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Alternate Delivery of Disability Coverage

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Summary: Panelists discuss nontraditional disability delivery approaches and competitors for insurance companies in disability management. Nontraditional delivery will include direct marketing, banks, Internet-type services, etc. Competing managers will include health maintenance organizations (HMOs), management consulting firms, etc.

Mr. Stephen M. Maher: I work at The Hartford. I'm responsible for a couple of different areas, one of which is the group reinsurance plus area, which is basically group reinsurance for primarily life and disability products. We also do back room services, so we act as the manufacturer of the product and distributor of product in most company's names. Another area we refer to for lack of a more creative title, as strategic initiatives is where we have put together some joint ventures and done some acquisitions. It's in those two areas that I've had the pleasure of working with these four gentlemen on the panel.

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Darnell Dent is president of QualMed Health & Life Insurance Company. QualMed markets many auxiliary products through the HMO field force. Dale Johnson is senior vice president of Union Central Life Insurance Company. Union Central distributes disability products through a number of means, but Dale is going to talk specifically about the association marketplace. Tim O'Donnell is division president of Health Risk Management Inc. (HRM). HRM markets a combination disability and workers' compensation product, which is actually a product he co-markets with The Hartford. The Hartford does the long-term disability (LTD) side and the self-administered compensation side, and HRM handles the medical management and the clinical management for the LTD. Rich Zenker is senior vice president of Liberty Life Insurance Company; in addition to traditional marketing methods, Liberty Life markets their disability products through banks. Margaret Sullivan, who is responsible for all the dirty work that has to be done after this session, is the recorder.

Mr. Darnell Dent: I have been associated with managed care for 12 years, and I don't need to tell you that almost everyday when you pick up the newspaper you see that there's some major acquisition or merger that is taking place in the managed care arena. A major consolidation is still underway. I'll draw parallels between what is taking place in managed care and what has happened on the technology side.

If you go back 10 or 15 years there were little high tech shops, chip makers in Silicon Valley. We had the personal computer (PC) revolution going on. The Apple computers and IBMs were battling, and if you look at those same companies now, you'll see they have aligned with each other. The Power PC was a project that was done between IBM, Apple, and Motorola, and I understand that Motorola now is going into the PC business. If you look on the chip side of the house, many of the semi-conductor firms, in order to compete against the Japanese, aligned with each other and found creative or nontraditional ways of doing business, as opposed to manufacturing a product on a separate stand-alone basis and going out to market share.

I draw that parallel because the same thing is happening in the insurance arena, especially in the managed care arena. In the past, managed plans were very regionally based. One HMO would support one particular community, and that was the niche product. It was either a capitated model, or a fee-for-service model, or some mixed model in a given community. About ten years ago, you started to see these local health plans starting to move beyond their borders and to formulate multilocation communities even if it's the same state. A book was just released called*, Mission Impossible*, co-authored by Ken Blanchard of *One Minute Manager* fame. It says, "companies have to focus not only on today and continue to improve,

but they have to have an eye on the future." And that future, they said in the book, involves creating what they call *new core competencies.* In the managed care arena we have the core competency of managing the delivery of health care. At the same time, we recognize that the marketplace is changing more rapidly than we can ever keep up with—we have to seek new avenues and create these new core competencies.

With that introduction, I've listed a few reasons why managed care companies are seeking these new arenas, especially in the disability management arena. The first one I'll note is the name of the game in managed care—it's market share plain and simple, and that's why you've seen all the different companies and combinations. These huge companies are being created by consolidation, acquisition, or merger, because it is a volume game. There is leveraging the providers, and leveraging to build these networks, and he who has the market share rules. It is not only a game of market share, but it's also a game of increasing market potential, because what you do for a provider today is no longer going to last much beyond a few months and this always happened to drive more patient volume through the system.

The second reason, and this goes back to my opening comments, is the fact that the market is changing. In *Mission Impossible*, Ken Blanchard says, "The change is taking place at a killingly rapid pace," which is a new twist of the word for me, but it is true. I think each of you know that in the insurance world, things move relatively slowly. In every three to five-year clip there may be some new intervention. I promise you that is now closed in, and every six months there's a new product, there's a new player, and there's always a new twist. Because of these constant changes to stay competitive and to keep that edge, the managed care companies have moved and migrated to more from managed care to what we are now calling care and benefits. We view ourselves more in the vein of not only providing quality health care, but in the arena of doing more of the employee benefits. My company started seeking alliances and looking for new product entrances. One of the affiliations that we have with The Hartford is to get into the disability market. What do we bring to the table? We bring the expertise of care management of the delivery system. There's one secret weapon, and that weapon is called data. With medical data, we are able not only to offer our customers the quality of care that they seek from a typical managed care concern, but we're also to get involved in the earlier intervention, if you will, in the case management of the disability. We're seeking ways of capitalizing on that.

