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Hot Product Issues: Long-Term Disability (LTD) and Short-Term Disability (STD)

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Summary: The presentation will be given by the direct managers of actual cases under the new types of disability products, including managed disability, 24-hour coverage, and voluntary disability. In addition, it will lead to the awareness of current developments for group LTD and STD.

Mr. Thomas R. Corcoran: This session is intended to be a discussion of three of the hottest new disability products from a nonactuarial perspective. Our first speaker will be Bill MacLafferty. Bill is assistant vice president of group voluntary products at American United Life (AUL). He has 12 years experience in the disability and product environment. He is responsible for marketing, administration and profitability of their voluntary product line, which includes voluntary disability, voluntary term life, and voluntary universal life. His topic will be a product discussion of voluntary disability.

I will be the second speaker. I am a consultant with Tillinghast/Towers Perrin. I have 20 years experience in individual and group disability insurance, and I am chairman of the Disability Special Interest Group. My topic will cover managed

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disability and what employers want from a managed disability environment. It will provide a specific discussion of research that I have done into the total cost of disability.

Our final speaker will be Pam Saunders, who is president of the Disability Consulting Group. She has extensive experience in short- and long-term disability. Her firm specializes in product development and marketing intelligence and also underwriting, contracts, claims, and management of disability. Her firm is expert in managed disability and 24-hour coverage. She will be presenting an overview of current initiatives in 24-hour disability.

Our recorder is Laurie Fede. She is assistant actuary with ITT Hartford, working in reinsurance and pricing for private-label reinsurance of long-term disability.

Mr. William P. MacLafferty: I will be speaking about voluntary disability. I am an actuary by trade, but my current position is nonactuarial. I am product manager for our voluntary products. AUL is a fairly small disability insurer; however, our voluntary line has been quite successful and it is an interesting niche-type product that will be growing in demand and popularity. I hope I have some things that you can take back to your offices with you that will be of value.

I want to cover four areas of voluntary disability today. First, I want to quickly tell you "what" is voluntary disability. Many of you have voluntary disability products, either long term or short term, but different companies have different types of definitions, so I want to make sure that we are talking about the same thing. Second, I will give you some of the reasons for voluntary disability. We'll look at this from several different perspectives and see what the reasons are that a company would want to offer this product or that people would want to purchase it. Third, we will talk a little about who is buying it. I have some statistics from my company's block of business that will give you some things to think about. Last, I will touch on some of the biggest challenges in this market.

What I am talking about with voluntary disability is a product that is sold on a group basis, with the employee paying 100% of the premium. The premiums are generally payroll deducted, but the coverage works very similarly to traditional employer-paid LTD or STD. Some companies use a percentage of salary up to a benefit maximum, just as you are used to with LTD. Other companies will have a table of indemnity amounts, so if your salary is between two specified levels, you would have a maximum monthly benefit that you can purchase.

There are a few significant differences between voluntary disability and traditional employer-paid disability. With voluntary disability, the employees generally pay

100% of the premium. So the employer allows you to solicit their interest, but normally does not contribute anything to the cost. There is an enrollment process, because we have to explain to the employees what the product is about and why it will meet their needs. The enrollment process is much more elaborate than it is for the traditional product, so that is one of the challenges that companies need to figure out.

Voluntary products normally have a lower minimum participation requirement than traditional products. Traditional noncontributory coverage has 100% participation. Contributory coverage is normally 75%, but with voluntary products, the minimum participation percentages are usually in the 20–50% range. Very commonly companies will use 25% as a minimum participation requirement.

Another product difference is that these products are usually fairly streamlined from traditional coverage. Bells and whistles such as cost of living adjustments (COLAs), extended own occupation, and all sources integration are difficult to explain to the employee, and including them may hurt participation. That's why plan designs are normally of a plain, vanilla variety.

Let me touch on some of the areas as to why this is a product that can be successful. First, from an insurer perspective, why would you want to offer this coverage? Number one, there is a demand for this product. Employees are wanting to purchase disability coverage, and employers want to offer this coverage to their employees. They often do not want to pay for it, but this is a product that enables them to offer it without having to actually pay any of the premium. Second, it helps the insurer avoid what I call the commodity syndrome. I am sure a lot of you are familiar with the rate competition that we see in the disability arena. Voluntary disability is a product that offers value-added services through the enrollment process and the administrative process of handling payroll deduction. The insurer doesn't say, "here are the benefits, here are the rates," and then employees buy the cheapest plan. I believe that the insurer can truly add value to the coverage. Therefore, at the present time, this is a product that supports higher profit margins than traditional employer-paid coverages do.

Lastly, I believe this is a product that opens opportunities for other business. Whatever other lines of business you are in, whether it is group life or medical or stop loss or casualty or individual disability income (IDI) products, doing voluntary disability well will give you another entry to the market. You do not just have to be a company on a spreadsheet with ten or fifteen other carriers that do these products.

From the perspective of the salesperson, the agent or the broker, why would they want to offer voluntary disability? First, employers want it. LIMRA has done a lot of

studies in the voluntary benefits market, from the insurer perspective, employer perspective, and employee perspective, and I am going to use some of their statistics here. It is interesting that one of their surveys showed 45% of employers were planning to offer a voluntary product to their employees within the next five years. That has a big market potential, and 84% of employers who were planning to offer a voluntary product said the first person they would turn to for advice is their current agent or broker. If you are an agent and your customers want this product and they come to you and say, help me offer this and you are not able to, they are going to go to somebody else. I think it is important for the agent to understand that so he can increase his control over his client base.

Voluntary disability also provides an additional revenue source. Any new product that provides commissions to the salesperson is something that allows them to make money. Given the demand and the desire of the employers to purchase this, I think agents would want to be able to offer it.

Why would employers want to offer voluntary disability? It is a product that meets diverse employee needs. If you think about the origin of group insurance, group insurance came about in the 1950s and 1960s, and you had a fairly homogenous family structure at that point. You had the husband that went off to work and brought home the money and his wife stayed at home with the kids. It was like a *Leave It To Beaver*-type arrangement. We do not have that today. We have a lot of working women, and we have a lot of single-parent households. These people all have different needs. Younger people have employee benefit needs different from older people. The whole concept of voluntary products is to allow employees to purchase the coverage that they need the most. However, the employer, because of rising health costs, does not always want to pay the bill for all these benefits. Benefits eat up something like 40% of payroll, and this is the type of product that the employer can offer, yet the employees pay the premium and employers like that. It allows the employer to enhance his benefits package, and hopefully he will be able to attract and retain quality employees.

Finally, it helps the employer avoid difficult or potentially discriminatory paternalistic decisions. What do I mean by that? Let's say you run a 20-person shop and everybody there is like family. Joe, who has worked for you for 25 years, is in an auto accident. You know his wife, and he has kids at home. However, there is no disability program in place at your company. You are going to feel a very strong paternalistic feeling towards continuing Joe's salary. Meanwhile, you have to hire someone else to replace him, so this costs the company money. What's more significant than that is you have now set a precedent, so if someone else is disabled two years later you will be legally obligated to continue to pay that person. You cannot pick and choose who you want to continue salary for. With the voluntary

disability program, the employer can make the coverage available and not feel as guilty or as much of an obligation to the employees to continue their salary in cases of disability.

