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Hot Topics in Group Disability Income

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Key Words: Disability, Long-Term Disability, Short-Term Disability

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Recorder: THOMAS R. CORCORAN

Summary: This session starts with a short presentation of current results and experience trends for the group LTD and short-term disability (STD) marketplace. Following that, the panel discusses issues of timely relevance to group actuaries.

Mr. Thomas R. Corcoran: I'm going to be speaking on industry trends and benchmarking studies. Andrew Galenda from the Hartford is assistant vice president and actuary there. He has 20 years of experience in group insurance. He is going to be speaking on reserving and surplus issues. Pam Saunders is the president of the Disability Consulting Group. That firm specializes in disability consultations and reinsurance underwriting management. She will be giving an update on the LTD marketplace.

This session covers industry trends and benchmarking studies in group LTD and STD. I will talk about what they are, why you need them, where you get the information, and how you use the information. I will then provide a case study that shows some of the information we have collected and some of the things that we use it for.

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The industry trends are things we look at, such as overall industry, profit level, closing ratios, lapse rates, market growth, and market saturation. We review how big the potential market is and how much has already been written. In this area you're really looking at the big picture, trends of the industry as a whole, intended more as an aggregate than a specific view of what's going on. The benchmarking studies involve much more specific data, such as competitive rate studies, claim incidence rates, termination rates, expense levels, compensation levels, and profit margins.

Why do you need this information? The industry trends indicate where the industry is moving, what you can do, how you can realize your opportunities, and how you can compete. This is what you need for developing your strategy. The benchmarking studies measure you against other companies and determine how you will execute your strategy, where you are, where you need to go. Some of the questions you'll be asking: Is the market growing or is it a saturated market? Are the trends you're looking at typical trends or are you really entering a new environmental stage that will determine the things you have to do to react? How competitive is the marketplace and what's the total size of the market?

How do you use this data? In developing your strategy one of the key parts is having an objective baseline. How do you fit into the total? When you're projecting your results, is this realistic or unrealistic? A lot of strategy development is done without a quantitative base. The benchmarking studies and other data are really the quantitative aspect of strategy development. They are often overlooked or skipped in the strategy development phase because it is very hard to get the data. It can be time-consuming. People want to have a plan tomorrow. Data usually takes weeks or months to pull together. I also think people don't like facts that conflict with their preconceived outcome. These studies tend to give people data that they don't want to have to deal with.

On the strategy execution side, a GAAP analysis identifies where we are, the industry’s best practices, and where we have to go to be one of the top companies. There are two key elements to strategy execution, the quantifiable targets and the objective measurement of progress. In any strategy seminar, the companies may have three or four steps, but two of them always have clear objectives and quantifiable targets. You then measure your progress toward them. I think this is how you get there.

Where do you get this data? There are several sources. There's publicly available data. The Disability Risk Management Services (RMS) Survey is one of the sources of data we'll be looking at here, as we’ll as the SOA Termination Experience Table and the Employee Benefit Plan Review, which shows in-force and sales data. This is

publicly available data that's published and relatively easy to get access to. There's a series of close surveys, meaning that if you participate you get the results and if you don't participate, you don't. Tillinghast has put on several surveys. The Disability Consulting Group has several surveys and we'll be talking about those later. Others are John Hewlett and M&R. Most of these are developed based on what the sponsor of the survey thinks people want to know. What I want to stress is that when a company wants information, they can sponsor their own survey. Often they'll use a consulting firm or a third party to keep that information blind to all the participants, but just because somebody doesn't have a survey that has the information you want to get doesn't mean that you can't get that information. Many surveys are sponsored by a company that is looking into a certain aspect of the STD or LTD business.

Let's move into LTD case study. In the industry trend side for LTD, these are the things I think you'd like to look at: Profit levels, market growth, growth versus profitability, closing ratios, persistency, market penetration, and forming an analysis of the overall marketplace. What I want to do is go through some of the data we collected and make some observations. Chart 1, the Disability RMS Survey, shows a tremendous drop in profits in 1993-94. Since then we've had three years of consistent growth. Is this a trend and will it continue? One of the surveys we've done on partial results through 1997 indicates yes, the trend does appear to be continuing. What other evidence do we have? In finding out what's going on to develop these actions, some of the things we're seeing are strong actions on certain segments in the marketplace. The doctors and hospitals, and to some extent the lawyers, have had very strong rate actions, sufficiently I think to move the entire average. I think there's some question as to how much the profitability has improved on maybe two-thirds of the marketplace and if there has been a strong improvement on 25% or one-third of the market place. Some of the information we're seeing on competitive levels indicates that competition is not decreasing, but probably increasing.