The third reason, which is a very obvious reason in our business, is shrinking margins. When I entered the managed care business from the insurance side the HMOs were boasting about 8–12% margins. In some cases, companies were

getting as high as 15%. That is no longer true. We would be happy if to seek out 3–4%, and that's still better than some of the other lines of business. The margins are shrinking; therefore, companies are seeking ways to expand and increase margins.

The fourth reason is to create product distinction in the managed care ranks. Managed care companies, as I said, are moving and migrating more toward care and benefits, and if you look at the continuum from the insurance side of the house and the HMO side, they have moved to center stage. It's virtually impossible to figure out who's really on first base.

The fifth reason is the one where I will close my remarks. This ties us more into the spirit of why we're coming to you, and that is earlier intervention in the care process. The U.S. enjoys some of the best health care in the world, and the reason is because we have taken advantage of technology; we've taken advantage of new ways of treating patients. In the disability management area, one of the keys to returning people to work is getting their illnesses or disabilities diagnosed as early in the game as possible, making determinations, and devising a treatment plan. By using the data that we have in our databases, we can track members' health profiles. We have every aspect of each person's health profile. It makes it easier for us as we interact, on the disability side, with those things that will help that person get back to a level of work. We think that early intervention really will improve the overall process as much as early intervention and prevention does on the medical side of the fence.

My last comment is that you will see more and more nontraditional companies entering into the disability market. The next wave will be the managed care companies from one end. They have many people in the system, and they will continue to roll out products in the disability area. You'll see more and more managed care companies moving along that continuum that I talked about before in care and benefits.

Mr. Dale Johnson: I'm going to take you from something that's cutting edge and brand new to something that has been around for a long time—marketing through professional associations. I'm going to focus on an experience that we had with one of our clients in the last year or so. I'd like to start this out with a little bit of trivia. Some of you may recall Charlie Finley, who was a colorful owner of the Oakland A's in the 1970s. Mr. Finley made a lot of the money, which he used to buy the Oakland A's, by marketing life and disability products through associations, particularly medical associations. What's interesting, and the reason I bring it up, has to do with when he did it. He did it in the 1950s and 1960s, so this form of marketing has been around for a long time. Since then, these programs have had

ample time to mature and that has created management problems that the associations and their marketers have had to deal with.

For those of you who aren't active in this area, let me describe a typical arrangement that you might see in the association world. When they started out, a marketer/administrator would solicit associations to pick up endorsements for products tailored for direct distribution to their membership. The coverages involved were typically term life insurance, LTD, accidental death and dismemberment (AD&D), hospital indemnity, and so on.

The marketer would also bring more and more carriers to the table to underwrite the risk. In the beginning a marketer would bear much of the solicitation costs, and he would do the billing administration, which would leave him in control of the billing records. That was important to him for two reasons. First, it was a natural extension of the marketing function, and second and more importantly, controlling the billing records was his ultimate means of staying in control of the program. When push came to shove with the association, he would assert his ownership over those records, and he would be very difficult to replace. The marketer would be compensated by level commissions, typically, with a small piece going to the association for its sponsorship.

This resulted in certain internal dynamics to the deal. From the association's point of view, they had marginal control over the programs (just a broad oversight function) and were often very passive players in the arrangement. This positioned them so they did not like to see any change occur in the programs that might be adverse to any of their members. The relationship between the association and the carrier was ranged from weak to nonexistent. The marketer would position himself squarely in between the two, again to enhance his control over the program. With all this in place you can see that the programs were distributor driven and often run with priority given toward maximizing the value to the marketer.

In the early days, the marketing results were generally very good. The programs grew to be quite substantial, and they were growing right along with the membership of the association. This was a very happy relationship generally for many years. The early underwriting results were generally quite favorable. There were experience gains to be either distributed back to the members in the form of cash dividends or left on deposit with the company for the future benefit of the program. But these surpluses also generated some behavior that was detrimental in the long term. For instance, underwriting rules would occasionally be relaxed. There were forays into guaranteed issue offerings to the membership, and generally, little or no pressure on commission levels. In fact, the marketer would often seek to

get solicitation expense paid out of the program, leaving him with nothing more than his time at risk.