Let's move on now to the employee perspective. There was a time when very few employees understood the need for disability insurance, and there is probably still a significant number of employees in that category, but I believe this is changing. There has been a lot of education in financial publications. Think of all the sources of information you have now with newspapers, television, and the Internet. I think employees generally understand that they need disability coverage. They are protecting their most valuable asset, which is their earning power. It is important for them to be able to insure the risk of income loss.

Second, the employer supports the coverage. Particularly at smaller employers, the employees will trust it if it is something that is available. If an employer is allowing this to come in, and they support the offering of this product, then this is a good deal, and employees might feel the need to take advantage of it.

Third, whether we in the insurance industry like it or not, there is a general feeling of employees not really wanting to have contact with agents. Another LIMRA study on voluntary attitudes showed that when employees were given a choice of purchasing benefits through the work place or through an individual agent, 50% preferred to purchase benefits through the work place. Some 25% said they did not care and would purchase it from either source, and only 25% said that they would prefer to purchase it through individual agents. So this is a way that people like to buy their coverage. Finally, they get the convenience of a payroll deduction for the premiums. They can pay the premiums before they see the money, and it is a little less painful that way.

Let's look now at who is buying it. Table 1 shows some data from the cases sold by AUL during a recent 16-month period. This represents 139 cases that we wrote, and the first one I want to show you deals with eligible group size. These are the sizes of the groups that we have made the product available to and you can see that it is fairly evenly split between my four categories of size: under 25 lives, 25 to 49 lives, 50 to 99 lives and 100 plus lives. If you look at this table, you would think this product is something that is primarily offered to smaller employers, and I think that is right. Many of your companies probably operate in larger case markets than this. Think for a minute about the target group size for voluntary coverage. If the group is too small, there is a very expensive cost in enrolling the group. When someone goes out and explains the benefits to employees for a case of under 25 lives, it is difficult to recover your fixed expenses. However, on the other side, say

500 plus, most cases of that size already have traditional disability coverage and they are probably pretty happy with it, so there is not a big market there.

My conclusion would be that the 25 to 500 or 50 to 250-life case holds the biggest market potential. A lot of those cases do not have disability now and they would like to purchase it. Table 1 shows eligible group size. Remember though that participation minimums can be fairly low. If we look at this on the basis of enrolled group size, you will see that the size of enrolled cases is even smaller (Table 2). Nearly half the cases that we sold are for under 25 enrolled lives, and only 9% are larger than 100 lives. Again it is a small- to medium-size market.

TABLE 1
ELIGIBLE GROUP SIZE
(AUL Cases Sold 1/95–4/96)

Group Size	Percentage
<25	19%
25–49	34
50–99	22
100+	25

TABLE 2
ENROLLED GROUP SIZE
(AUL Cases Sold 1/95–4/96)

Group Size	Percentage
<25	47%
25–49	26
50–99	18
100+	9

As far as industry, it is my belief and my company's belief that a lot of white collar professional people are probably either insured by group LTD or they have been able to purchase individual coverage on their own. It is hoped a voluntary product will appeal to the rank-and-file, blue collar and gray collar employees, and some white collar employees too. I think the broadest appeal is to the rank-and-file employee.

Table 3 shows a breakdown of industries that have purchased the coverage, and I think you will agree that this is fairly diverse. A little over half are in manufacturing and services, which are very broad categories anyway, but I think this demonstrates that it is not a white-collar product.

The overall participation average for AUL during this period was 50%, but interestingly, the standard deviation of the participation percentages is fairly large. Nearly

half the cases that we have written have gotten over 60% participation. On the other hand, 21% got less than 40%. What are some of the reasons why participation varies so much? There are a lot of them, but I want to give you the three that I think are probably the most significant.

TABLE 3
INDUSTRY BREAKDOWN
(AUL Cases Sold 1/95–4/96)

Industry	Percentages
Construction	9%
Transportation	7%
Finance	10%
Wholesale/Retail	14%
Manufacturing	25%
Services	35%

Number one is employer support. If you go into a company and meet with their employees and they have the idea that their employer really could not care less whether they buy this or not, it will be just another meeting that they have to attend. They are going to sit through it and think about getting back to work; they will not buy it. The biggest factor in achieving high participation is getting strong employer support of the program.

The second big factor is the quality of the information provided to the employees. You cannot get up there and say, "Here is some disability coverage, buy it." The employees have to understand what it is they are buying. So giving a clear explanation of the benefits, how they work, and how much they cost is very important.

The third significant factor is the number of employer locations. It is very difficult to go into a school or a bank that has 20 branches or 20 different locations and be able to see all of the employees at each one of those locations. Obviously if you only see 60% of the employees, and 60% of these employees buy, you only have 36% participation. The more employees that you can get to attend at the fewest number of employer locations, the more employees that you will be able to see during the enrollment process.

Finally, I will touch on some of the biggest challenges. Many of these things are difficult for any company to solve. The first challenge is that this is a product that must meet diverse needs, but we have to keep it simple. I mentioned early on that different employees have different needs, so there is a desire to try to tailor-make different benefit options for the different employee needs. On the other hand, if

you get up there in the enrollment and you say here are the ten things that you can potentially purchase, people get so confused that they decide to buy nothing at all. So achieving that balance between a flexible product and a simple product sometimes is difficult.

Second, this is a product with a very different sales and enrollment process from traditional group coverages. If you are a traditional group writer with a sales force or a captive agency force or brokers that you work through, they have to undergo a paradigm shift in order to be able to effectively communicate, enroll, and administer these cases. It is much more complicated than traditional coverages.

Third, achieving and maintaining high participation is important for a couple of reasons. Number one, if participation dwindles, the expenses of administering the case get prohibitive. Second, antiselection is bound to set in at some point, and if you only have 10% of the employees signed up, you can bet that those are the 10% that plan to use your coverage. Being able to achieve a high participation level is very important to the product's profitability.

The fourth challenge is effective administration of a payroll deduction. Most of us are used to sending the employer a bill once a month, the employer pays it, and it is not a problem. When the premiums are payroll deducted, sometimes the paychecks are on a weekly basis, sometimes they are on a semimonthly or biweekly basis. People are always being added to the plan as newly eligible or terminating employees. Coordinating all the payroll deductions and making sure that you are getting the right premium for the right people at the right time is very difficult.

The next challenge is proper pricing. As I mentioned before, there is a danger of antiselection if participation drops, and there is also the danger of not being able to cover the additional expenses of the enrollment process and the administrative process.

The final challenge is renewals and reenrollments. Some companies will calculate rates for the group based on the people who are eligible, or they just provide a common table of rates that all groups use. When a case comes up for renewal and the experience is bad, or the participation is low, or the people who bought the product are all older people, or all females, or all highly paid, or all low paid, or all truck drivers, what do you do with the rates? Do you want to renew them at the same rate? Do you want to increase the rates on some groups and lower them on others to better reflect the risk? What do you do about reenrollment if the participation was 50% initially and then the next year it is 45% and then 40% or 35%? At what point do you send someone back in to explain the benefit again and enroll

more people? Do you take them with evidence or do you have a strong pre-existing condition?