Chart 2 is an assessment of the marketplace. The chart measures total LTD premiums written in each year. There's a consistent increase averaging about 8–9% over the last ten years—a very consistent pattern. It seems to indicate that the marketplace is growing, that there's a lot of room to gain market share by gaining a part of the new market. Within this I think we're seeing some underlying trends, that 3% of this may be salary growth and another part may be the rate increases that we saw on those problem blocks I just talked about. There may not be much left for the growth in true new business or expansion of the marketplace.

CHART 1
GROUP LTD—NET GAIN AS PERCENTAGE OF PREMIUM

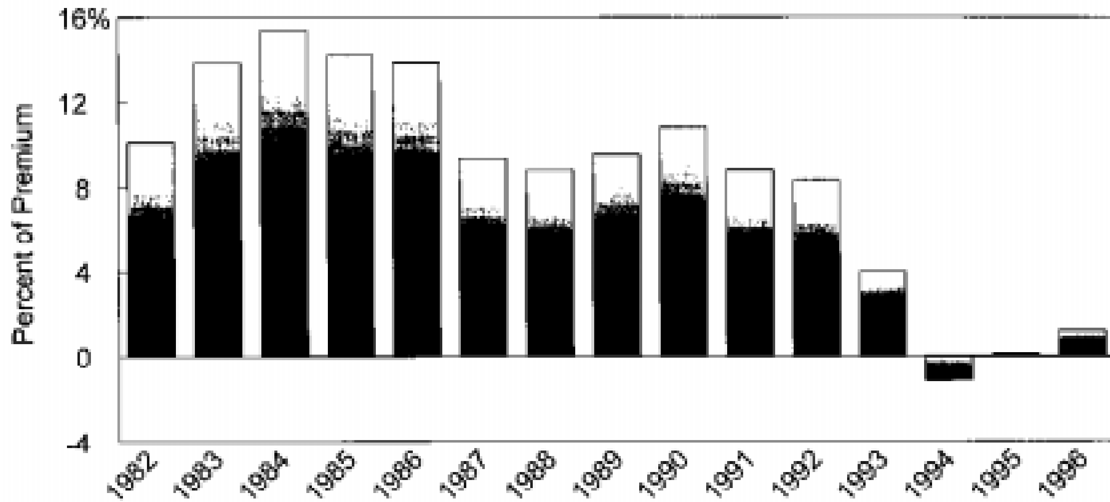


CHART 2
GROUP LTD—PREMIUM

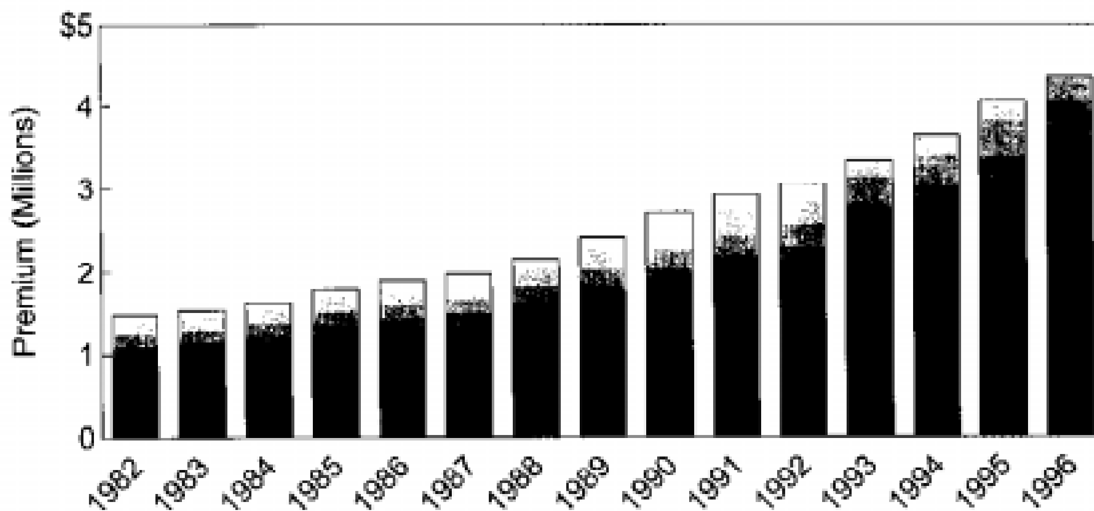
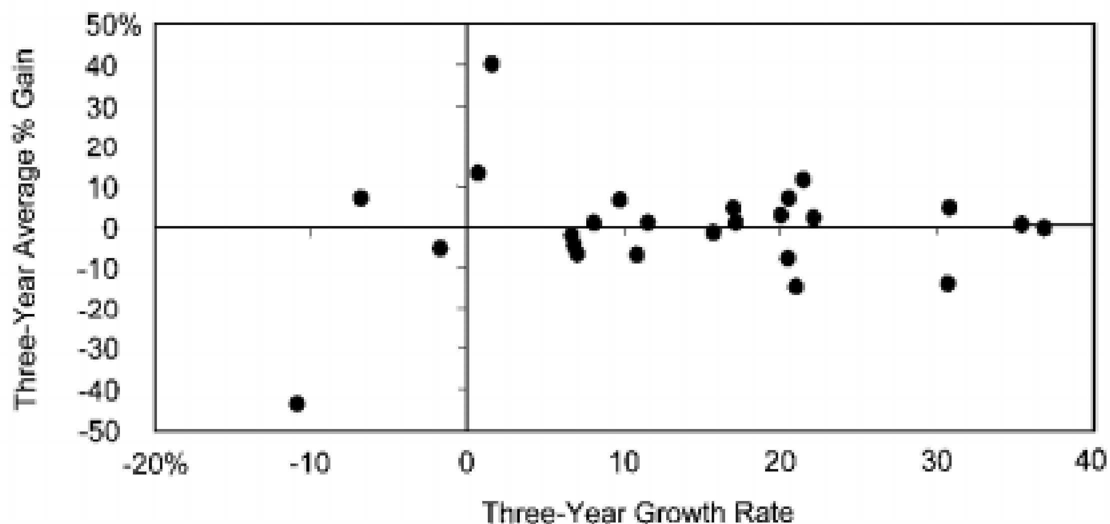


Chart 3 shows the growth map against the profit for the last three years average net gain as a percentage of premium on the Y-axis, and on the X-axis the three-year

compound growth rate. This chart shows the detail behind some of the aggregates we were looking at and the underlying question is anybody making any money? Clearly a few companies are. The interesting thing is there seems to be a one-to-one correspondence. For every profitable company, there seems to be exactly an opposite unprofitable one. Another thing we can see is that very few companies seem to be making substantial profit. There are few companies that are making more than about 5%. The other reason we put this test together is to see the correlation between profitability and growth, and of course there was absolutely none. I think the profitability level may be more of a function of the markets that companies have historically been in than anything related to growth or those types of trends. Companies that essentially have not been in the problem markets have had reasonable profits, and the companies that have, have not and have been trying to work their way up.

CHART 3
GROWTH VERSUS PROFIT



In 1988, the LTD closing ratio was 1 in 9. In 1992, 1 in 11. In 1997, 1 in 14. You can see the closing ratios as a measure of competition, have shown a deterioration. The new business is extremely competitive and shows no signs of slowing down. On the other side, we can look at the persistency that remains in the 85–90% range for the bulk of the cases. It has shown a minor deterioration except for segments that people have really wanted. That's a surprising result, that the persistency has remained good despite the intense and increasing competition.

