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MASS MARKETING OF INDIVIDUAL HEALTH INSURANCE

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- Section 125 products
- Impact of AIDS on premium levels
- Trends and problems in direct response
- New products
- Marketing of noninsurance services
- Claim settlement issues

MR. JAY M. JAFFE: The speakers today are Jim Daly and Dick Wille. Jim is Senior Vice-President at Celtic Life Insurance Company which is located here on LaSalle Street in Chicago. He is responsible for the individual health department. He has been in the individual health business for over 20 years. He started out as an actuarial trainee at Mutual of New York. Dick Wille is Executive Vice-President of Thomas L. Jacobs & Associates here in Chicago on West Monroe Street. His firm specializes in controlling claim costs for insurers, employers, and third party administrators.

MR. JAMES P. DALY: I'd like to cover many of the concerns that insurance companies have to keep in mind as they design and attempt to market individual health insurance products on a mass marketed basis. I will illustrate, by means of examples, what direct response marketing means, why an insurer might decide to use this as part of his marketing portfolio, how to design an appropriate product, what the correct sales message and technique for that product might be, and finally, how to evaluate the results of this direct response.

Celtic Life Insurance is very strong in the small group marketplace. We have, at this point, about $200 million of premium in small group health. The average size of each group is about three employees. We've just started into the individual health marketplace over the last couple of years. As a matter of fact, we didn't decide to get into direct response marketing on our own. The market pulled us into direct response through some other products that we had.

If you're thinking about getting into direct response marketing, you must have a good stomach for failure. In any industry where a 1% response rate is looked upon as a success, you know you're in for some tough sledding. Let's define what we mean by direct response marketing. We're talking about selling an insurance product without the physical presence of a salesperson, neither at the point of inquiry nor at the point of sale. As an insurance company, you would look to this form of marketing as potentially a strong way to boost your sales efforts. Celtic deals very strongly with agents, but we use direct response marketing as an additional way of generating some revenue and some good profits.

I'd like to explain how we first got involved in direct response marketing and describe one of the products that my division is responsible for. Celtic has been providing conversion coverage to large employers and other insurance companies. When an employee loses his or her group health insurance, Celtic provides that person with the opportunity to purchase a conversion health plan. Conversion plans are not very exciting insurance coverages. They tend to be very, very expensive,

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have limited benefits and have a very high loss ratio. Celtic is providing conversion insurance for approximately 400,000 active employees. When you consider that 15% of those people terminate in a year and are given the opportunity to convert to an individual policy, there are many people looking to buy health insurance coverage for a short period. When they were given the opportunity to convert, they tended to be somewhat dissatisfied. The opportunity to pay upwards of $2,500 to $5,000 a year for minimal benefits was not viewed as very exciting by the buyer. These potential converters, then, complained enough to us that we developed a new option them when they were losing their group health insurance. That option was a short-term major medical plan. These individuals could buy a plan for a period of one to six months, and it would provide excellent coverage at minimal cost. We would charge them anywhere between 50% and 75% less than what a typical conversion plan would be and generally about 40% to 60% less than what these people could get under their COBRA coverage. So, it was a very well-priced product. The downside was that it did not cover preexisting conditions at all; but, remember, it was offered to the people as an option. They could either choose their COBRA coverage, their conversion coverage, or this individual, short-term, major medical policy. We were lucky enough to find the first thing that is necessary in a good direct response program. We identified the market. We had this built-in market of converters, and they came to us telling us what they wanted. So, the first thing that you have to do is identify a market. The second thing that you have to do is develop the appropriate product.

