or website sales and the use of technology may emerge as an increasingly important form of group insurance marketing and sales.

INTERNET OR WEBSITE SALES (E-COMMERCE) AND TECHNOLOGY

Internet and website marketing was already emerging and growing increasingly common prior to the COVID-19 pandemic, with the pandemic driving and mandating adoption at a rapid pace and electronic distribution becoming an important part of e-commerce. Technology is playing an ever larger role in helping employees understand and make decisions on their benefits with the emergence of interactive programs, particularly among larger employers. Technology helps employees consider their decisions and frame the available choices around the trade-off between premium rates and benefit levels.

E-commerce extends beyond product distribution. Insurance companies routinely use e-commerce for a growing number of the marketing functions that may pave the way for sales, including advertising, public relations, product promotion, image building, and brand management. For example, insurer websites provide information about companies, their products and services, local sales offices and contacts, community service activities, and other information. The internet and e-commerce have evolved into a primary vehicle for communicating with, and enhancing service to, agents, brokers, and customers.

Insurers are also relying on the internet as a cost-effective and efficient vehicle for transaction execution and customer relationship management, giving their customers access to secure websites for plan administration purposes. Plan sponsors can edit their group bills in real time.

Participants enroll in benefits using their employer's or the insurer's website, making paper communication and forms unnecessary while possibly creating an opportunity for the insurer to sell additional valuable products. Once enrolled, participants can obtain information on policy and account values, find providers or physicians, check on the status of claims, and download forms.

Insurers are not the only ones leveraging the internet and technology to market and sell products. Brokerage or agency websites, often supported by third party vendors with platform and technology expertise, may allow consumers to obtain rate quotes and proposals for various insurance products, including group insurance. Plan sponsors and individuals may have access to the products of several insurers to compare pricing and benefit information, while the brokerage or agency maintains its licensing for the states where proposals would be delivered. Firms failing to keep pace in the e-commerce space face an environmental risk of losing some portion of their customer base to more technologically advanced firms.

Beyond providing convenient access to plan sponsors and consumers for exploration, insurers and their sales and distribution continue to expand their use of analytics and machine learning to deploy the data they have to better understand, serve, and sell to their customers and prospects more efficiently and cost-effectively. Often with the help of third-party vendors, insurers and their distribution may use emerging software and platforms to provide actionable insight to customers and prospects. Such insights may include timely, customized content to drive increased customer engagement, retain enrollment in existing products, and promote sales of additional products.

WORKSITE MARKETING

Worksite marketing of voluntary programs tends to be like distribution methods already described. A broker is often involved, and sometimes the group field force may be involved, as well. Employees may receive information at their workplace in group meetings or via email blasts, which are often followed by an expression of interest and individual conversations to answer further questions and guide completion of the application. An electronic application for coverage, policy illustrations, and other marketing materials may typically be available.

Products distributed in this manner often include dental, vision, critical illness, short and long-term disability, supplemental term life, accidental death, and other supplemental coverages, typically 100% paid for by the employee through payroll deductions. Certain products that accumulate benefits over an extended period, such as group universal life and long-term care, are also effectively marketed through these product and enrollment specialists. Sales commissions tend to be higher than under the employer's base plan due to the expense of an enrollment team.

MASS MEDIA COMMUNICATIONS

The sale and distribution of products via mass media communications (television, radio, newspapers, publications, and direct mail) generally differs from group benefits because products sold via these mediums and methods tend to be individual insurance products. Products sold in this manner may include Medicare Supplement; simple dental, vision, or hearing benefits; cancer-only or critical illness coverage; hospital confinement benefits; accidental death benefits; and term life insurance, as well as property insurance. Mass media advertising for these

sample products often includes a creative branding to gain attention, such as a celebrity endorsement, fictional spokesperson, or memorable mascot. Insurers may link direct mail solicitations to use of a credit card or to membership in an association. There is no broker or group field force compensation because the insurer markets the coverage directly to the consumer. Significant marketing expenses are typically involved, with insurers often retaining separate specialty marketing firms for such distribution.

METRICS AND ANALYTICS

The job of insurance carriers is not done with developing products and making them available for distribution. Metrics (i.e., periodic measures to compare and track performance) for products in the market should be customizable to the situation. Metrics may include counting items such as tracking sales and retention against established goals as well as related sales measures such as call center contacts, website hits, and average customer time on the website. In the earliest stages of taking a product to market, companies may establish a monthly data report, known as a data dashboard, to summarize progress on established measures, with the frequency of such reporting possibly changing over time as the product matures and priorities evolve.