And then, with the passage of time, response rates started to fall. This is a product of the general maturing of the programs. There was increasing resistance to bulk mailings from the membership. That's because in the 1970s and 1980s, the amount of material that people were receiving was getting to be so voluminous that they found it easier just to throw it away. The products coming from the individual distributors had improved greatly and created much more competition there. The claims experience ultimately matured, and that dried up much of the experience margins. Commission rates remained at the original levels set at the outset of the programs, even though the marketer/administrator had achieved a great deal of productivity improvements by applying technology in both the soliciting and mailing functions and of the administration.

In the 1980s, association membership had leveled off. This was largely a product of more and more of their potential members entering into employment relationships, even group practices or managed care firms. When people do this, they have much less need for an association membership. As a result of all this, the plans often became stagnant from a marketing point of view and then competitive from a pricing point of view. This is where a couple of clients found themselves in the last few years. So, from their perspective, they saw a need to improve the overall value of the services that they were bringing to their members in order to remain relevant to them and to attract new membership. They saw insurance plans as a significant service that they were providing. They also saw the insurance plans as a potential revenue source beyond the sliver that they might have been getting off of the programs. So what they decided to do was put themselves in the marketing and administration business by internalizing these functions into the association itself. They only did this (1) to get control of the programs so they could tell who was taking advantage of their services, and (2) for the revenue stream. They found that they could do both of these things and reduce the expenses to be borne by the plan by nearly a third.

Now, part and parcel of this was a better ability to integrate product promotion with other membership contacts and services, including educational seminars on practice management and personal finance in other meetings they may host. Now that the association was in active management of the programs, they sought to modernize the plan design, contract provisions, and the pricing, particularly of the life and disability programs. The disability program, in particular, needed a great deal of reworking.

I should be reporting to you that their initial marketing results were wildly successful and they are going to live happily ever after. Unfortunately, that didn't happen, which we don't entirely understand, although I would speculate that it has to do with the association needing to do some credibility building with their membership. Given the plan improvements and the new cost structures inherent in the programs, they're going to stick with them and so are we. The next step in the process is to get them in position to offer employer-based coverages for group life and LTD. Since many of their potential members are now either employees or employers this is a natural move for them to make. In analyzing how they might be able to do this, we see it's apparent that they can do it at considerably lower distribution costs than your typical group representative brokerage distribution system. They have natural entree into the market through their contacts with their members on practice management issues. We think that if they're reasonably successful at distributing a group product, it will also increase their sales of the association member direct product through the credibility building that will ensue and, also, by promoting the use of both products in combination for the higher incomers. One thing that is necessary here is that they build their own expertise with the insurance products, and this will take some time.

To sum up, although this approach is yet unproven, we do see very good potential that particular associations can become effective distributors of these types of products and that I think their success is going to depend largely on how well they execute their plan. And if they are successful, I would expect that we would see more of this from other associations of their type.

Mr. Timothy O'Donnell: I'm going to speak to marketing disability, but within the context and framework of marketing total health and productivity management. I'm from a company called Health Risk Management. We're based in Minneapolis, and I'm an example of a company, as Darnell mentioned, that's coming from the group medical side of the business and moving into the disability side of the business.

I'll give you some information on HRM. It's a nearly $60 million company, publicly traded on the National Association of Securities Automatic Quotation Systems (NASDAQ) under HRMI. We've been in business for about 17 years, and our core competency is doing utilization management mostly for self-funded employers. We have been in the lead in doing that for 17 years. Seventy percent of our revenue is from self-funded employers, mostly nationally self-funded employers. We have many Fortune 500 clients like Upjohn, Goodyear, Boise Cascade, and Columbia Hospitals. Of that 70% of our revenues, about half of it comes from performing claims services or paying claims for these self-funded employers. Another half goes back to our core competency in our origin, which is care management, utilization management, and all the permutations that have occurred over the years. It's no

longer just utilization management. Now there's maternity management, disease management, and many other components.

We have a sophisticated system for performing care management, and it is built around guidelines that we sell nationally. There are about ten million members across the country from different HMOs and other organizations that are using our guidelines. They're "Quality First" guidelines. It's a software product from a subsidiary of ours called the Institute for Health Care Quality, or IHQ. I sell our care management systems to self-funded employers for $3 or $4 per employee per month. For other self-funded employers, I'll sell claims care management, and we'll get $20, or $23 per employee per month. But the systems are really built around these guidelines. Another fundamental aspect of our care management system is it's open access, so you don't have to go through a primary care physician to see a specialist or a hospital. Again, I'm talking about group medical.