There are four things that you have to keep in mind when you're developing a product to be sold on a direct response basis. The first and most important item is that the product must be simple because you don't have an agent there to explain what the product is. All you have is your sales literature. The product that we developed is called Transition Coverage. It has a very simple and easy to read brochure. We spent a lot of money on communications on this brochure because not only is this our sales literature, it also doubles as the certificate for the insured. The second thing that you have to do, again keeping in mind that you don't have an agent there helping that client make his choice, is to have a rate chart that makes it simple for a novice to calculate his own rate. After you have designed the rates for the product, hire a communications consultant to put your rates in a simple format. The third thing to remember is that you should have as few underwriting guidelines as possible. If you can make it a guaranteed issue product, make it a guaranteed issue product. We have four simple questions on the application to determine whether people are eligible for coverage. For instance, we ask them if they have any other hospital major medical group health or other medical coverage that will not terminate prior to the effective date. If they do have some other coverage, we do not issue the certificate. You have to be wary of anti-selection when you're talking about direct marketing to individuals. The preexisting condition limitation and your internal rescission rules are absolutely crucial when you're dealing with this marketplace. Finally, the fourth item is that the coverage must be affordable. As I mentioned, with this particular product, the individuals could save as much as 75% of premium versus their alternative of conversion coverage.

So, we've identified the market. We've developed an appropriate product. The third thing that you have to do is choose the correct communications. This is where insurance companies fail most often. Choosing the correct communications is absolutely crucial. With this particular product, it was very easy for us to choose the appropriate communications technique. It's called piggybacking. We had converters who were requesting information about their conversion insurance. Along with this information, we would send them this option. When you're able to piggyback an advertisement with some other communication, it's a very cheap and effective way to get your message out. Piggybacking is common when you send premium notices, claims adjudications, or a bill. There are many opportunities where you can piggyback communications with your present client base.

As you can see, Celtic was pulled into this direct response marketplace. Our clients told us what they wanted, and we developed a short-term major medical product. We then started considering other areas where we might use the product. One area that came to mind was the college graduate marketplace. As you know, college students lose their group insurance coverage when they graduate from school. They lose coverage under their parent's programs, so they are eligible for conversion insurance. We went after the college graduate marketplace with what we call postgraduate coverage. Postgraduate coverage is exactly the same coverage that we used in the conversion marketplace. It's just packaged differently. It's a short-term, major medical product. It covers the college graduate between graduation and commencement of employment or when he fulfills the waiting period. The college graduate has a need for this insurance. It was the same

short-term, major medical product that we had for the conversion coverage. We then tried to determine the appropriate manner of soliciting the college students. The first thing we tried is what we call the "take-ones." Take-ones are advertisements placed in a display or literature rack in a high traffic location. We learned that while take-ones are probably successful if you sell pizzas, they are not as successful if you sell health insurance. Then we decided to try direct mail, which I think is probably the most commonly thought of direct response tool. Direct mail is the most expensive form of direct response marketing, but it tends to be the most successful method of direct response marketing. Again we ran into a wall of not generating enough of a response to cover our costs. Then we did focus interviews to find out why the market wasn't buying the product. We found that the college graduate does not feel that he needs health insurance. It is very low on his list of priorities. He is not concerned about health insurance. His parents, though, are very concerned about health insurance. Our third approach used the direct mail technique. But this time we mailed to the parents of graduating seniors. This time we were very successful. We generated enough response to cover our costs and, indeed, to develop a profit.

In conclusion, direct response requires constant research and testing. You must accept that, at least initially, you may be unsuccessful. You have to concentrate on the market and truly understand your market. Don't make the mistake that we made where we thought our market was the college senior, and, in fact, our market was the college senior's parents. You must have an appropriate product. Let your marketplace tell you what product it's looking for. Then, evaluate the various direct response media opportunities. There are many opportunities; take-ones, piggybacking and direct mail. We have a call-in telephone system that we've used for direct response products. We've also used classified ads. There are many different direct response systems you can use. Try them on a pilot basis, set out your goals for each of your projects, and evaluate your success with each. Once you cover your costs, concentrate on increasing the penetration of your product in the various markets. Remember to keep the market and your method of reaching that market in mind. And, above all, stress simplicity.

MR. JAFFE: Section 125 plans are insurance and employee benefit programs based on the provisions of Section 125 of the Internal Revenue Code. Often these plans are referred to as cafeteria plans. The advantages of Section 125 to employees are:

1. the employee's contribution to the plan uses pretax dollars, and
2. the contributions made through salary reductions are convenient.

The employer looks favorably upon Section 125 plans because:

1. Social Security and other taxes may not be payable on the amount of contributions, which are the result of salary reductions, and
2. the plans fill in gaps in coverage for the employees, which the employer might otherwise be requested to provide.