More advanced metrics may include benchmarking to track progress on critical marketing and sales processes (e.g., sales calls, follow-ups, lead acquisition, actual sales) against internal measurements for similar products or external market information that the carrier may obtain from public competitive information or independent sourcing or surveying.

Data analytics should also be situation-specific while commonly taking a longer-term view. Such analyses may quantify a version of return on investment (ROI) by comparing actual sales to the cost of different marketing and sales campaigns to estimate the company's actual cost of acquiring business. A company may measure the efficacy of specific advertising campaigns or use of certain distribution methods by comparing the costs of such campaigns or marketing funding to their accompanying sales.

Predictive analytics encompasses various advanced statistical techniques to analyze current and historical data to identify and project possible future outcomes. Carriers may use predictive analytics, in conjunction with robust reporting, to personalize campaigns and content to different audiences, identify and prioritize leads, and predict customer responses to promote cross-selling and to attract, retain, and expand their base of profitable customers.

SALES CHALLENGES: CHANNEL CONFLICT AND TECHNOLOGY

Two sales challenges may be ongoing issues for group insurers to consider and address:

1. The use of multiple methods and channels presents the opportunity for channel conflict among those methods and channels. Group insurers may need to manage potential conflicts by establishing rules of engagement and determining sales leads and

compensable parties. Such conflicts might otherwise emerge in situations such as the following:

a. The use of multiple distribution models to approach different size groups with individual or group products

b. The use of multiple distribution models (e.g., independent brokers, captive agents, and e-commerce) that may concurrently approach a group through various channels or contacts

2. The marketing and sales process may continue to evolve as technology changes, facilitating new ways of doing things along with greater efficiency and cost-effectiveness. With such changes, expectations from marketing and sales personnel, and the customers they are selling to, may also continue to evolve. The insurers who are well-prepared and positioned for such a dynamic environment may be able to better respond to the resulting competitive challenges and demands of their group clients and targets.

CONCLUSION

The marketing and sales of group insurance continue to evolve rapidly as employers strive to manage the costs, optimize outcomes, and sustain the competitiveness of their benefits programs while leveraging the emerging technology available. The ACA led employers to re-evaluate their benefit strategy alongside the social contract they have with their employees. Plan sponsors continue to weigh the costs and taxes of their benefit offerings against their ability to deliver such benefits in a cost-effective, program-sustaining manner, while engaging their employees in constructive dialogue about benefits, program costs, and possible alternatives. Economic performance, evolving consumer expectations, emerging regulation, competition for labor, ongoing demographic changes, and increasing technology needs and demands may all play a role in the evolution of the insurance industry.

As the group insurance landscape shifts and evolves, successful carriers must respond to these changes and define their futures by developing and executing their marketing and sales strategies. Regardless of the size, scope, or scale of the organization, all group insurance companies will identify their primary markets, create products to serve those markets, aim to satisfy and retain their customers, and push to achieve sales targets while managing the competition and conflicts that may emerge in striving for sales with the support and use of available and emerging metrics and analytics. The challenges and rewards are in the execution of the marketing and sales process and the corresponding management of accounts sold.

3 PRODUCT DEVELOPMENT

Andrea Sheldon

INTRODUCTION

WHAT IS PRODUCT DEVELOPMENT?