The system is attractive to members because they don't have to go through the gatekeeper. What we've actually found is that this HMO juggernaut, over the last several years, has caused our revenue growth in the self-funded marketplace to stagnate. We're picking up new business, but we're losing business in flex plans to HMOs. HMOs are cutting into our self-funded business, which caused us to move in a variety of different directions a couple of years ago.

One of the directions we moved in was to expand and leverage our care management capabilities into managing lost time at work. We created a product called disability care, and that product now represents about 10% of my care management revenues. We sold that product separately to employers, on both the occupational and nonoccupational side, who were looking for a medical management capability for managing their lost time. These were believers. These were folks who didn't necessarily need the proof right up front that this was going to work. They just believed that early intervention with the clinical management model was going to save them money. For our trial cases we were doing disability management, and getting $2 per employee per month or whatever the number was.

For us to really be successful, we need to be able to sell the group health component and our disability management piece, which is a stand-alone piece developed with the idea that we would be in total health and productivity management. We searched for a partner with disability expertise, particularly on the claims-paying side, because we don't have that capability. We found The Hartford. Jointly we developed total health and productivity management. It's a model with a single point of contact for all medical events, regardless of cost. Our care management nurses are managing the medical care and the claim, if it's a disability claim, short-term disability (STD), or LTD, it will be paid by The Hartford.

Group medical claims will be paid by us. If it's a workers' compensation claim we actually tie it in with another Hartford division, Specialty Risk Service (SRS). They will take care of the workers' compensation side of it.

So we've created a single point of contact product. We signed a joint marketing agreement back in the second quarter of this last year so that my half dozen national sales representatives selling to self-funded employers now have had the ability to leverage that sales capability with the sales representatives from The Hartford, as will their 45 SRS sales staff members. All of those sales representatives are out there talking to self-funded employers and they're talking about total health and productivity management. They are not just looking at group health costs by themselves, but they are looking at LTD, STD, and workers' compensation costs combined. Naturally, my sales representatives have greater experience on the group medical side, and so they're talking from the group medical angle. The other sales representatives are talking from their own particular disability perspective.

What we've done is to leverage our sales forces, but, at the same time, we've leveraged ourselves higher into the organization. We're not selling at the HR side or the risk management side anymore. We're actually selling at the chief financial officer (CFO) level. All of our sales representatives are talking to higher-ups in the organization because they're talking about a larger model that rises above the individual constituencies. That discussion has been very effective. We've been able to get an audience with just about every CFO and CEO as well. They like the story.

There are some things we've observed. It has only been operating for a short period of time, and while the story is very compelling, it's an educational sale. You're going in and talking a new concept. The CFO is coming down saying, "Why can't we do this?" There's a great deal of education that occurs, so in terms of closing cases, it's a longer sale than a traditional sale when you're selling just one of those individual products. Fortunately, the marketplace is providing more of a need creation out there. There was a recent *Wall Street Journal* article about how disability costs are rising. More of those articles are being published, out there, and our competitors, like HMOs, are talking about this more often. There's also the greater receptivity in the marketplace to being able to sell this type of product. We haven't reached critical mass yet, but we believe we're getting there.

It's an educational sale. At this point, its early data are limited. We can't actually go to the CFO and guarantee that we're going to be able to make this change. It must be a belief sale at this point, and we believe we're going to be collecting the data. We're in the process of doing that. Two years from now, when I'm speaking

to you all again, I'll be able to talk to you about the data and the savings. The sale will become a financial sale at that point and not a story sale.

What we have found is that we have activated all of our sales forces in this. In the short period of time we've been doing this, we've made about 15 different proposals. That's actually fairly quick if you think about selling a concept to getting an opportunity to make a proposal on all aspects like group health, LTD, STD, and workers' compensation. In just a little less than half of those cases, one of us has obtained a piece of the business, so we haven't sold the whole thing in any one case, although I'm expecting a sale for the whole thing soon.

What we did find is that those who were buying a piece of the business were very impressed by that. They're actually buying the vision of the future, but they weren't able to overcome the inertia of their organizations to implement it all at once, so they're taking them in pieces and using what they need at the time.

The thought I'd like to leave you with is this is a new approach, a new product. It has been very well received in the marketplace. By linking with an enlightened partner as we did with The Hartford, we leveraged ourselves into many more organizations than we were able to leverage ourselves into before. I think it has afforded them the same opportunity.

Mr. Richard C. Zenker: I've been in the insurance business for about 16 years, and most of that time I have been dealing with financial institutions, banks, and so forth across the country. In my more recent experiences of the last couple of years, it seems like I'm spending more of my time with actuaries. Maybe that's because the market is changing so very rapidly. I can't remember any time being in a room with more than three actuaries, so this is certainly a high water mark for me.