There are two broad types of Section 125 plans. The first provides for salary reduction based on actual usage (a flexible spending plan) and the other uses fixed-premium insurance programs. It is the latter which I will discuss.

The various products, which can be marketed to groups of employees using the Section 125 approach, include term life and various forms of accident and health insurance. The A&H coverages may range from broad hospital/medical plans to limited coverage medical insurance such as cancer insurance and even to disability income insurance.

Section 125 rules have opened up an entire new marketing opportunity for payroll deduction types of programs. Granted, it is a concept which normally does not appeal to very small employers because of the record keeping requirements, but it can be marketed to companies with only 50 or so employees providing that the company's payroll system is automated.

In order to make a Section 125 plan offering fixed-premium insurance programs successful and attractive, the program has to: (1) provide for simple enrollment, (2) use limited underwriting, and (3) offer money purchase type benefits.

Since enrollment has to be efficient, the concepts of the program have to be easy to explain to employees who are usually granted only a limited amount of time to meet with plan enrollers.

Typically, enrollers are not highly trained insurance agents, so the program also has to be readily explainable to them. The use of limited underwriting will simplify the enrollment process and speed underwriting. The products don't contain margins for major underwriting, so in this sense, limited underwriting is necessary as well. Even policies of modest size should contain an AIDS question on the application to the extent permitted by the state in which the application is being taken.

Waiting period and other exclusions can be used in lieu of detailed underwriting questions. This approach may be the best practical way to keep the enrollment process relatively simple, but it can lead to misunderstandings at claim settlement time. However, if a company takes care to disclose the limitations of the contracts and is courteous and sympathetic at time of claim settlement when a claim may have to be denied, then the use of policy provisions as underwriting tools should be feasible.

Because employees are always concerned about the cost of the program, the money purchase type of presentation addresses what is on the minds of most applicants. Those employees who want larger benefits only have to buy additional units of coverage.

Section 125 programs are not unique. They are only a different way to market programs, which employees would normally purchase. The opportunity to market programs using tax advantages and an employer's endorsement often by using noncommissioned enrollers can make for a very successful undertaking by an insurance company.

The programs are usually designed for the bulk of a company's employees and not its executive staff. Of course, the enterprising insurance company would want to also have something available, which has more appeal for the upper echelon of workers.

Any insurance company active in this market must pay close attention to the IRS rules and regulations. Even small changes in the regulation may cause significant alterations to a Section 125 program.

TRENDS IN DIRECT RESPONSE MARKETING

The most obvious trends in insurance direct marketing are: (1) declining response rates, (2) increasing media costs, and (3) increasing marketing regulation.

The declining response rates are, in part, the public's reaction to receiving more solicitations than are needed for the market. Other possible reasons for declining response rates include changes in the Medicare laws, which seemed to fill in some of the perceived gaps in Medicare, but which also have confused the older age marketplace. In this same regard, the shear magnitude of American Association of Retired Persons (AARP) may also be constricting the older age market for companies that are not endorsed by the AARP.

The increased costs of postage, paper, advertising space and other items associated with insurance direct marketing are making it necessary to either have higher return or larger premiums per applicant in order to keep marketing costs to acceptable levels. It is not an easy job for a marketer to constantly be faced with always generating better results just to stay even with the marketing allowances, which we actuaries indicate are available in the products.

The direct response insurance industry is not coping well with the requirements of today's markets. The solutions to the dilemma are far from simple, and for some companies, they may not be able to survive under today's market conditions.

Certainly, using more sophisticated marketing techniques will be helpful. All too often I work with companies that continue to mail to market segments, which are known nonbuyers, yet these companies don't make the effort to purge those names from the file before mailing. The cost of the purging is usually cheaper than the cost of the mailing, so it makes economic sense to make the purging effort.

Companies are exploring ways to use new media. Television is used by several companies, and an increasing segment of the industry is becoming expert in using telemarketing as both an independent and complimentary marketing system.

There is a definite need for companies to create products, which will excite the insurance-buying public. The products we often see today are clones of policies used by other companies. Is it any wonder that response rates have headed in the wrong direction?