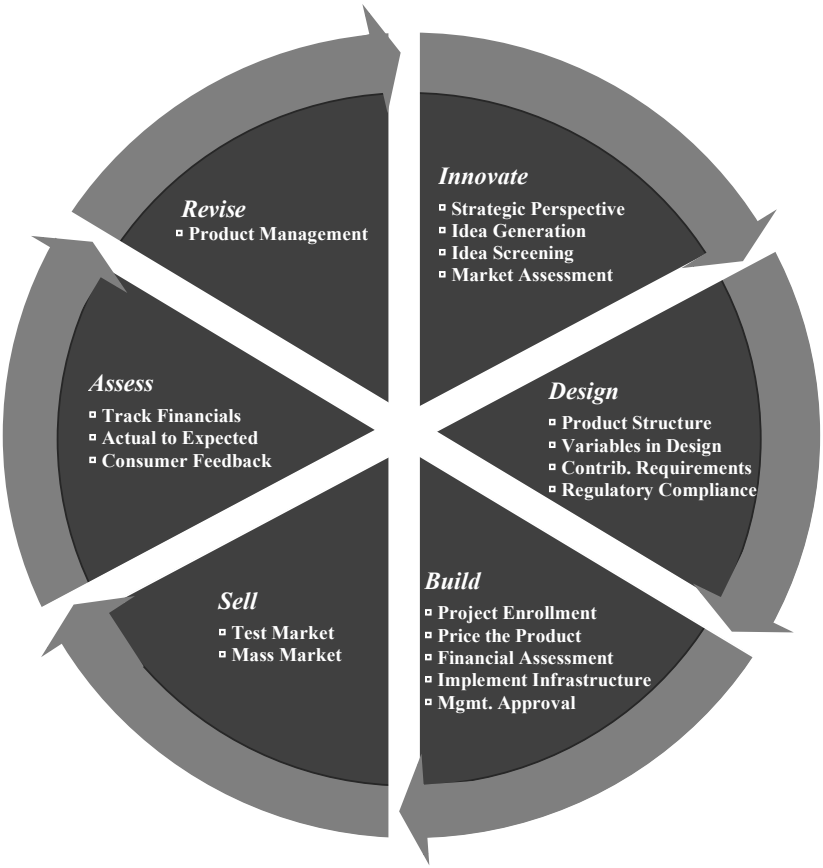
Product development is the process by which new products are created and existing products evolve. All products used on a daily basis are at some phase in their life cycles. At one point, each product was a mere concept. Eventually that concept evolved into a fully developed product that was brought to market. That product will evolve to adapt to a changing market, or it will risk being removed from the market and replaced with a better or less expensive new product.

The same general product development processes used for consumer goods are also used in the insurance market. While every industry, and every company within each industry, takes a slightly different approach to product development, this chapter explores the overriding principles that can be found in the typical product development cycle: innovating an idea, designing the idea, building the idea into a product, selling the product, and continually assessing and revising the product throughout its life cycle. In the context of this chapter, product development is not limited to the development of a new idea—it takes place throughout the entire life cycle of a product.

THE PRODUCT DEVELOPMENT CYCLE

INNOVATE

The first step of the product development cycle is the innovation of a new product or the next evolutionary stage of an existing product. The process of innovating is made up of understanding the company's strategic perspective, idea generation, idea screening, and market assessments.



Understanding Company's Strategic Perspective

The innovation of a new product begins with an idea. However, it is important to understand the company's strategic perspective before discussing and evaluating ideas. This goes beyond understanding the strategic goals of the company and includes understanding why the goals were developed. Understanding why a company has adopted a particular strategic goal will help the product development team better align its work with the goals of the broader organization.

For example, if a company's strategic goals include growing membership in the senior segment, it may be that this is a strategic goal because of projected growth in the senior population in the United States. The product development team would naturally be led to evaluate product needs in markets where the population segment is projected to grow. There is an ongoing shift in various population segments across different states driven by climate, state tax policies, and other factors that make some states more desirable than others for retirees. Understanding the strategic goals will lead a product development team to incorporate geography into its analysis of market needs and, thus, into the product development process.

Understanding strategic goals will also help reduce unnecessary work and focus the product development team on ideas that are aligned with company goals. If a company's overall strategy is to exit or de-emphasize a given market, then the product development team may avoid

creating and vetting ideas that would lead the company to grow in that particular market. If management within a company is considering a particular product, understanding why they are thinking about that product will enable the product development team to create ideas that align with corporate strategic goals.

Understanding whether the insurer would consider entering a particular market, whether defined by geography or product type, will provide direction for the product development team. This level of understanding will help define the parameters that are needed to narrow the potential scope of ideas and give guidance to the team members responsible for creating product ideas. Overall, it is critical that the product development team is informed of strategic corporate goals, so it can efficiently generate new ideas.

Idea Generation

Product evolution depends on the development of new ideas. Each of the following describes a common driver of product ideas:

Innovator or Follower: There are companies that successfully innovate, and there are companies that successfully follow the market. There are advantages and disadvantages to both positions. The company that innovates must invest in the development of concepts, while the company that follows can learn from their competitors by observing what works and does not work for the products that their competitors bring to the market. There are costs incurred by innovators that followers do not pay. On the other hand, the innovator will have access to a larger initial market since they will be the only company with a particular product (albeit for a limited amount of time), while the follower may lag behind the market and will not have the advantage of the initial surge from members attracted to a particular new product.