Darnell talked about picking up a newspaper or a trade publication. The same is true in our business. You cannot pick up any of those publications without reading something about banks getting into the insurance business and insurers then responding in terms of how they're going to react to that new evolution. The decision that was made in the *Barnett case* there certainly opened up a great deal of opportunity for banks to get into the distribution business. That's certainly a force to be reckoned with. I'd like to talk to you about some of the experiences that we have had in the bank business. It is definitely something for us as insurers to be able to reckon with and recognize that the landscape is definitely going to change, that the banks have a very, very strong connection to their customer base. They know more about their customers than we know about our policyholders, a vast amount of information.

I'll go off track just to tell you a little story about a deal we were working on with a large credit card company earlier this year and they had somewhere in the neighborhood of 12–14 million active credit cards. And as we talked about potential insurance programs because they, too, were looking at the *Barnett* decision and asking, what does that give them in terms of an additional opportunity? As we explored some of those opportunities it became apparent that the credit card company has databases and the ability to load information, even information about our transactions we use that credit card for. The credit card company can create models of our purchasing behavior, and feed that information into a database. I can look at a Rich Zenker and determine he has used his credit card at a Toys 'R Us several times this year, which may mean that he has a young family, which may mean that there are certain products that could be delivered to his household that may fit his particular needs. That's very powerful marketing data that we have to recognize. Banks will become a very big force, and they're going to change the way insurance is sold throughout the U.S. We recognize that the agent distribution system, as we know it now, is expensive. The banks also recognize that, so there will be a movement toward less expensive delivery systems and ones that offer convenience to the customer.

What we're seeing now is a great deal of movement toward direct response marketing, exploration in the Internet, use of 800 lines, and so forth. If you look at some of the case studies on the property and casualty side, you can see direct response, like GEICOs, following many of the European companies where much of the insurance is sold through banks. So it's definitely changing everything having to do with how insurance is going to be sold. Insurers, like Liberty, have to recognize this and figure out a plan. What that is doing for all of us is building defensible positions around either our products or our customer groups. That's the position that we've taken at our company.

I want to narrow some of this presentation down to a discussion of disability. We have built an expertise and carved out a niche in marketing disability to mortgage customers. It is a very interesting market, and one in which I've been involved for many years now. I've gone through a great deal of change. There is a vast audience out there, and the bottom line is, whether we work in an insurance company, or a marketing organization, or whatever, it's the customer whom we need to get to. There is a vast audience out there; there are about 48 million outstanding mortgages in the U.S. The way that we get to those 48 million or a portion of those 48 million is through the relationship that they have with banks and mortgage servicers. That's basically where Liberty has, in its specialized marketing group, come up with strategies to approach it from the bank side. These institutions have really grown over time. It used to be that your local savings and loan would offer you a mortgage loan and, also, service that mortgage loan locally. They, over

time, would amass maybe a couple thousand loans to service. That has all changed now, and the largest percentage of loans are now serviced by about 100 financial institutions across the country. Those 48 million loans I talk about are concentrated in about 100 institutions, of which Liberty has about 50 under contract. But those are high-volume, low-margin types of servicing facilities and are very technologically advanced. Because of those thin margins, they must look for alternative fee income sources.

While that market is so vast, we, as an industry, have done a poor job in terms of penetrating those households for which they service those loans. I would estimate, in all mortgage protection markets, including life, disability, and AD&D insurance, that we're probably less than 10% penetrated, so there is a huge opportunity.

The competition in that business as we look at banks and so forth in the mortgage protection side is limited to only about five competitors that control the majority of this business. That includes those that have a specific strategy to go after mortgage customers with disability products and so forth. However, not a single one of those five can claim any kind of dominant position at all on the disability side until now. We expect that Liberty, along with The Hartford, will be able to create that dominant position soon.

It's our plan to build a defensible position around that customer group, around that market. That means using a rather traditional product that has been out there to cover mortgage payments and developing a new product and then delivering some more innovative marketing delivery mechanisms to get to that customer. This means first looking outside of that box that, in certain situations we always find ourselves in. Some companies are more dynamic than others, but certainly at Liberty we looked at ourselves and said, we've been in this market for some time, and we haven't really taken any kind of leadership position in it. So let's look outside that box and find a carrier that has some leadership in the disability marketplace. That's where The Hartford came into the picture. We are ten months into our arrangement with Hartford, and it's really too early to proclaim any great victory in being able to amass a huge number of policyholders in our program. It is a process that we're going through now. It involves a great deal of research, product development, and market testing that we hope will, obviously, take us over the top and get us that dominant position in mortgage disability.