These are all very difficult questions to answer, and will definitely provide a challenge, but I believe that with proper attention, we can overcome these challenges. I think this is a product whose time has come.

Mr. Corcoran: My topic is managed disability. There has been a great deal of talk about managed disability recently, but so far the talk has been a lot more about what people intend to do than about actual practices. Hard data has been scarce on what managed disability is and can do. This presentation looks at managed disability from a big picture perspective and tries to bring some hard data to the subject. Two specific issues that I will address are what large employers want and how to measure and define the total cost of disability.

The Antliff/Lachance study on group LTD profitability shows that LTD has gone from being a very profitable product to one that lost money in 1994 and one that made a very small amount of money in 1995.

I believe the disability environment is undergoing a paradigm shift. Long-term disability, which historically had high margins, no longer does. It has become much more difficult to realize the profit margins that insurance companies would like. Product-driven risk is becoming a commodity. The standard disability products are much more price-driven than they used to be, which is essentially the definition of a commodity. Disability management represents value added, and value added represents the opportunity to increase margins and to get back some high-margin business. This is why everybody is interested in managed disability and, I think, as is typical in the insurance industry, everybody is trying to differentiate themselves by using the same strategy.

I think most people have their own idea of what managed disability is. To give you a little bit of a background, people have traditionally looked at these products separately, both internally at the employer and externally at the insurance providers. Each one of these coverages has been handled by different people. There is lack of coordination.

A simple solution to managed disability is seamless disability, which is combining the short-term and long-term disability products. The idea is that you reduce long-term disabilities through early intervention; the fewer the number of people who make it through short-term disability, the fewer long-term claims you will have. You reduce short-term disability costs through more intensive management. Because you are saving the long-term disability costs, the payback is worth the cost

of the short-term intervention. Combining those makes a lot of sense from an actuarial point of view. Seamless disability is a strategy many companies have claimed they have implemented.

The next step that companies are trying is integrating workers' compensation and nonoccupational disability (24-hour coverage), and trying to capitalize on the best of both systems. This eliminates duplication of administrative services and it is a very hot concept in the industry. Right now there is very little of it actually in place, so it is difficult to tell how well 24-hour coverage is going to deliver what it seems to have the potential to do.

What I have talked about so far is the insurance company perspective of the market. What I would like to look at now is the employer perspective. The employer environment has changed dramatically. The primary concern of employers five years ago was the rising cost of medical care. With managed medical care, increases have slowed tremendously and medical costs are fairly stable. Workers compensation prices had the same issue. There were tremendous increases in workers' compensation costs five years ago, but with legislative and other regulatory and product changes, that has stabilized. On the other hand, the cost of disability is rising.

As everybody knows, economic changes have created much more stress and much less job security, and that has driven disability costs up. In addition, the same environment has increased the emphasis on employee productivity. From the employer's perspective, he or she has fewer employees due to rightsizing, so when any of those employees are out it has a greater impact on the productivity of the whole company. As a result, the employer's interest is becoming more focused on absence management rather than on claim management or reduction in claims. Employers are interested in keeping their employees at work and keeping them productive.

This leads to an increased recognition of the total cost of disability. Employers are not looking at their disability programs as stand-alone pieces anymore; they are recognizing that each of the pieces has an impact, and together they have a pretty big impact.

This presentation primarily addresses the large employer market. The principles apply to all employers, but large employers are approaching these issues first. What employers are saying is that they want their vendors to help them manage a very complex environment. They are not looking for a canned product solution, but are looking for a partnership to address the entire environment.

The managed disability market is evolving in response to employers' concerns. One of the clear issues for employers is that a claim-management model must demonstrate a value for the cost the employer is spending. That value needs to be measured; right now providers are just promising it.

I have already mentioned that processing-based capabilities are becoming a commodity. The value-added capabilities that employers look for now are being driven by technology, and would include things like data management, telephonic input, and paperless claims. Employers want the data captured once rather than several times. They want automated claim protocols, electronic transfer of information from the employer to the insurance company, and the ability to share information with other vendors and the employer.

Employers are demanding consultative and partnering skills from vendors. They like the relationships they have with their existing vendors, and they are demanding that those vendors work together, as opposed to having somebody new come in who promises to do everything. Large employers see 24-hour capability as something nice to have, but they see the real solution as being a consultative one. That raises some questions for the 24-hour product and how that is going to be received by the marketplace. Pam will be discussing that later.

This brings us to the total cost of disability, what is critical about it, and how big it is. Tillinghast has researched the total cost of disability, which has led us to the following conclusion: the total cost of disability is much higher than most employers realize—and the costs that are the highest are the ones that employers manage the least. The fact that the actual total cost is much higher than previously realized can create an incentive for action from the employer. To effectively manage these costs, employers need solid data. What they have had so far are rules of thumb and promises. The biggest problem with the managed disability marketplace, and especially the total cost of disability, is that very little is currently captured in the way of solid data.

Effective cost management also requires tracking all of the costs, because when you squeeze one piece of the disability environment, the costs shift to another piece of the environment. Measurement of cost-management plans has shown that employees have the ability to shift an occupational claim to a nonoccupational cause or vice versa, depending on what is being managed more closely.

Rigorous methodology is necessary for employer buy-in. To effectively address the total cost of disability, employers are going to have to create culture changes. Culture changes are very difficult to implement; to change culture you have to convince the employer and the employee that what is happening is necessary. That

requires very credible data. Also, company specifics make disability costs real. When quantifying costs that are subjective, the employer and employees have to be able to relate to those costs. They need to see that it is in fact their real cost, rather than an estimate, that they are addressing.

Moving to specific findings, Tillinghast has researched several large employers; what follows is the total disability cost of a specific large employer. We have separated total costs into three pieces for analysis purposes: (1) direct, (2) indirect, and (3) prevention.

Direct costs are the ones you are used to. These include benefits for short-term disability, long-term disability, and workers' compensation. Short-term disability, in this case, is defined to include sick pay, which starts from day zero. Most employers do not have any idea what their short-term disability costs are. In some cases employers start tracking short-term disability costs after the first week or two of disability. Although short-term disability is the biggest direct cost (1.8% of payroll), most employers do not even think about it. Employers traditionally look at long-term disability (0.5% of payroll) and workers' compensation (0.9% of payroll) and think of those as their disability costs, because those are the costs that employers measure and are therefore the costs that they see. Long-term disability and workers' compensation total 1.4% of payroll, only about half of the benefit piece of direct costs.

To further examine the short-term disability costs, Tillinghast created a sick-pay continuance table based on the experience of several large employers. This table is based on employers who have actually tracked their absences from day zero. The table showed us that over one-half of the cost of short-term disability occurs in the first week of disability. That is the period that employers never measure.

Most employers have accepted absences of a few days as a cost of doing business. What they say is everybody takes a few days off and there is nothing you can do about it. At Tillinghast we believe there are things that can be done, but employers need to first be convinced that it is a big cost and, second, be shown that there are things that they can do.

Next we researched disability-related direct costs. These fall into three categories; the first is the medical cost of treating short-term disabilities. What this means is that people who are on disability incur much more medical expense than people who are not on disability. This is no big surprise; however, very few people track their costs that way.