Insurance regulation is an area, which I find to be very burdensome in comparison to other areas of advertising. For example, it seems permissible for James Garner or some other personality to endorse red meat -- a product which may be unhealthy for many Americans -- yet Art Linkletter can't endorse an insurance policy. I don't quite understand why insurance seems to be the "whipping boy" of state advertising regulators, although I'm willing to acknowledge that there may have been a prior advertising campaign that could have been better prepared.

All of these points lead to the fact that there will be changes to insurance direct marketing. I predict that the number of companies active in this market will decline, and there will be a few new players including some of this nation's largest insurers.

MR. RICHARD H. WILLE: I'd like to make a few comments regarding the middleman and the fact that there are good, bad or indifferent issues to having agents out soliciting and "watching over" a block of business. In some respects, it's good that you have agents out there soliciting business and controlling the type of risks that a company is getting. However, when certain agents put substantial blocks of business on the books and then don't service them, or "play games" with the business sold, then you have more of a cost problem from an administration standpoint. I'm sure that many of you share a similar opinion. When you're in my side of the business, and you look at many different companies' administration departments (since we're involved with over 60 insurance companies), you occasionally see the same agent with problems that have gone from company to company creating administrative nightmares. We also do about 100 claim audits yearly, which really shows what's happening.

An important part of whatever you do is educating the policyholder or, when you are handling a claim, educating the claimant. To accomplish this, you must have clear policy wording, and all your brochures should spell out exactly what the policy is providing. What frequently happens is that we analyze the policy and the brochures being used, and many questions arise. This makes it much more difficult and expensive in administering the program. As a suggestion, let someone who is not in the insurance industry read the policies and brochures, and ask that person to give his or her interpretation. You'll be amazed as to what someone else will tell you what he or she thinks is being said in your policies and brochures.

The next issue involves basic claims processing. Without question, basic claim processing must involve using claim forms and clear, simple instructions on filling out claim forms, along with asking claimants to submit all information at one time rather than piecemeal. If you receive a claim and it is fully complete, it should not take 2 or 3 follow-up letters, which are costing the company $7-$10 to process. Instructions must clearly state that a fully completed form is necessary before processing. Giving the claimant an envelope to put bills in will help immensely.

The next most significant issue is the telephone. When questions are asked on forms and you need answers to issue a policy or process a claim, use the telephone. For some reason unknown to me, most claim departments or administration areas handling policies seem reluctant to use the telephone. According to our industrial engineers, the least expensive way to get information is to use the telephone. Finally, whenever possible, use the computer, rather than manual steps to handle a transaction. I don't intend to cover the full implications of this, but I think the computer could be used in terms of letter writing via specific formats; reports on productivity, quality and service time; payment detail given to a claimant, so he or she doesn't have to write a letter back to understand what the company is trying to do; etc. Somehow these things are being done manually, or "half done manually," and when you are dealing in direct response or mass marketed products, it is critical that you approach the handling of administrative issues with some basic computer direction.

TECHNICAL ISSUES

We now must proceed to the technical issues. The following areas cause many problems for administration departments, particularly the claim department. The first issue involves preexisting or rescission actions on the basis of an individual misrepresenting his or her health history on an application. An applicant may indicate that he has a medical problem, and the company proceeds to issue a policy; or, the company may review a claim and the individual has indicated a

history, and no action is taken. More frequently, the applicant indicates a partial history, and the company takes little or no action. However, I will limit my comments to those individuals who do not give a history, have serious medical problems and the company reacts by denying benefits, or in some cases rescinds the policy by returning the premium. In this area, I have a couple of suggestions:

- First of all, on any rescission I would return the premium along with some interest. This practice recognizes that the individual would have made interest on his money had he not purchased the policy. Furthermore, you're really putting the matter of the application back to "ground zero."

- The second item is that in a rescission, be certain that you have someone signing off from a Medical Department (or a physician consultant) and an attorney, before taking action of this type. Frequently, an adjustor will proceed and fails to note some specific information or only gathers "half the story" before really checking out the medical records, and all kinds of complications occur later on. In this day and age, litigation is very expensive and should be avoided particularly if you have a "clear cut" rescission to take on returning a premium to someone because he or she made misrepresentations on an insurance application.