The way we are doing that currently is, again, not a new way to distribute. But we're mainly using direct response to get to those mass audiences, and that puts some kind of confines around the look of the product. Thinking of it from a customer's perspective in a direct response environment, we need to make that product very simple. We can't load it up with so many interesting features and go

overboard. We must make the price very attractive so that it can be purchased in a direct response, nonagent-oriented manner. We must turn around the application very promptly in that kind of environment.

We utilize the information that's provided to us by our financial institution partners, personalize the application, precalculate the rates for that particular consumer, ask them to fill in three or four health questions, and then we wait to see the floodgates open in terms of all those applications coming back to Liberty. We wish that were the case. The challenge continues.

We have developed, through our arrangement with The Hartford, two product variations. One is a five-year disability program. One is a two-year disability program. Again, we are paying the mortgage payments for these claimants, but we've also built around those varying elimination periods of 30, 60, and 90 days. It's an age-banded plan, but the plans were designed to cover a wide audience, which again, gets back to the 48 million customers. You know that everybody is different, and these plans have to cover mortgages from $300–$2,500. That's the scope of this plan, so within that you can, obviously, determine that there are many different demographic characteristics among that crowd.

Here's where it becomes very interesting from a marketing standpoint. We must be able to design the right product with the right length of benefit and the right elimination period and other features that have yet to be added so that we can penetrate each of those market segments. It gets down to you, the customer. What are you going to receive in the mail? What's going to grab your attention? What's going to create value in your mind? What value does that financial institution bring to the table in terms of having done some pre-underwriting or preselection of the carrier? That's the dynamic that is going to change an old traditional carrier, like a Liberty, being in the mortgage protection market. There is going to be that dynamic of the financial institution being a great low-cost distributor of plans.

So we have a great deal of work to do as an industry, and in this project as well, in order to be able to segment those customers very specifically and give them what they need. We, again, as an industry have done a poor job on the disability side. I can speak for Liberty in that respect. I read an article written by a retiring industry executive. He said in his closing remarks that we've done a great job as an industry in insuring the doctors and the lawyers, but we've done a very poor job in insuring the masses of the American population. They are the people who probably need the coverage more. And so there is a challenge, but I take it personally actually for us to develop those kinds of programs and give mortgage customers, in particular, an opportunity to cover their payments with a good, well-thought-out, low-cost program.

As banks emerge, it's something for us all to take back to our companies. We must realize how that's going to change. We need to establish some new paradigms and that's what we're looking to do with The Hartford. It has established that new paradigm or what it will be like to receive a mortgage disability program that is not geared to the needs of the financial institution in terms of fee income, but rather is directed to the customers in providing them good benefits at low cost, so the challenge remains.

Mr. Roy Goldman: I have several questions, but I'll start off with one to Darnell. What exactly is the product that you offer at QualMed. Is it underwritten by a subsidiary of QualMed?

Mr. Dent: The product that we offer is underwritten by QualMed Health and Life. It's a fairly traditional disability product right now. We are looking to enhance the case management component and streamline many of the rehabilitation components, especially taking advantage of some of our contracted providers. I think this will help to eventually drive down the costs. That's one of the areas we'll keep our focus on.

From the Floor: So is it both a short-term and a long-term-duration product?

Mr. Dent: Yes, both short-term and long-term duration.

From the Floor: Disability insurance unlike many other kinds of insurance, is not often foremost in the minds of consumers. For instance, you can't drive a car in Maine unless you have car insurance, at least liability insurance. You can't get a mortgage unless you have homeowner's insurance, and you can't be an employer in many states unless you have workers' compensation. I've often heard it said that disability insurance is sold, not bought. I really haven't heard from anyone how you're going to confront that issue.

Mr. Zenker: I can respond from a bank perspective in terms of some of the strategies that we're looking at, and some of these to a large extent change just the way mortgages are offered out there. We're looking at what we call embedded strategies that include our product in the insurance document itself. It's just like homeowners' insurance. You can't get a mortgage without homeowners' insurance. We're looking at breaking through that paradigm and asking, what is it that we can do in working with the financial institutions to prepackage a loan that you get from Fleet that would already have a disability plan included in it as part of the loan document? That would be a huge leap forward for us as an industry, but the product is needed out there, and we must work through how we will embed some of these products into other processes.