Second is the cost of benefits that are continued for people who are on long-term disability. Many employers, like the one we studied, continue medical coverage and pension accruals for disabled employees. Life insurance is continued under a waiver-of-premium provision. Although these are not usually considered costs of disability, disability is in fact what is driving them.

So far I have discussed disability-related benefit costs. The third component of direct costs is the cost of administering disability benefits. Administrative costs have two pieces. The first piece represents vendor fees for administering the short-term disability, long-term disability, and workers' compensation programs on an ASO basis.

The second piece is the amount of time supervisors spend managing employees who are out sick, rearranging work schedules, reprioritizing other employees' work loads, and dealing with employee performance issues. Absence is a performance issue, and dealing with performance issues is a very time-consuming process. Tillinghast quantified the amount of time that this employer's supervisors spent dealing with these issues and it turned out to be very significant. For this employer, that cost was 1.4% of total payroll. People do not usually think of 1.4% of somebody's time as a big deal, but 1.4% of payroll was equivalent to the combined long-term disability and workers' compensation costs of this company.

One of the most interesting facts that emerged in the process of performing this analysis was that senior management did not see absence as being as big of a problem as the direct managers did. The reason was that senior managers are not directly involved. The people who report to senior managers come to work all the time; senior managers do not have absentee problems. It is the first-line supervisors who have to deal with absentee problems, and they insulate senior management from seeing those problems. So the magnitude of these findings was news to senior management, especially the amount of time supervisors and managers spend trying to deal with absenteeism. It was not news to the supervisors, although they did not think of it as something that could be managed.

Now we will address the indirect cost of disability. The first aspect of the indirect cost of disability is the net loss in productivity of the remaining work force. This is caused by the fact that, when workers are out, the remaining work force has a loss of efficiency due to the fact that there are now gaps in knowledge. When your work team has four people there and the fifth person is missing, there are things that do not get done as well or that take much more time to do.

A second aspect is the loss of quality of the work product. Quality is not something people think about in relation to disability, but the fact is that when employees are

out who have a specific type of knowledge, the quality of the work product suffers. That has a measurable cost to the employer.

The third indirect cost is the higher cost of replacements. When you are dealing with hourly or nonexempt employees, you have to pay overtime for their replacements. For somebody to work the same amount of time, you are paying 50% more and usually it takes them 20% longer. If you fill in with temporaries, there is a very similar total cost pattern.

The indirect cost of disability is important to recognize because it is such a big cost. For the employer under discussion, it was 3.2% of payroll or equal to the direct benefit costs of short-term disability, long-term disability and workers compensation. What's even more important is it is a cost that the employer does not recognize. Some vendors have created rules of thumb to estimate indirect costs of disability; however, a rule of thumb is not something that an employer can relate to. To gain employer buy-in, you have to make the indirect cost real to the employer by giving him real examples from his own company of these costs. The employer has to believe it to take action on it.

We developed this number by modeling what happens when an employee is out. We needed to make cost development specific to the employer's work force; we needed to look at the type of employee and the specifics of their job and how the supervisor handles employees being out. In doing this, we put together a model that included four different responses to people being out. We used overtime and temporaries. We used overstaffing, which means hiring more people and having a shadow work force in anticipation that all these workers will not all be there at the same time. The last response is to just not do the work, which is a common response, because when a key person is out, nobody else can do their work anyway. People try to fill in, but things do not get done, and that can be the most expensive cost.

Also, we looked at the different classes of employees. We classified employees as hourly, clerical, salaried, management, and sales. The impact of absence by different classes is quite a bit different because their skills are different and the feasibility of replacing the work they do is different. Management people have unique skills; those skills cannot be replaced, and sales people have unique relationships, which cannot be replaced. If a sales person is out, not much selling takes place for a while, but after several months, there are no sales from that territory. Since sales people are supposed to generate revenue that is many times their income, the cost of a long-term absence can be very significant.

Another thing to look at is the duration of disability, because the impact of disability varies by type of job and by type of skill. Management and salaried employees are expected to make up their time, so if they are out for a day or two, they make it transparent. However, if they are out for two or three months, then it will have a very significant impact. Hourly employees are often replaced with overtime, and the quality of the work produced is not much different. The impact of hourly employees' absence over time is fairly flat. There is not much additional productivity loss for hourly workers when they are out two days versus out two months, because the skill is fairly easy to replace, even though it is done at a higher cost level.

All these issues—class of employee, response to absence and duration—can be combined with a disability claim continuance table to generate specific costs. It is a fairly complex process, but it is important to be able to explain to the employer where those costs came from. One of the things that was very interesting in the presentation to the employer was the high degree of interest in the specifics of how each number was calculated. The employer's staff wanted to see how specific jobs were reflected in the modeling process. They were initially skeptical. They wanted to understand how specific situations were reflected in the cost development, and when they did understand it they believed it. If you want the employer's staff to take action, it is critical to convince the employer's staff that the numbers are accurate.

Another major piece of cost management is that to be effective you have to measure the cost of things going forward. If you are going to promise employers cost savings, you have to be able to measure cost savings on the other end.

The last piece of cost to this employer was loss-prevention costs. Loss-prevention costs are essentially the dollars spent to reduce disability costs. These include parts of what the employer spends on safety training courses, ergonomics programs, employee assistance programs (EAP), human resource management, medical exams, and drug tests. There are many different programs, and they are managed in different places. They are not usually pulled together in this type of analysis because they are managed by different people at the employer, and the employer has never looked at them from the perspective of saying these are really to reduce disability costs.

The first piece of loss prevention is the cost of training courses and the trainers. The second piece is the cost of the employees' time spent attending courses. This is time they are not spending producing.

The employer we were analyzing is very safety conscious and loss prevention was a big cost. However, the costs were all spread out and the employer had never looked at them all pulled together, so he had no idea how much he was spending. He also didn't have any idea what benefits he was getting from those expenditures. Even though he was spending this money in order to reduce disability costs, at least for a large piece of it, he was not measuring if there was any relationship between the amount he was spending and the costs above.

In the end, we are talking about 13% of payroll. This may be the employer's largest benefit cost when you look at it on a combined basis, and this cost is increasing. Compared to the disability costs the employer usually thinks about, 1.4% of payroll, we are talking about a huge difference, and the opportunity for savings is much more than what has normally been addressed. Many of these are subjective costs and a great deal of work goes into pulling them together and measuring them. However, they are part of an interrelated environment. Each one of these costs affects the other ones.

The next question is what should the employer be doing about this. We did some additional research on that and came up with some additional statistics. Twenty percent of the employees use 80% of the medical and disability benefits. That is true of most things, but what is striking is that it is true across all the benefits. When you look at the 20% who spend the most on the disability benefits, they are also the 20% who spend the most on medical, the most on short-term disability, and they give the most performance issues. Tracking expenses across plans is very important. There is a strong correlation between employee performance and disability usage. This is a big indication that performance management is a major issue for managing disabilities; performance management is something that has to be addressed, but it is outside of traditional claim management practices.

There is also a strong correlation between socioeconomic factors and satisfaction with disabled status. What this means, basically, is that surveys of people with low advancement opportunities in their careers, i.e., hourly and clerical employees, especially with the existence of a home life, have shown that a majority of them are more satisfied with their quality of life after becoming disabled than they were before they became disabled. This is a huge issue, because it identifies that those issues are going to have to be addressed to have a major impact on some of these costs. Those are issues that insurance companies do not normally address.