Changing Laws and Regulations: Compared to other markets, the insurance industry is highly regulated. For example, there are oversight bodies that regulate the pricing of insurance products, and there are laws and regulations that dictate the benefits that can be sold. While these rules can limit some product development, since products must operate within this tightly regulated market, this can also be the genesis of new ideas. When new laws or regulations are created, or existing laws or regulations are changed, products are developed to operate within these new sets of rules.

Consumer Demand: It is very important that companies remain attentive to the needs and desires of consumers. Companies interested in remaining competitive must constantly seek consumer feedback and market intelligence. If there is an element of a particular product where consumers are consistently providing negative feedback, this may induce a change in the product. If consumers are particularly happy with a component of a product, this may encourage growth in that area. There is an entire market of companies that are paid by the industry to seek consumer feedback through surveys and other outreach. The results of this research are used to shape future product development.

Marketing and Sales Demand: Marketing and sales teams have direct access to the market and are often aware of the demand from the market. They can spot gaps in the product spectrum where consumer demand is not being fully met. This insight may lead to new ideas. Incorporating sales feedback into the product development process is essential to gaining a comprehensive understanding of market needs.

Leveraging Insurer's Capabilities: While insurers are looking for ideas to develop new products and even acquire other companies to grow in new areas, product development does not necessarily need to encourage growth into new product areas. There are efficiencies gained by leveraging the insurer's existing capabilities. Product development teams will be more successful if they fully understand what the insurer does well and find ways of growing in those areas. For example, a dental insurer may benefit more from adding a new type of dental product than from adding a vision product to its portfolio. Consideration of the organization's strategic goals, and the prioritization of the opportunities that each idea presents, is necessary to determine which product better leverages existing capabilities and fits with the company's goals.

Competitive Advantage: Insurers often have a competitive advantage in one or more areas. The competitive advantage may be in a particular geographic area due to name recognition or within a particular demographic due to affinity relationships (for example, with retiree associations or military associations). Any competitive advantage should be utilized to its fullest extent and, thus, should influence product development ideas.

Technological Advances: Advances in technological capabilities create important opportunities for generating new product ideas. InsurTech is a broad name for technologies that are evolving the insurance industry. Insurers, startups, and venture capitalists are making significant investments in InsurTech with the development of innovations including products and pricing based on the use of wearable devises, predictive analytics, and artificial intelligence (AI). It is critical that product development teams understand, incorporate, and build on the insurer's evolving technological capabilities.

Social Need: Products are developed to address specific social needs. For example, the Affordable Care Act created subsidies making health insurance more affordable for lower-income citizens of the United States. Many companies have developed products to sell to this market through state exchanges. Medicare Part D is another example of product development originated by new legislation that was intended to serve social needs. Prescription drug costs grew from approximately 1% of health care costs in 1965 (when Medicare was started) to more than 15% by the early 2000s. Some seniors on limited budgets had to choose between food and the cost of their expensive medications. The social need for this coverage emerged from high pharmacy cost inflation and expensive new drug innovations.

Changing Demographics: With the aging baby boomers and people generally living longer, the demographics in the insurance markets are changing. Changing demographics means a shift in the types of products that will be marketable and saleable. Changing demographics can lead product development teams to generate ideas that address the shifting market needs.

Changing Economy and Financial Markets: Shifts in the economy and financial markets change purchasers' views of their need for insurance. Insurance products that do not appear critical may lose members during downward swings in the economy and financial markets. However, insurance products that purchasers believe will increase their financial stability may gain members. The attractiveness of a new product is influenced by the economy and financial markets; therefore, the genesis of ideas should be influenced by the economy and financial markets.

Idea Screening

Product development teams create many varied ideas. For the initial idea generation phase, teams may take the approach that no idea is a bad idea, which generates as many ideas as possible. One idea, perhaps not a great one, may influence the creation of a different, great idea.