- The third suggestion involves claim settlement difficulty. In direct response marketing, one of the big problems you have involves trying to settle with an individual without an agent being involved. This can be both good or bad. I find that most of the time, it's better to deal directly with the individual applicant/claimant. Personally, I always send a letter out advising someone that he or she cannot be paid. I then wait for the response either from the attorney or from the claimant before proceeding with a claim settlement process. The difficult question is when to proceed to an offer, rather than to get involved with expensive depositions, attorneys fees, etc. Measure what it's costing you. If $5,000 or less is involved, and you can get the policy back; it's frequently better to get the policy back rather than to go through the expensive litigation process, particularly if there are some facts that might be "clouding the water" on what was admitted or omitted on an application.

- The fourth item involves claim fraud. Without a doubt in this day and age, claim fraud is more and more an issue. I spoke at the National Insurance Fraud Organization the last two years on computer fraud in claims. What amazes me is how many companies have paid the same individual or group of individual, clearly involved with fraud. Companies must be alerted to people who purchase policies for gain and then have routine accidents causing extensive hospitalizations and periods of disability. Here are several tips that I would like to provide you:

  1. Be careful of many policyholders occurring in a rather small zip code area. This may be an indicator of "overloading."

  2. Be alert to applications and claims that come in with post office box numbers. Frequently, these people do not want to use their home to have mail delivered and will take out post office boxes.

  3. Be extremely careful with people who purchase your most expensive products and have "menial" positions. Frankly, they are probably going through a "loading up" of coverage.

- The fifth suggestion involves a claim appeal process. Most policies in direct response do not have a claim appeal process. If an individual has a question or problem in terms of how his or her claim was handled, he or she should have the right to a claim appeal. In this way, the consumer/individual feels protected.

  Frankly, the wording under ERISA legislation is quite good in this area and would be very effective to use in direct response policies. To me, this could be added to a sales approach so that, if the person had a claim and a questions arises, he or she has an appeal and reappeal process, rather than having all kinds of problems with litigation, depositions, and other inconveniences.

The final issue I want to bring up is what's ahead in administration. Without a doubt, administration issues in the future will involve telephone subscription or television marketing. Someone

once asked me about that, and I didn't see any particular problem from the administration side. However, there will have to be some sort of document asking someone to sign something before the policy is issued. Also a claim will not be able to be processed with television marketing, so this will not change what will happen except for us to become more efficient.

Paperless processing is a continuous issue. If you have any medical expense or you have to supply proof of disability, an individual will have to submit some sort of document to collect benefits. I cannot ever see us going to 100% paperless processing. Although I think we can make it easier for our policyholders and claimants if more industrial engineering is done to get documents processed.

Another item involves focus testing or interviewing. Frequently, focus testing, interviewing or surveys are done to determine whether someone will buy a product or not and what entices them to buy a product. For some reason, no one asked the people being surveyed what they think a company should do in terms of how a claim should be settled, processed, etc. I've only been involved with one company that in focus interviewing has gone to the point of saying, "If you have a claim, how do you want it processed or what do you want to happen, and what are some of the problems you've seen in the past in terms of how claims are being processed?" This is an important part of an insurance contract and somehow simply gets overlooked. Also, survey your claimants on policy wording, pricing, and servicing. They will give you more candid answers than anyone.

One last issue, a TPA in certain situations (like mass marketed products) can be very cost effective with proper controls, standards and administrative contracts.

MR. JAFFE: In the United States, three things are happening in the direct response market: (1) declining response rates, (2) increasing media cost, (3) increasing regulation. These are three of the things that are going on right now. Now, here is what's going to happen in the business: (1) there will be more sophisticated marketing; (2) we will use new media; (3) we will create new products. In the 1970s, we came up with some new media ideas. We started expanding on what was happening in the direct response business. In the 1980s we became more sophisticated in our marketing. The 1990s will be the era of new products. To help improve the situation, we must work for better regulation. I've never really understood why it was all right for a celebrity to get up and say, "I drive this kind of a car because it can go from zero to 60 in four seconds flat," but it's not all right for a celebrity to say, "I think this is a good insurance policy." That is something that can't be done. So, there's a double standard. I think we have to try to eliminate that double standard.