The last point I want to make is not a major issue, but it does indicate the same thing. There is a strong correlation between the Family Medical Leave Act (FMLA) usage and disability usage. What happens is the people that use one program tend to use the other program. FMLA is great for people who are habitual disability users

because it gives them a new way to stay out of work. Because it is a federal regulation, most employers and most supervisors do not know how to deal with it. They feel they have lost control of the issues. There are ways to deal with it. They feel they have lost control of the issues. There are ways to deal with FMLA, but they are not traditional ways, and there are not good methods in place now.

What are the implications of all this? It implies that behavior modification, especially in the predisability phase, may provide the biggest payback in disability management. The hardest thing to do is change behavior, yet behavior changes would have the biggest impact on some of the costs you have seen here.

Measurement will be a key. These costs are difficult to measure and right now there are very few mechanisms out to measure even the direct costs well, never mind the indirect costs. That is an area where employers are looking for help. Insurance companies have not been successful in providing good measurement tools in the past, but that is going to be a big issue for employers.

You also have to focus on the high-cost factors. Clearly there is a core group of people who are using up the bulk of the costs. The things that drive this group's costs, i.e., performance issues, socioeconomic factors, etc., are not traditionally things that insurance companies have addressed. To have an impact on those things you have to start to bring new factors into account.

Insurers have traditionally concentrated on disability and postdisability management. Yet the data we have seen indicates that there are many predisability issues that are going to have to be addressed, and that may be where the value-added comes from in the future. This may be a big opportunity for actuaries and insurance companies.

Ms. Pamela J. Saunders: Many times we, at my company, go out and talk with companies about managed disability and are also asked to talk about 24-hour coverage. When we do that, our audiences very often become confused. They assume when you are talking about managed disability, you are really talking about 24-hour coverage, when in fact managed disability is, as we view it, and as many of the life and health operations that we have worked with view it, a step or a phase-in towards a fully integrated 24-hour program. Many of the concepts that Tom talked about are realized through the same paradigm shift and delivery of integrated or 24-hour programs.

We are going to talk about the concept of 24-hour coverage, what public activities are underway, private activities in the employer marketplace, as well as insurer and

managed-care-operations activities. We are often asked the questions, Is this real or is it just mirrors? Where are we headed from here?

Basically 24-hour coverage blends together coverages, eliminating occupational and nonoccupational distinctions, establishing a single point of service, including a managed-care wrap. In disability for the last ten years we have begun to try to more effectively manage our claims, and I would say 10–15 years ago many companies talked about processing claims. With this movement, we are seeing utilization of managed care concepts not only on the employee benefit side of the house, but also, as Tom pointed out, these activities taking place on the workers' compensation side of the marketplace, and blending in.

Additionally, we are seeing a streamlining of administration through 24-hour-coverage delivery, and systems that are set up to accommodate integrated programs rather than a single product line. We see the simplified claims process and a single point of service, teleclaim set up and everybody sharing the detail. If you have multiple operations, even within a single office, handling workers' compensation, the STD, the LTD, you are still coordinating, you are not necessarily integrating. In the meantime, others are actually setting up skill sets within a single individual for a region of the country or certain state where that individual covers all the aspects of occupational and nonoccupational disability and medical employer liability pieces that affect that coverage.

In addition, the bottom line is everybody is trying to contain costs. There are many varieties of 24-hour programs out there. The drivers, as we see them, have been trying to contain costs on the workers' compensation the house. The disability side of the house, for those writers who have an associated workers' compensation company, is seeking opportunities to take the managed disability concept from the employee benefit piece and overlap them with the casualty piece. We are seeing workers' compensation with managed care referred to as 24-hour coverage and little nuances as to how they handle that managed care concept. There's workers' compensation with accident and/or disease benefits, workers' compensation with managed care and employee benefit medical, and workers' compensation with managed care and employee benefit disability coverages. Then there is occupa-tional and nonoccupational medical, life and accidental death and dismemberment (AD&D), managed care, and ER ability, which is a more universal concept.

A couple of companies have combined the workers' compensation, the medical, the STD, the LTD and potentially life and AD&D for that survivor benefit coverage. The managed care overlaps everything. We found true efficiencies in managing STD and LTD through managed disability programs and now utilizing it even further,

through inclusion of the workers' compensation piece, which allows further containment of costs.

In addition, employers are required to pay for workers' compensation premiums. It is a mandated statutory benefit. Therefore, they do and have been doing for some time, everything they can to minimize their costs relative to return-to-work and disability case management. Employers are incorporating in their operations very aggressive safety and wellness prevention programs. We are now beginning to promote such programs on the group side of the house through managed disability operations of life and health. Group insurers have only recently begun to recognize the significance of these programs within employer operations, and are now attempting to employ those same programs within the employee benefit or nonoccupational plans.

The three different drivers of change are public, private, and benefit providers. From a public perspective, there are the insurance departments and regulatory agencies. These groups are very concerned about spiraling medical and workers' compensation costs, and their resulting increases in benefit costs. Additionally, the federal governments' nationalized health care initiative facilitated a more general acceptance of managed care. Therefore, the insurance departments and workers' compensation agencies are looking at opportunities to bring those managed care concepts into both the compensation and disability markets as well. They are looking for an innovative means of containing costs.

Let's discuss the private perspective. In addition to all these public initiatives and concerns that are driving towards 24-hour development, employers are concerned as well about the prospect of nationalized health care with one more mandate, such as the statutory nature of workers' compensation. They are convinced they will not be able to control those costs to any significant degree. Additionally, there are state-sponsored alternative programs, opt-out programs for workers' compensation, or alternative programs that allow the employers to do some unique things. The work environment and employee demographics are also driving change towards 24-hour coverage and overall control over benefit costs.

From the benefit provider side, expressed customer needs is the primary driver of what is happening with 24-hour coverage. In other words, I have been at a few of the NAIC and NCSL and other regulatory agency discussions on 24-hour coverage, and labor always comes forward and says that it is the insurance industry and consultants that are driving 24-hour coverage. In fact, there are a very large number of larger employers that are very clear on the fact that they are *not* getting what they want from the insurance industry; therefore if the insurance industry doesn't respond, they are going to take it into their own hands and do it themselves. As

such, we are seeing employer consortiums being structured, to bring together these programs for these large employers. Thus, it is our belief that 24-hour initiatives are also a private initiative.

On behalf of the benefit providers, these demands are driving their action. They want to be in better control, they want the insurer to play a bigger role in that and they are willing to make fundamental changes in what they do today to escalate these activities. Enabling legislation is also better positioning the insurance industry to approach 24-hour coverage. With such 24-hour programs and initiatives underway, that will allow a single contract to write all coverages of occupational and nonoccupational medical, disability and employer liability wrapped with managed care.

Market encroachment as well as market opportunity are very key to what is going on within the insurance industry. We are seeing managed-care providers coming in and purchasing up insurance shells. We are seeing property and casualty companies coming in and encroaching upon employee benefits, and we are also seeing the employee benefits marketplace encroaching upon property and casualty. Everybody is trying to protect their position and also seizing opportunities. The ultimate goal all are seeking is cost containment; cost savings and increased productivity, not only in the employer workplace, but also within insurance and provider operations.