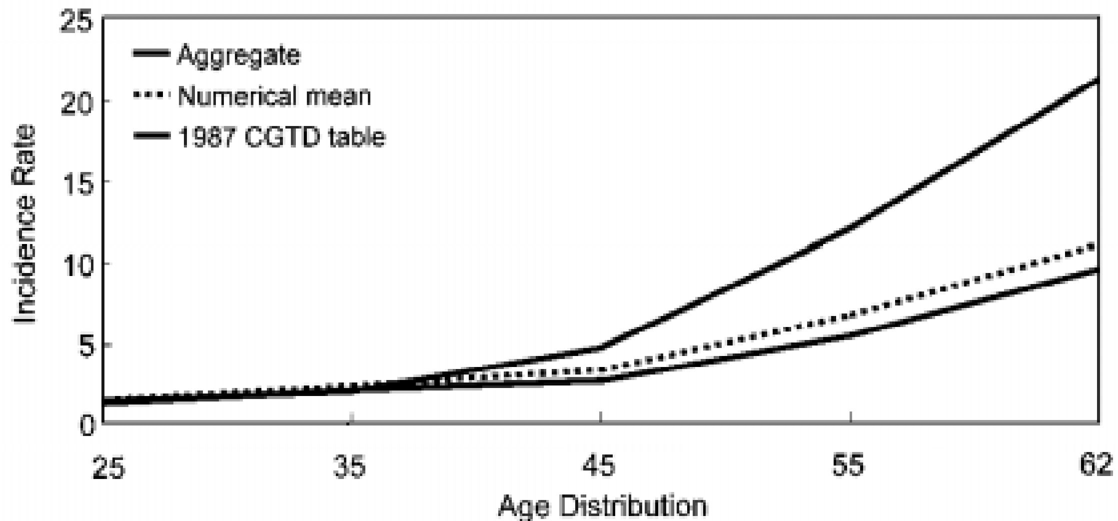
Let's analyze the marketplace. There's an in-force block, which I've described as a traditional market, and that covers the 30% of employees that have LTD coverage currently. Within that block there's a certain amount that rolls over. That is essentially the lapse rate we just talked about. There are some in the 15% range or so that is the group that's up for grabs and for which everybody is competing. For most companies that counts for the bulk of their sales, which basically means that it is taken away from somebody else. The ASO-insured block is a separate source, which are people who are not currently insured. They currently have LTD, but they're usually large self-insured claims and companies are trying to save money, so a lot of those plans are becoming insured. It's a very sophisticated market. It has special needs and special data-processing and reporting. It's very competitive as well, and it's more driven among a smaller group of insurance companies that can supply those large case services. There are also those with no prior coverage, who don't have LTD now. This is a nontraditional market with a different marketing approach. There's a higher cost and benefit because the people tend to have lower incomes with lower discretionary dollars. It requires specialized distribution and product design and specialized skills. There aren't many people who are successful in this marketplace. New sales to those with no prior coverage, and to the ASOs add up to 8% less whatever other dynamics we're driving at, so these are small pieces.

What are benchmarking studies? These get into competitive rate studies, claim incidents rates, claim termination rates, expense levels, compensation levels, and profit margins. The objective here is to know where you are, to address and identify the issues directly. Do I have higher expenses than everybody else, and how much higher am I? Where do I fall in the range? Now I can form a plan to do something specific about it. The first of these competitive rate studies, I think, have turned out to be unsatisfactory in terms of getting real hard information. They measure manual rates, rather than what's sold. They show extremely wide variances. The big problem is that nobody really believes that they represent the real marketplace, so as a result the data that have come out of most competitive rate studies are in conclusive. What we're intending to do is to move on to things that can be more definitive. One of these is claim incidence rates.

Chart 4 shows claim incidence rates. One line is the 1987 Commissioner's Group Disability Table, and the other two lines are survey results of 12 companies covering over 20 million light years exposed. The dotted line is the numerical mean of the companies and the button line is the aggregate. Both are shown so that you can tell if one company is distorting the results. This is for male 90-day elimination period (EP) and it shows that the company's actual experience is much a bit lower than the 1987 table at the higher ages. This may be primarily an underwriting issue, or it might be plan design, claim management issues, or