Mr. O' Donnell: In my market, it's fairly straightforward. We sell to the employer directly, but there's actually a subtle sale to the member or the consumer. In our care management focus we add health education, a 24-hour nurse line, and essentially we create a single 1-800 number for them to call at any time. So there's an awareness sale that we have to do to penetrate down to the member or consumer level. The main financial sale is still at the benefits level.

Mr. Dent: One of the other revolutions that's taking place is in the small group arena. Small businesses used to be required to buy coverages through multiple employer trusts and tried to take advantage of volume. The introduction of health insurance purchasing coalitions and the state-run or sponsored alliances has created some advantages to small business. So one of the approaches we're starting in California is to package small groups. When they buy the medical coverage, we will offer disability and the life insurance. Your point is well taken that disability and some of what the market views as ancillary products have been a sideline, and more optional. We're taking the approach that if you package it as a complete benefit program for the employers, there's a greater possibility of those employers purchasing the entire package as opposed to just the medical program and maybe the life, but then the disability is on another page.

Mr. Johnson: I'll add one more comment to that question. I couldn't agree with you more. I don't believe the problem is so much in people not recognizing the need, particularly in the professional association market where they are aware of the need. It is an easy purchase to put off, though, and the object of the game and the thing that's hardest for this method of distribution to overcome is getting them to actually make the purchase.

Mr. William R. Lane: Darnell and Tim, are you running into problems with conflicting priorities with your medical panels? On the medical side, you might be looking for less aggressive treatment in order to lower cost, but on the disability side the savings from returning people to work, at least from the employer perspective, are significant. They may want more aggressive treatment for certain conditions. Is that creating a conflict and difficulty with the guidelines?

Mr. Dent: It's still early, but what we're seeing with our providers is creating some confusion as we start talking about different products. Doctors really don't track products. They may know the structure of their contract, HMO versus preferred provider organization (PPO), but when they actually get into the care process they really don't focus that much on it. On the disability side we are recontracting and adding language in those contracts to accommodate more of our product. We're finding that we're having to spend more money in provider education so that they can understand the scope of their contract and the type of patients that we're going

to be sending their way. The focus of this discussion was not on some of the other coverages. We are also moving into the 24-hour product, time, workers' compensation, and some of the other components. We have a sister company doing auto PPO, which is also bringing a different perspective to it. I think the challenge is going to be with provider education and the provider contract. It's going to be very interesting, and we're finding that, obviously, the more we ask providers to do, the more money they want. It is more of a push-pull relationship in trying to get them to understand that we are moving more toward the total care management. The product is not the issue. We highlight the fact that we're bringing more volume to them in the form of patients.

Mr. O'Donnell: A difference between my model and an HMO model is that an HMO will be managing the providers. Our model doesn't have the contracts, and we don't manage the providers. We actually work with the member, so it's a member-focused model. What we have found is that we don't really have to work and train the providers, but we did have to train the utilization management nurse, and we did have to bring in some additional expertise with lost time. Managing a clinical event is managing a clinical event. Nonetheless, when you're doing it with an eye toward lost time, you will make different decisions. We had to bring in specialists and do some additional training for those folks, so the case is identified as a lost time case. We have specialists in our disability care area manage that case, so it is managed differently, though it is a clinical event.

From the Floor: I was just wondering if you could describe for us the relationship that you have with the banks. Is it more like the relationship with the professional association where you ask the bank to endorse your product and maybe provide billing capacity or services like that?

Mr. Zenker: The traditional relationship between the insurance company and the financial institution is similar to the association group side. We seek an endorsement. The actual product is blanketed with the financial institution's logo. Liberty takes a very small bit of the press, and the direct mail, or the telemarketing approach that we might use. In return for that list being given to Liberty for marketing, we pay the financial institution a service fee. It could be a list fee. It could be to a licensed entity. It could be a commission. Typically, in this business, it has been a level of commission or a service fee approach, so it can mount up with aggressive and effective marketing campaigns. That financial institution can amass quite a bit of service fee income coming in off their loans on a renewal basis. It is very much a third-party type of marketing approach using the financial institution's logo.

Obviously, a key point here is what affinity level exists between that customer and their financial institution? That's a big and current issue in many focus groups that we have gone to and conducted. You would probably put yourself in a similar situation here with respect to your mortgage service. As you know, there have been many transfers and selling of loans back and forth. I bet if I asked half the audience members, they wouldn't know whom they make their mortgage payment to. That's going to begin to change, though, as banks become much more interested in developing those multiple customer relationships. There's not going to be as much of a loss of affinity in that market, and it will grow. The bank would like to have four to five relationships with you, which could be a mortgage relationship, a checking account, a savings account, a certificate of deposit, an annuity, and so forth. But the more relationships that they can establish with you, the longer you will be a customer of that financial institution.