I would like to review some of the initiatives underway in the public forum. Alternative workers' compensation programs are now structured in 22 states nationally. We have three states that offer opt-out and another 19 states that offer an alternative program for workers' compensation In addition, 19 of these 22 states have managed care workers' compensation combination programs in place. We have six authorized managed care pilots in place and actually only four authorized 24-hour pilots in place. What often happens in the marketplace is that we get confused about pilots in place and there are actually only four authorized 24-hour pilots in place. What is 24-hour and what is a managed-care initiative because of the fact that the managed care is overlapping both occupational and nonoccupational coverages.

Table 4 lists those states that are offering each of these programs so that you can see the representation nationally. We know also that three of these states, Texas, South Carolina, and New Jersey offer full, workers' compensation opt-out.

Table 5 outlines those states that are offering integrated or coordinated workers' compensation (WC) with managed-care (MC) programs. As you can see, there is a

significant number of formal or pilot managed-care programs in place and only a number of states are not known to regulate as yet.

TABLE 4
STATES OFFERING ALTERNATIVE
WORKER'S COMPENSATION PROGRAMS

Alabama	Nebraska
Georgia	New Jersey
Minnesota	Oklahoma
Louisiana	South Carolina
Missouri	Texas
Illinois	Utah
Indiana	West Virginia
Maine	Wisconsin
Massachusetts	Wyoming
Montana	

Table 6 shows the activity with both 24-hour and managed-care pilot programs. The four states that are doing the 24-hour pilot programs are Maine, Florida, Kentucky, and Oregon. Other states have in place only a managed-care pilot program, but these programs are offering the opportunity to do some things from both the employee benefits and the casualty side of the house.

There have been a number of studies conducted throughout the industry, and we are going to review some outcomes of those studies. From a private initiative or employer market study survey, the two largest and most recent we have seen that indicate opportunities for employee benefit disability writers are the Tillinghast/ Towers Perrin Reality Testing Survey, which was released in March 1996.

The second is the American International Group (AIG) Response Analysis Study, which was done on middle-market case size, 250–750 lives. The Tillinghast study looked at 686 responses of CEOs, risk, and human resource managers to determine what they were seeing relative to workers' compensation, and how that affected potential employee benefit costs. AIG's Response Analysis Study was of 300 employers, 250 employees each.

TABLE 5
STATES OFFERING INTEGRATED
AND/OR COORDINATED WC/MC PROGRAMS

Formal or Pilot MC Programs	Mandated MC	Not known to regulate MC
Arkansas	Colorado	Alabama
California	Florida	Alaska
Georgia	Nevada	Arizona
Indiana	Oklahoma (part)	Connecticut
Kentucky	South Dakota	Delaware
Minnesota	Texas (part)	Hawaii
Montana		Idaho
Nebraska		Illinois
New York		Iowa
North Carolina		Kansas
Ohio		Louisiana
Oklahoma (part)		Maine
Oregon		Maryland
Pennsylvania		Massachusetts
Utah		Michigan
Washington		Mississippi
West Virginia		Missouri
Wyoming		New Hampshire
		New Jersey
		New Mexico
		North Dakota
		Rhode Island
		South Carolina
		Tennessee
		Texas (part)
		Vermont
		Virginia
		Wisconsin

TABLE 6
24-HOUR AND SINGLE PROVIDER
MANAGED CARE PILOT PROGRAMS

California	Louisiana
Florida	Maine
Georgia	New York
Indiana	Oregon
Kentucky	Washington

In Tillinghast's study, they were looking at how employers were controlling their workers' compensation costs and most reported that workers' compensation costs have leveled off or dropped. The results of these decreasing costs are thought to be related to 24-hour coverage and what is going on within managed care. This might indicate that some of these actions taken relative to managed care and integrated management are resulting in cost containment or the controlling of costs within

these organizations. The employers attribute success as primarily driven by their own initiatives, and not necessarily due to state reforms and economic change. Substantiating this, 42% reported it was their own initiatives that impacted cost savings.

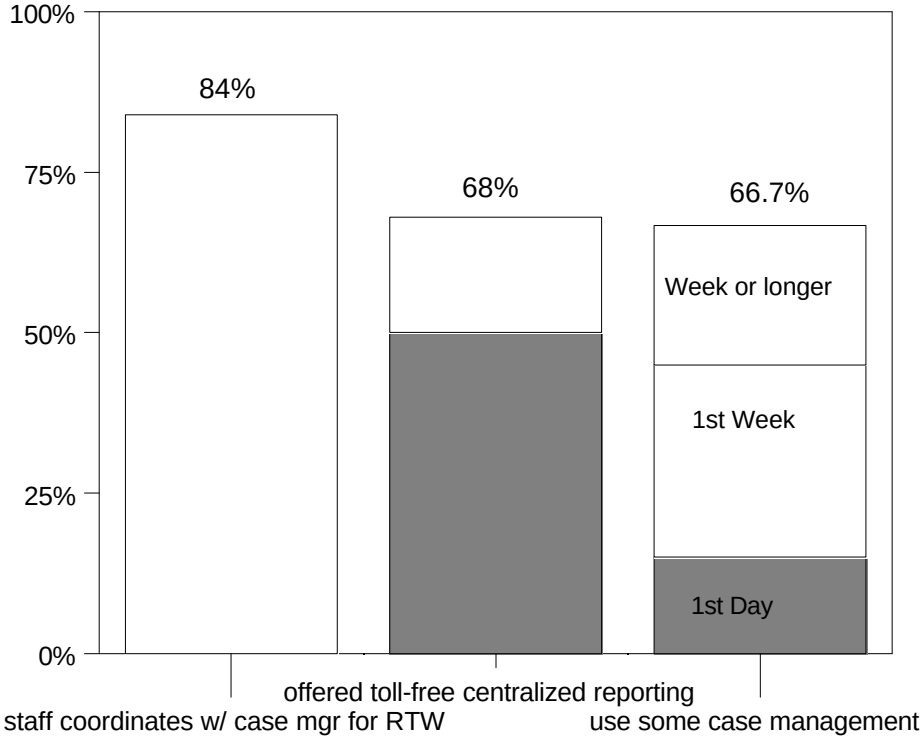
Furthermore, Tillinghast/Towers Perrin looked at the effectiveness of cost containment initiatives both at incident of claim and also during disability. Of the three primary areas "At Incident" (1) channeling to their preferred providers, (2) coordination with health programs, and (3) consolidation with STD/LTD programs, 74% indicated that coordination of STD/LTD programs was a primary driver in saving costs. Of the three primary areas "During Disability," early return to work was the largest contributor to controlling costs. Eighty-four percent reported that case management was viewed as more effective through utilization of clinical review, and 82% indicated utilization review was a primary driver.

AIG's Response Analysis Study also looked at workers' compensation costs and trying to manage down expenses and overall benefit costs. They concluded that the response from this study was consistent—extensive case management does result in a 30–40% savings, according to the employers they solicited. Further, those employers who were applying only some case management techniques indicated that they still realized a cost savings of 10–30%. These are very big numbers. Generally we've seen numbers more in the area of 15–35% depending on the size of the firm and the scope of the project undertaken.