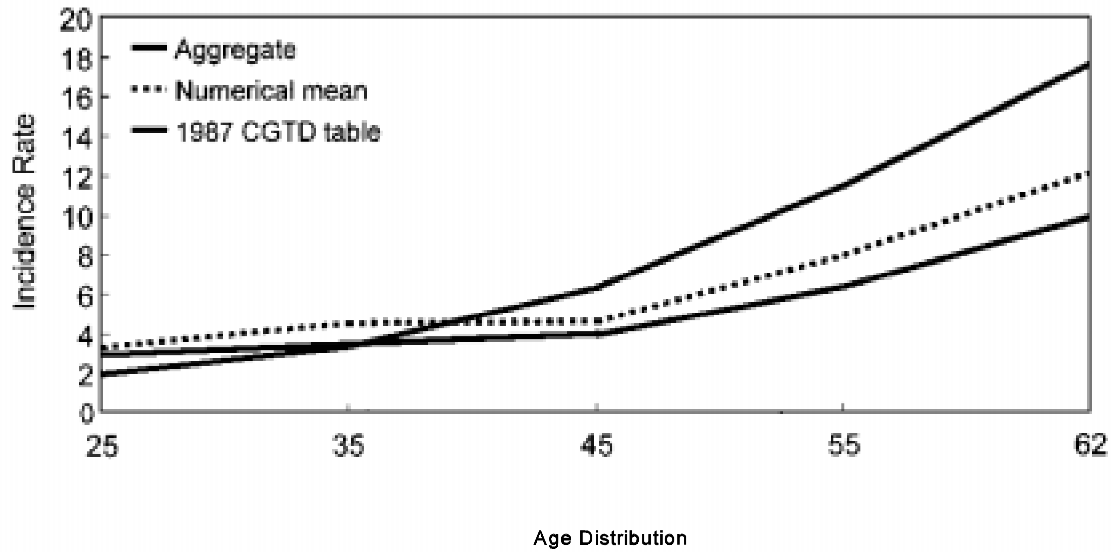
possibly the markets you're in. You have to adjust and normalize these for your distribution of business by voluntary and contributory. This happened to be a closed study that Tillinghast-Towers Perrin put together for several companies.

CHART 4
INCIDENCE RATES VERSUS AGE—MALE, 90-DAY EP



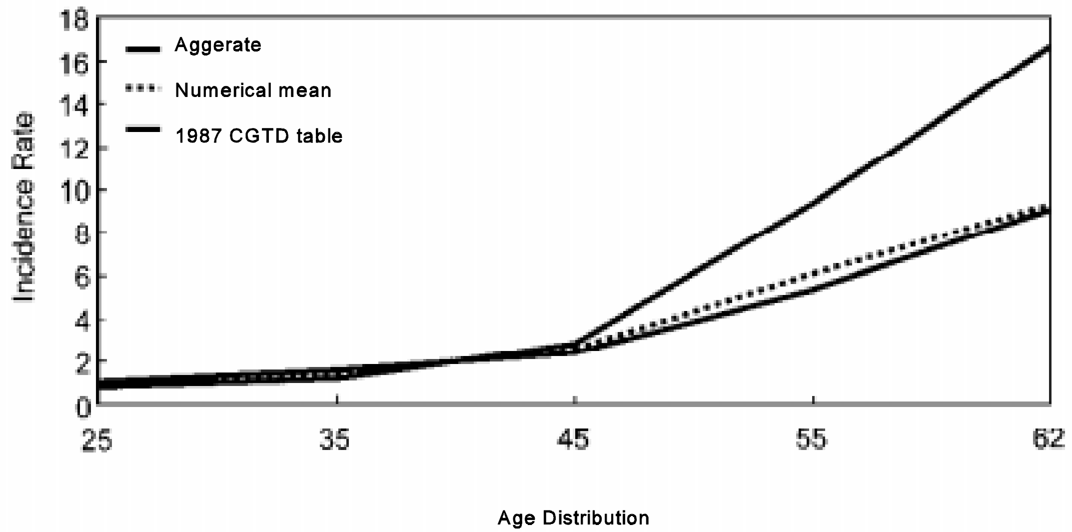
With Chart 5 you can see that for female 90 days the pattern is similar. Male 180-day EP and female 180-day EP have consistent patterns as well. (See Charts 6 and 7). Again, can you use this as a benchmark to judge how your company is stacking up against other companies and does it give you a specific piece of information to take action on?