After the initial surge of ideas, it is critical to begin screening these ideas for consistency with corporate goals, and for feasibility within the corporation's abilities while still meeting financial targets. A variety of processes can be used for screening, such as size and scope appropriateness, fit with corporate goals, resources and cost, or other filters that will help assess the feasibility of the product idea. A repository for discarded ideas is often a good idea, since the ideas that may not fit well today may be better suited for the future.

Market Assessment

Once the large list of ideas is screened down to a few that are worth pursuing further, it is important to determine if a market exists for the potential products. This is often referred to as a "market assessment" or "opportunity analysis." The market assessment commonly answers the following questions:

What exists in the market today? An analysis of the products sold both by competitors and the insurer in the target market will help the team to determine how the product fits in the market and identify the product's competitive advantage.

What is the product objective for the consumer? This analysis helps to determine if the product is meeting the needs of the consumer. If there is a demand for a particular product, the team should ensure that the product it is developing meets that need.

What is the regulatory environment for this product? This analysis will help the team understand whether the product features it is developing would be allowed in the market. It will also help the team understand whether the regulations that govern this product are expected to change in the near future in such a way that the product will not be feasible.

Financial value and other benefits for the consumer: Market assessments can help the product development team to better understand the financial value consumers place on the type of product being sold. This financial value will influence the price targets for the product.

Price Targets: Based on the market assessment, pricing for the new product may be an input to, or an output from, the product development process. There is a balance, or interplay, between price and product features. More specifically, a market assessment may indicate that a certain range of prices are acceptable in the market. The team may then use that range to back into a plan design (and product provisions) that meet profit targets at the given price. Alternatively, the market may be more sensitive to the product features. In this case, the team develops the desired product features, and then determines the price expected to make such a plan profitable.

Competitors' likely reaction: The market assessment will help the product development team understand how competitors will likely react to the proposed product. For example, if competitors are expected to follow up with a similar product, this may create a very price competitive environment that will impact the financial projections for the product and, thus, the product's feasibility.

Sales reaction: This stage of the market assessment determines whether the sales team thinks that such a product is saleable at the price targets. If the product would be priced out of the market, then it may not be worth pursuing further.

Each of these steps helps to sort out and revise ideas, until the decision-maker (perhaps the group as a whole) decides that one or more ideas are worth pursuing further.

DESIGN THE PRODUCT

Once the team decides that they are going to pursue a particular idea further, it moves to the design phase of the product development cycle. This phase consists of determining (1) product structure, (2) variables in plan design, (3) contribution requirements, and (4) regulatory compliance.

Product Structure

When a new insurance product is designed, the product team must consider how the product will work. It must decide on the features to be included with the product. In group medical coverage, issues like network size, network structure, and medical management will typically define whether a product will be a health maintenance organization, preferred provider organization, or some other type of product. In addition to the product type, a very important component to the structure is the inclusion of risk mitigation features. This can be especially challenging for certain types of group insurance products that have the potential for antiselection, such as voluntary dental coverage or products that offer coverage that is relatively rich compared to other insurance coverage.

Variables in Design

The team needs to analyze plan design options, such as coverage duration (very often annual) as well as member cost share. Cost share for group medical insurance could include deductibles, coinsurance, copays, and other cost sharing requirements. Defining the scope of coverage (whether and how to limit coverage in any way) is also considered in the design phase of the product's development. These variables help to refine the idea into a product that can be both marketable and profitable.

Contribution Requirements

The product development team must consider how the product will be marketed and sold. If it is marketed to employer groups, the team should decide if it can be a voluntary benefit that is 100% paid by the employee (which comes with antiselection risk), or if the employer will be required to contribute to the premium to reduce the risk. Also, there will be antiselection risk if this product will be one of various options available for the employee (for example, dual choice or multi-choice products). The team can create marketing and underwriting requirements around these options in order to manage the risk.

Regulatory Compliance

The new or revised product will not go far if it does not comply with insurance regulations. It is critical that the proposed plan and plan features be reviewed by someone well versed in the applicable regulations to verify that the product will comply. For example, guaranteed renewability of a plan is a feature that will make the plan riskier for the insurer, but it may be required for regulators to approve the plan. Also, the development team needs to be aware of minimum loss

ratio requirements or benefit mandates that may modify the plans for the product. Early discussions with regulators can often help the product team understand the requirements that must be met and prevent rework later in the process.

BUILDING THE PRODUCT

After the new product or the revision to the existing product has been designed, it is time to begin building the product. To build the product, the company must project enrollment, price the product, perform financial assessments, implement necessary infrastructure, and receive approval from senior management.