The first bar in Chart 1 indicates staff coordinating with case managers on return to work (RTW): 84% of employers indicate this was a big driver. Sixty-eight percent reported Telecalls or telephonic notification of claims helped control costs. Others also cited case management at first day of claim. However, the majority indicated case management within the first week of claim. A week or longer was reported by the remaining respondents. The majority had a very aggressive first-day/first-week approach to claim management.

Some studies have been performed on the life and health side of the marketplace, as well as for property and casualty insurance and HMOs. Disability Consulting Group conducts an annual study, its LTD Rate and Risk Benchmark, which determines activities within the life and health marketplace and writers of disability. American International Group performed an HMO study to determine what was going on in the managed-care marketplace and the movement towards 24-hour coverage. Then Hewitt Associates Limited Liability Corporation conducted a health-value initiative this year.

CHART 1
AIG & RESPONSE ANALYSIS
MIDDLE MARKET CASE MANAGEMENT STUDY, 1996



DCG's study reports that 79% of life and health companies who are primary writers of disability in the U.S. offer some form of integrated group products. Of those, 87% indicate they are coordinating and/or integrating workers' compensation with their group products. It's very significant. We had asked the same question last year. There is a significant change for this year.

We also asked them such things as, what was going on relative to their overall program, how was it structured? Close to 35% said it was a 24-hour disability program; in other words, it was occupational, nonoccupational managed-care and disability, with or without the managed-care piece. Some referred to it as a 24-hour disability with managed care. We know for a fact that some of the ones in the first category were also including managed care, but did not report it on that basis; it is shown as reported. Companies also indicate 24-hour with managed care and did not indicate what the distinction was. We assume there is some disability in there. They had indicated that it affected their disability and the state equivalent to workers' compensation benefits. Rather than offer a fully integrated program for workers' compensation, some may be offering an alternative compensation product with their employee benefit disability pieces in managed care, then 24-hour medical, STD and LTD all wrapped with managed care. As you can see, there is significant activity going on in the life and health marketplace. Companies are

attempting to leap from managed disability concepts directly into the workers' compensation market.

We questioned participants relative to how they were split in administration/ operations. Fifty percent indicated that they are managing all coverage through their life and health operations, whereas another 50% indicated they are partnering with casualty companies.

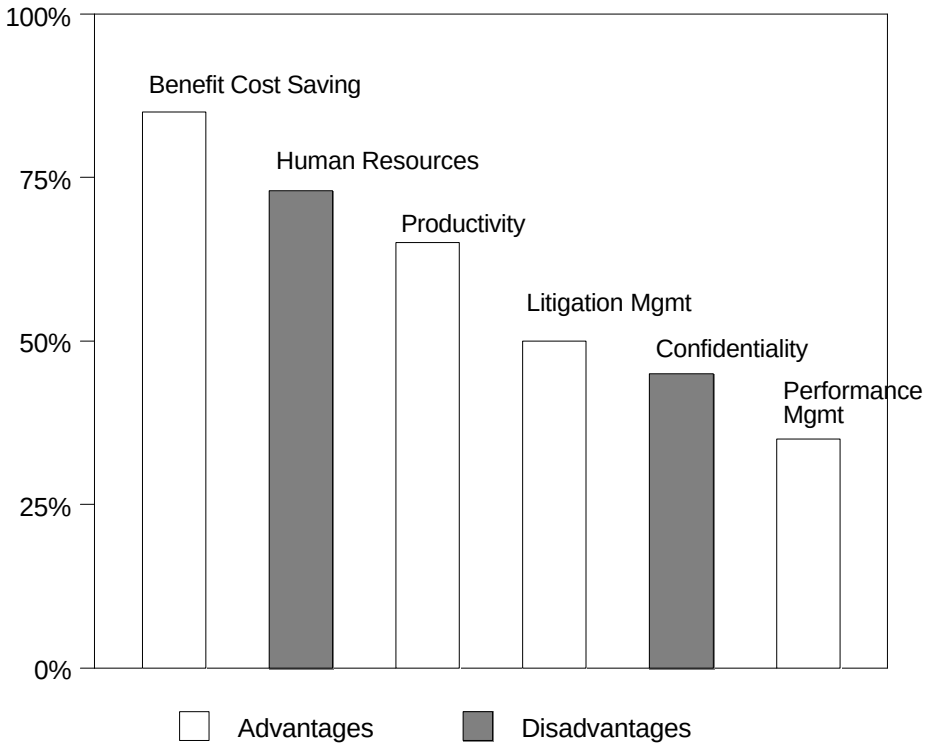
Relative to single point of services, we asked these same companies what they were doing for primary activities that are integrated today. One hundred percent of them indicated that case management and premium billing accounting were fully integrated. There's toll-free contact for claim management, and 84% of the companies indicated that they have integrated that process. In the area of issue of contracts and forms, only 50% indicated that they achieved integration.

The AIG HMO survey performed in mid-1995 indicated that 85% of managed-care providers believe that they will be a major workers' compensation medical provider within three years. So significant change is planned. We are seeing them not only move over from employee benefit medical to disability employee benefit pieces, but also moving the other way into the workers' compensation marketplace. They are trying to more effectively structure themselves to pick up and be able to write that business themselves.

Drivers have changed for HMOs. Seventy-five percent report that the cost advantages of a 24-hour coverage program outweigh the risk of integration; they feel that benefit cost savings and productivity gained will be their primary drivers moving forward.

Chart 2 indicates what employers perceive as the advantages and challenges moving forward with 24-hour coverage. The white bars indicate the advantages; the black indicates the challenges for them. Most indicated that benefit cost savings is what is driving their activities towards integrated programs. Productivity was very high as well, and so was litigation management relative to workers' compensation. Companies report that roughly 25% of workers' compensation benefit costs are paid towards litigation. What's driving down those costs is the setup of programs such as some implemented in 24-hour pilots; such as the requirement of equal benefits, not necessarily exact benefits.

CHART 2
EMPLOYER PERCEIVED ADVANTAGES/CHALLENGES



You can take some of the realistic management techniques and language that we have in employee disability products and incorporate them into a workers' compensation statutory program under the pilots, as long as what you are doing is not viewed as taking something away but rather replacing it with something better. For instance, in the programs we have written, we might take the definition of disability under workers' compensation, which is extremely subjective. We pull over a strengthened definition and language from employee benefits, and then in turn give the return-to-work incentive benefit. The insurance department views this as a positive means of providing an incentive for people to return to work. Thus, we're bringing down overall costs. There are some unique things that you can do relative to 24-hour coverage within these pilots.

On the challenge side, all recognize that human resources will be a challenge. We see the distinction between risk managers handling the workers' compensation piece and the human resource people doing the employee benefits. Bringing that all together is a major hurdle. They are also concerned about confidentiality relative to their employees and making sure it is maintained.