CHART 5
INCIDENCE RATES VERSUS AGE–FEMALE, 90-DAY EP



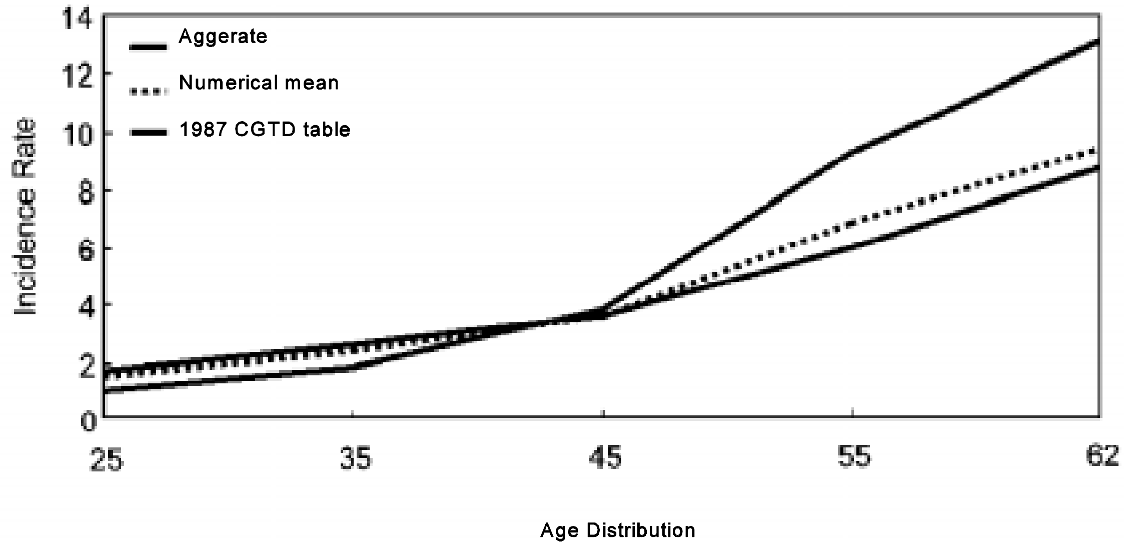
Source: Tillinghast - Towers Perrin

CHART 6
INCIDENCE RATES VERSUS AGE—MALE, 180-DAY EP



Source: Tillinghast - Towers Perrin

CHART 7
INCIDENCE RATES VERSUS AGE—FEMALE, 180 DAY EP



Source: Tillinghast - Towers Perrin

On termination rates, we have the 1996 SOA Intercompany Experience Study. This is a published table with very extensive data. Claim termination rates might be looked at primarily for claim management.

Among the conclusions that we draw from this is that the traditional marketplace is largely saturated. Even though only 30% of the people have LTD coverage, getting growth to the rest of the population is difficult. The large case may be a temporary source of insured lives, but that has to run out fairly quickly. The unsold markets require specialized expertise, distribution, and administrative capabilities, usually systems. On a traditional marketplace, it's extremely competitive. Closing ratios have dropped. On the other hand, the in-force blocks appear to have remarkable stability, which can raise some strategies. You clearly want to fix any problems you have with your in-force block because that you have a better handle on that block or a better opportunity to keep that block and get the actions you need than you do if you're going to compete in the open marketplace for new business, where the closing ratios are getting very aggressive. Again, what you want to do is identify and close the gaps in your operation. Incidence might be underwriting, termination might be claim management, and expenses might be administrative capabilities. Profit margins can affect your ability to compete. Compensation is one of the great mysteries of the business. Everybody has different and sometimes complex compensation arrangements, and nobody really knows how they stack up.

As the margins shrink, these issues become more important because you have less room to make up a deficit in one area by doing a superior performance in another area. In addition, do you have a competitor, are you better than average in certain aspects, and can you build a competitive strategy around that? There's a lot of information you can pull together out of something like this.

STD case study will be very brief mainly because there are fewer studies. Profit levels remain stable despite intensifying competition for new business. There appears to be many similarities with the LTD market. The market growth for STD is better than LTD. The current market penetration is very low for insured products. Interestingly the market itself is bigger for employees having STD coverage or sick pay coverage. Half of the employees actually have that coverage, but only about 12% of our employees are covered under insured programs. There is a possibility to expand coverage there. Most people think of STD as being a much smaller marketplace. I think there is a billion and a half of STD premium in force. If you look at the premium per life, STD has about $130 per life and LTD has about $180 per life. STD is not that much lower on a per-life basis and there's a much higher percentage of lives that are suitable for STD coverage. That opens up possibilities for increasing the market place.