Project Enrollment

Once the product is designed, the team will estimate how many members will purchase this new or modified product. Projection of enrollment is critical to helping senior management decide whether the product is worth pursuing and can be sufficiently capitalized. It is also essential to estimate the volume of claims, as this will likely help determine staffing, reporting, and information technology (IT) requirements associated with the product. Primary market research, as well as surveying the market for similar products, may be used to assess the demand for the product.

Price the Product

There are many challenges associated with pricing a new product. Finding appropriate sources of data is generally a good place to start (for example, finding products with similar structure and design or finding a consulting firm that has appropriate data that can be used to price the product). Determining the necessary assumptions needed to translate the source data into a claim projection and selecting those assumptions are both important in this step of the process. Once initial pricing is completed, the marketing team should reassess its enrollment projection to see if a revision is needed. This is an iterative process, since the projected membership will impact pricing, which will in turn impact projected membership. Part of this step includes an assessment of the market price sensitivity for the type of product being designed.

The projected enrollment will impact the pricing, mainly because of the spreading of fixed costs across members. (Higher projected enrollment will result in a lower required price to achieve the same profit, since fixed costs are spread across more members). In addition, changes to the projected enrollment might imply risk selection, so antiselection must also be reconsidered. The product team must work closely with the pricing team to ensure that pricing and enrollment projections are consistent.

Financial Assessment of Product

Once the projected premium and projected enrollment have been developed, there are a few critical financial measures that a new product will be expected to meet or exceed in order for it to be implemented. Each company has different targets that must be met for a new or revised product to be pursued. A few common measures include return on investment (ROI), which is the lifetime projected profit from the product over the total investment required to build and sell the product; and the return on equity (ROE), which is the annual projected profit from the product over the amount of equity allocated to the product. The finance department is typically charged with performing this analysis and providing the results to senior management for

discussion and decisions. If the corporate financial objectives are not met by the projections, then the team must consider what would have to change to meet the objectives. The product must be revised, and these steps must be repeated with the revised product.

Implement Necessary Infrastructure

Before a product can be sold, the company must build the infrastructure necessary to administer the product. This includes the abilities to process claims, bill and collect premium, and service member inquiries. Unique marketing materials, website development, and revisions to existing websites must also be planned. Development of this necessary support may take time, and coordination is needed to ensure that the product release goes smoothly. The product team often oversees the efforts of a cross functional group that includes finance, pricing, IT, sales, marketing, compliance, actuarial, and other areas. Having their involvement throughout the entire product design process will often prevent unnecessary rework. Also, it is important that the company fully understands what needs to be built and the costs associated with this build, so that it can determine if it is worth the investment. That analysis is part of the ROI assessment mentioned above.

Senior Management Approval

Once all analyses are completed, senior management will decide if they want to proceed with the product. There are typically check points throughout the process, allowing for continuation if the results of each step of the process are positive and discontinuation if not. If ultimately continued through to full approval, then the company can begin building infrastructure, training sales staff, and preparing marketing material.

SELL THE PRODUCT

Once a product has been fully designed and built, it is time to begin selling the product to the market. However, in many cases before the product is offered in all markets, companies will test market. Test marketing is selling the product to a subset of the market. This is done to ensure that the infrastructure is functional, incorporate consumer feedback, refine pricing assumptions, and improve the product so that it will be more successful when the product is offered to the full market. Once the necessary revisions are complete and the company is satisfied with the product, the product will be mass marketed.

ASSESS THE PRODUCT

One of the most critical phases of the product development process is assessing the product after it has been sold. The insurer should track the financial results of a new product very closely. As soon as preliminary enrollment information becomes available, the insurer can assess the types of members attracted to the product. As soon as actual experience becomes available, the insurer can begin “actual-to-expected” studies. These studies compare how the emerging experience compares to what was expected to happen. These studies can indicate that a product was overpriced or underpriced. If the product was underpriced, a reserve may be needed to cover the unfunded liabilities. This is known as a premium deficiency reserve. Additionally, the sooner the actuaries realize that there is a pricing problem, the sooner they can adjust their pricing assumptions, so that ongoing sales are not bringing in additional unprofitable business. If the experience is emerging as better than expected, this may lead to a decrease in the price and an increase in the sales projections.