The Hewitt Associates Health Value Initiative was recently conducted and released. It reported that if you look at HMOs nationwide, wherever you tend to have the

greatest penetration of HMO activity, you seem to also see the greatest cost effectiveness of the HMOs. In addition, what they saw nationwide (approximately an 18% savings) is that HMOs are more cost effective than are traditional indemnity plans. They went a step further in point-of-service plans, indicating these organizations were not as effective in managing care. HMOs were 16% more effective than the point-of-service in this study as well. HMOs perform better than PPOs and POSs. This was concluded because of the fact that HMOs influence clinical management and utilization costs. Relative to disability, the clinical management piece is the key. What we are trying to do is through change in integrated programs.

What parts of the country were not only greatly penetrated, but more cost effective relative to HMOs? Not surprisingly, the west, northeast and southeast have the greatest penetration of HMOs today. They also found out what key urban cities had the greatest cost savings and effectiveness under an HMO program. They tie in with these key areas geographically. The cities were:

- Miami
- New York
- Los Angeles
- Dallas
- Cleveland
- St. Louis
- Houston
- San Francisco
- Tampa
- Chicago
- Washington

Is it real or is it a mirage? What we are seeing is that if you are in it every day, it is so real that it is incredible. We subscribe to a number of different publications. We talk with property and casualty, life and health and managed-care operations every week. We work with the insurance departments. We have set up contacts and relationships within both life and health, property and casualty, and the 24-hour groups within the insurance departments. There is so much activity going on that the states are looking at grants to help them structure their departments to accommodate it. The Robert Wood Johnson (RWJ) Foundation has set up more money to help the states establish their programs because they do not have the money to set up new departments. RWJ has, to date, given three states grants to allow them to do so, and they are looking at others as well for this year. They have also set up evaluation programs within states and in general for such initiatives so that outcome measurement can be had and quantitative analysis performed relative to cost effectiveness.

Relative to all private and public insurance, there is a great deal of activity going on and a number of programs are growing and moving forward. Participating companies are now beginning to be able to build data and to connect that data by performing effective analysis on them. Employers are more aggressive in that area. The insurance companies, because of the large bureaucracy of our corporations, are having a harder time. But some companies have done so as well and taken steps to fully integrate. We are seeing a great deal happening there. Managed-care organizations, employers, and insurers are all able to begin to measure out savings and are looking for more effective ways of managing data and understanding that data.

Table 7 shows a time line for activities that relate to 24-hour coverage integration. In the six years of this decade, what activity has taken place is significant and overwhelming. We have been talking about the concept of 24-hour coverage in the industry for years. I remember when I first came into the industry some 20 plus years ago, during a product brainstorming session, we considered how great it would be to come up with a product that would be all inclusive of all benefits, rather than distinguishing between on-the-job and off-the-job. Many of us have had similar thoughts, and now we are starting to see it happen. In the early part of the 1990s, we saw a movement towards 24-hour coverage, but it was still within P&C and L&H line constraints. We tried to better understand what all the coverages meant, and how the employer participates in managing those coverages.

TABLE 7
THE 24-HOUR EVOLUTION

Early 1990s	1994–96	1996–97	1998 and beyond
By Line	**"Coordinated"**	**"Integrated"**	**"Integrated"**
WC Medical/Mgd Care Disability Life	Proposal Pricing Policy Billing Care Mgmnt Systems	Care Mgmnt Systems	Proposal Pricing Policy Billing Care Mgmnt Systems

As we move into the mid-1990s, to 1994 through 1996, we have started to see coordinated programs relative to proposals, pricing, policies, billing, case management and systems. As we move into 1996, we now are seeing fully integrated programs relative to case management and care management, as well as systems that are now fully integrated. As we move beyond 1996, and over the next three to five years, we project that plans of life and health, property and casualty, and large employer groups, as well as managed-care organizations will become fully inte-

grated in all aspects of service relative to the delivery of workers' compensation, employee benefits, and medical and disability coverage.

Relative to true 24-hour coverage, we look for fully integrated care management through loss prevention, employee assistance, earlier knowledge of the event and expanded knowledge of the event, multiline case management, which is integrated, and multiline vendor support. Activity has taken place relative to all coordinated or integrated programs. On the life and health side of the marketplace, we have seen most significantly ITT Hartford, most recently adding to their product a medical piece. They have been testing different concepts of coordinated and integrated disability and employee benefit disability pieces for STD and LTD with managed care. They are also overlapping that with their workers' compensation. They have now set up a coordinated, fully integrated model office. It has only been a month since they began working with HRM (out of Indianapolis). HRM supports the medical aspect of their product that allows them to integrate the program and offer universal 24-hour coverage.

UNUM and Zenith have been working on the west coast with a single point of coverage product, which is a coordinated product. They have set up a model office, but within that model office are individual case managers relative to the various functional line or functional product lines that are managing that process. We have not seen activity on the East Coast. As I am sure most of you are aware, U.S. Health Care was a company that UNUM was looking at aligning with on the East Coast, until the Aetna deal came through. We in Portland have just heard over the last month that UNUM has hired eight workers' compensation case managers to work in its home office. It looks as though they may be trying to do a more national approach to their managed employee benefits workers' compensation, as well as the program with single point.

In addition, CIGNA and Intracorp are working together in their new integrated benefits service office out of Dallas. This is a fully integrated claims service operation, with clinical nurses taking phone calls relative to submission of claims on workers' compensation, employee benefit disability. Intercorp is packaging the managed care for all aspects of the product.

CNA has a similar product to one that CIGNA is offering, which is an integrated disability employee benefit piece with the workers' compensation, working with their own workers' compensation operation to provide the managed care. To my knowledge, CNA has not as yet set up a model office to manage those claims within a single location.

Aetna was very actively moving forward with their casualty operation and their Aetna health-care operation, working on an integrated program. With the sale of their property and casualty business, they have put out requests for proposals (RFPs) to bring in a workers' compensation carrier. To my knowledge, that has not been confirmed as yet. Now with the acquisition of U.S. Health Care, they have a major, managed-care component to bring together with their employee benefit health and disability components.

MetDisability and United Health Care have been working together on intermittent programs that are brought to them by their in-force employers or through brokerage consulting. To my knowledge, there is not a fully structured model office, but plans are underway.

On the P&C side of the house, again ITT Hartford, through its P&C operation, is driving this change in working with their employee benefits. Zenith is working with UNUM and is also doing some other things out on the West Coast in California, etc.

Kemper National has been very active in different pilots of managed care and 24-hour coverage and partnering with managed-care companies to wrap that coverage around their workers' compensation.
Liberty Mutual, from the workers' compensation side of the house has been very active. We have heard a lot of discussion about the potential of bringing in the employee benefit piece and they are testing some things, but we have not seen a great deal of activity on the L&H side. It is more managed-care wrap with the workers' compensation to date.

Reliance National is a compensation carrier out of New York who has developed a "Virtual 24" product, which they view as the main component to cost savings for a 24-hour program. They have added the employee benefit disability STD and LTD to their compensation and a managed-care wrap that overlaps everything with a single point of service.

The managed-care operations are driving change too. There is a great deal of activity there.

Relative to fully integrated systems management, we are looking for first notice of claim to all parties. In other words when the first notice of claim is required on workers' compensation, which is done within five to seven days relative to different state mandates, that medical information is being shared across lines.

The bottom line is that 24-hour coverage is no longer a mirage; it is real. There are cost-containment opportunities, and tomorrow's market may demand some form of integrated program.