Again it may be difficult to get these people and increase your business. The business in force is a relatively big block compared to the amount that people are competing for. That rollovers block again is 10–15% of the total in force. The closing ratios are similar, and the pattern is similar to LTD. On the other hand, we also have another big block that dwarfs the size of the business in force. The self-insured business is about three times as big as the in-force insured business. To that, there's a group moving toward insurance company insured and a group moving toward ASO basis. Often these tend to be the larger cases, which again have acquired some specialized skills. When they move, they're looking for specific things out of their potential carriers. There are not many employers who are not providing sick pay or some sort of extended short term coverage, who would be going from zero to a privately insured basis. That block is tougher to crack.

With benchmarking, you're looking for the same types of information. Again, fewer studies have been done. STD has tended to be of an auxiliary product. It has been carried along by other products, especially medical. Much of the STD in force was originally sold with medical blocks, and it's separating out to some extent. Many STD issues are the same LTD, but there haven't been good claim continuance studies done for many years. Disability Consulting Group has done a survey and you can get some information from Table 1. This is one aspect of how people handle STD and LTD combination plans. You can see that over half the companies

surveyed had a composite rate or a combined plan. Of the ones that have separate rates, two-thirds of those provided an LTD discount, and almost half an STD discount, the average discount being in the 5% range.

TABLE 1
STD/LTD PACKAGED RATES

Rate Discount* (if combination sold)		
	Yes	No
LTD	67%	33%
STD	40%	59%

Composite versus Separate Rates Offered	
Composite rate	56%
Separate rates	25%

*Average STD and LTD discount: 4% to 6%

STD and LTD have a major potential impact on claims. To move people from that self-insured block to that insured block, you're going to have to deliver that. That's what the employer is looking for. They're going to expect a delivery on that. My impression is the 5% savings that you're seeing on these average discounts are not what employers are going to be looking for. In order to make that difference and to give up control of their plan, they're going to be looking for something more substantial. The composite rates, that is the implicit discount is much higher, but it does raise the background for how you're going to set up your strategy.

Some conclusions on STD. There's no-prior coverage, which is difficult to get through. There's the traditional market, which we've identified as being very competitive, the same types of closing ratios that we see in LTD and are getting more competitive. Then there's the self-insured block, which presents many opportunities. It's a big block. If you can convince the employer you can do a better job, that has some real potential because there's a lot of business there. One thing I didn't get into are the three major approaches to the business. One is a stand-alone STD product, the traditional approach. What we've seen in the LTD business of interest to this group is the STD/LTD sale. You can drive down the LTD costs by getting early intervention on the STD, and you can do a better job possibly on the short-term disability than the employer can do.

One of the things that we haven't seen, and I don't know how many in this group are looking at it from the perspective of the combined STD/medical sale, but there's a tremendous amount there as well, because the STD management is really medical management to a large extent, and there may be a more productive tie-in or more potential savings from that sort of tie-in sale than there is from the STD/LTD. There has been very little done on that to date, but a lot of the HMOs are looking into that as a natural marketplace for them.

Mr. Andrew S. Galenda: I'm going to be focusing today on some issues that primarily fall into the regulatory arena, particularly the valuation standard for LTD reserves and risk-based capital. There are some potential changes that are being considered, and what I'd like to do is discuss some of those changes and try to translate the impact of those changes into terms that you can relate to.

Table 2 shows how actual termination experience is used in Nick Smith's study compared to the expected termination experience, where the expected is the 1987 CGDP table. As you can see, the termination experience is running at 177% of the expected. When the 1987 table was developed, the intent was that there should be a 10% margin in the termination rate, and that's clearly not what we're seeing today. The people that put together the 1987 table did an impressive job and that table has served the industry well, but much has changed since that table was put together.

TABLE 2
LTD VALUATION STANDARD

Duration	A/E Terminations*
1–24 months	176.1%
25–60 months	190.0%
61+ months	160.9%
Overall	177.0%

*Expected = 1987 CGDT

We went back and looked at how that table was constructed and found that the termination rates for durations 1-24 were based on experience from 1976 through 1980. The experience for durations in years 3-5 was based on experience from 1962 to 1980, where that experience had been standardized to project forward their male experience for 1976 to 1980. I can't remember what the disability marketplace was like in 1976 through 1980, but I believe that there is much greater emphasis and interest on claim management today than there was then. We don't see people using LTD programs as an early retirement option. Claim management techniques have grown to be much more sophisticated. Companies have dedicated rehabilitation staffs, and they're making increased use of medical expertise.