Mr. Thomas R. Corcoran: I agree with your assessment that the financial data are very important and, ultimately, will drive the marketplace. Once the data are there, the marketplace will take it up, because nobody will be able to not buy it at that point. But I'd be very interested in what sort of data you plan on capturing and whether you have thought that through.

Mr. O'Donnell: I'm not going to be able to speak to the details that we're looking to capture. We have a task force that is emphasizing and focusing in on that using the expertise of the actuaries at The Hartford as well as outside sources. I can give you some data right now that have been actually certified. We have a nonoccupational client that we've had for nine months. Again, this is very early on, but we've seen a 46% reduction in the indemnity costs. They have about 3,000 employees. Again, we haven't gone through to standardize all the information, and I don't think this is the kind of information that I'd be showing to an actuary, although anecdotally we can use this information when we're talking to an HR person. On the occupational side we have a 22,000 life group where we've seen a 52% reduction in their average lost time per claim. Even certain specialty areas like back problems have gone from 140 days down to 50 days. Now, that's a starting point. I think we're at a crude level. I can't answer your question in detailing the type of information that we would be presenting. I'm deferring that to experts who will be more critical with the data than I have just been in giving you these numbers.

Mr. Goldman: How does your product differ from those that have historically been offered by firms such as Minnesota Mutual or Prudential that have had many banking clients and offer mortgage life and mortgage disability insurance?

Mr. Zenker: The short answer to your question is, not enough. There's not enough difference yet, and that's what we're working toward. This business has gone through much change. When I first got into it, there was in-force business that would pay a mortgage payment through to age 65 no matter when you went out on disability. That quickly changed to ten-year benefit plans, then to five-year benefit plans, and then, in the late 1980s to two-year benefit plans. It finall y became one-year benefit plans. We're trying to break out of that because there is a need out there. So we're marketing some of the five-year programs again to segments of customers that we feel need a five-year plan versus a two-year plan. Much of it is in the delivery to the customer as well. We have used some mass marketing programs that we would consider competitive to Minnesota Mutual and some of the others where we've adopted a different marketing delivery approach to the customer. This involved a telemarketing approach to the customers and gave them an opportunity as a preferred customer to enroll in the program with less participation than what had been previously required. It's some of those more creative approaches to that customer that we need to consider in the disability environment.

Obviously, in the other example I'm using, it was a guaranteed issue type of program. It's a little difficult for us to get over that fear factor in terms of offering a disability program with that kind of guaranteed issue feature, but there are lessons to be learned in terms of how we've been very effective in delivering other programs, and we just need to apply that. We're not there yet, and we need to continue to push that envelope. We'll eventually get there.

Ms. Pamela J. Saunders*: Can you comment, from the medical and the HMO side, on how you've made the transition from utilization and medical expense time management to lost time management—in other words, the long-term disability side?

Mr. Dent: At this point, we are depending on the management side from The Hartford. They provide that level of service. What we've built into our program is the ability to transition, over time, where we can build that capability. Right now

we don't have it because it is a huge difference. On the medical side, because that's where our core competency is right now, we are exchanging information between the two components. We've had our vice president of utilization management and quality go out to The Hartford and meet with the medical case staff. It has really been a learning process, and it's still very much in development.

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*Ms. Saunders, not a member of the Society, is President of the Disability Consulting Group in Portland, ME.

But we recognized very early in the game that in order to develop this product correctly, we had to rely on the experts. The Hartford was willing to work with us in developing that, and down the road a critical decision is going to be whether or not we actually bring that in-house or we outsource it. It always must be a careful balance of measuring the cost, the volume, and the economies of scale. We have it on the medical side. They do their part well, and we do our part well. So it's one of those things that we'll decide as we go along.

At a clinical management level we've actually had to bring in some additional expertise in order to make that transition to the lost time. That has occurred over the last couple of years, but it has been facilitated by the fact that our subsidiary, the IHQ, developed workers' compensation disability guidelines about 18 months ago. They're being sold and have been sold very successfully to many workers' compensation disability entities. They have been very popular guidelines, and so by using the guidelines as a framework and bringing in additional expertise, that has helped us make that transition at a clinical level. We've been able to develop some interfaces at the administrative level where a great deal of education has been needed and is taking place. That's how the transitions have been accomplished, and it's an ongoing process.