In Canada the situation is as follows. Prior to 1980 there were very few programs in direct response marketing. There was an Allstate Sears program. In the early 1980s the Citadel dealt with the Amex cardholders, and Continental dealt with the Shell cardholders. In the mid-1980s there became, as Anthony Borg put it, a sudden onslaught of programs in retail stores, petroleum companies, and even compiled lists. The last 18 months in Canada have seen direct response insurance marketing in the banks and other financial institutions. Apparently there's less regulation in Canada than there is in the United States. The products originally used in Canada were low premium, simple accidental death products. There have been some temporary disability and hospital plans in the early to mid-1980s. These have been very successful. Recently, the products have changed. In Canada, there have been more hybrid accident plans, Hopital Indemnity Policy (HIP) products with bells and whistles and even some life products with term, decreasing term and guaranteed issue. Average premiums for accident plans have been around $120; HIP, $150; life, $180. These premiums are less than those in the United States. The premium volume in Canada has jumped from $20 million premium per annum about 10 years ago to about $75 million to $90 million today. Anthony Borg feels that the potential in the marketplace in Canada is $400 million to $500 million. It is an environment, which we can remember in the U.S. back in the 1970s. It is a different environment than the United States has today with more competition and more materials going out to the policyholders. The marketing methods used in Canada are no different than the ones we've used here: solo direct mail, stuffers, newspaper ads, television, and some telemarketing. The problems in Canada, however, appear to be different. The problem in Canada seems to be in large part a lack of insurers who are willing to write direct response products. There is also a lack of qualified personnel. Anthony Borg perceives this to be in part because the companies in Canada don't see an opportunity in this business. Another issue that the Canadians face, is that materials have to be prepared in two languages. Now, this may start to occur more and more in the United States with both English and Spanish so commonly

spoken in certain regions of the country. In Canada it's English and French. Double-language ads cause the cost of mailing to increase because different copywriters are required. In the near future, more sophisticated life, accident and health programs, homeowners, automobile and umbrella liability products will be offered in Canada. Canada is an open marketplace at the moment. The window of opportunity, though, is limited. Anthony feels that the competition will continue for the next three to five years. After that, the prime lists will be gone. The situation there is reminiscent of what happened in the United States some 10-12 years ago. Regulation by the regulatory authorities is less severe in Canada than it is in this country.

MR. RONALD E. BACHMAN: Will you explain how the Section 125 would best fit into the small group market to cover deductibles and copay, and is anyone doing that with any success?

MR. JAFFE: I don't know if anybody is doing it with any success. It has to be presented as a supplement, perhaps as a way for an employer to reduce cost. One of the difficulties in small group plans that I perceive is the payroll deduction element because many small employers do not use automated payroll systems. I don't know how you would get the deductions made on a regular basis. If I wanted to market small contributory group health plans, I would probably go to some of the large accounting services and try to market the plans in conjunction with the payroll services that they perform.

MR. BACHMAN: Do you see potential if you had a high deductible?

MR. JAFFE: I think if you have a high deductible, you offer a hospital indemnity or some kind of specific accident coverage. It's a tremendous marketplace, and the employers like it. I can see that really being effective when you're dealing with the administration on the claim side.

MS. G. CHRISTINA DOWHANIUK: I was just wondering if anybody here has any success in selling individual disability income through direct response?

MR. JAFFE: One of the interesting programs I have seen is a combined individual disability and life plan on payroll deduction. It was a profitable product. I think there will be more disability programs sold through direct response than we've seen in the past. It's not an untapped marketplace, but it's a different marketplace. I think the programs have to be geared to specific markets. They have to be very carefully tailored. You can't just come out with mass mailings. I've seen most of those fail. So, some creativity is going to be needed. There are many claim settlement problems and a lot of overinsurance in those marketplaces. Disability income that is sold to association groups is done via direct response and has done very well. More noncancellable programs are being offered to associations on a discounted basis. By purchasing them through your association, you receive a 10% or 15% discount. They sometime have guaranteed enrollment. This is an area which has been successful.