Besides having the benefit of more current information, I think Nick Smith's group had the benefit of more information in general. The NAIC model allows a company to use its own termination experience for durations from 3 to 5 years, provided that your company has credible termination experience and you get the commissioner's approval. The standard for full credibility for claims with the duration of disabled men of more than 2 but less than 5 years is that the company has to have 5,000 claim terminations over a period of no more than 6 years for those particular durations. We were surprised to find out that the 1987 table wouldn't meet that

standard. We looked at the development of that table and went back into the transactions which took us back to the 1982 reports. For years 3-5, the number of terminations from 1962–80 was roughly 1,600, and for the period 1976 through 1980, the number of terminations was roughly 3,400. Nick Smith's study had roughly 18,000 terminations in those durations.

The next table is intended to demonstrate what A over E means in terms of reserves. I did a rough calculation of one sample claim just to get a feel, and maybe you got more information on this at yesterday's session. The table compares reserves using 90% of the 95A terminations and compared those reserves to the reserves calculated using the 1987 table. Reserves are calculated at 5% interest for male age 47, 3-month elimination period, the diagnosis other than AIDS, other than mental or nervous, with benefits going to age 65. I've made some big assumptions here because the table isn't final and I'm also assuming that 10% termination margin will continue to be the standard. This does give you some sense of how the reserves might change.

TABLE 3
TABLE 95A VERSUS 1987 CGDT RESERVE @ 5% MALE AGE 47
3-MONTH ELIMINATION PERIOD

Duration	95A / 87 CGDT Reserve
25 months	91%
36 months	92%
48 months	93%
60 months	94%

The next topic that I want to talk about is risk-based capital (RBC). RBC is the method used to establish the minimum amount of capital that's needed to support an insurer's overall business operations. The formulas are intended to consider a company's risk profile. As the risk profile changes, the required capital changes. My focus today is on the C2 risk, that is the insurance risk.

Last year the health organization risk based capital (HORBC) simplification task force made a proposal to the NAIC that included some changes to the C2 factors for disability income. Since that time, the health organizations RBC group's efforts have focused on the coverages that health organizations are focused on, which isn't disability. My understanding is that the life RBC group is looking at the other proposals, including the disability income proposals. The disability RBC C2 factors are really a two-part formula. There's one set of factors that relates to premium and another that relates to reserves. The proposed HORBC premium factors were 25% of the first $12.5 million of premium, plus 10% of the excess. The formula also gave a credit for benefit periods of less than 24 months, in effect to recognize the

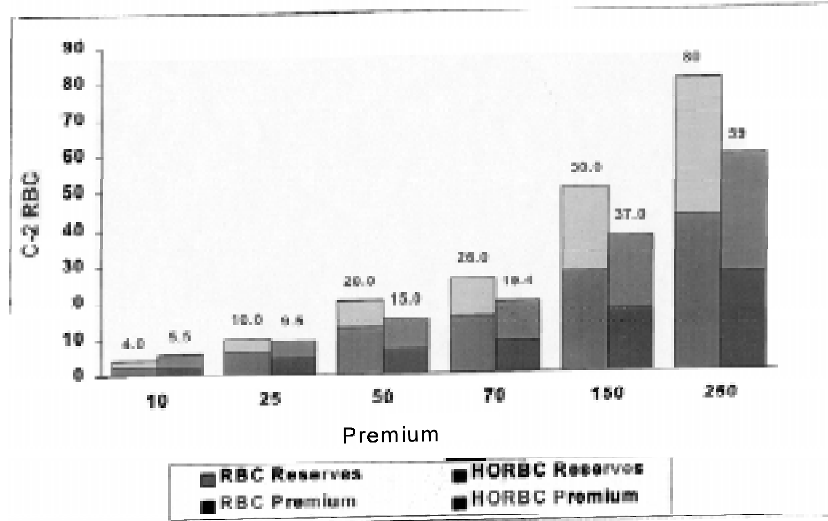
fact that some of the short term disability is less risky than the long term. The current formula is 25% of the first $50 million, plus 15% of the excess. Unless you have a small block of LTD with no STD, you probably would benefit from this change.

The second component of C2 formula are the reserve factors. The proposed formula here is 10% of the first $35 million of reserves, plus 4% of the excess. Again, there's an adjustment to recognize that there is less risk associated with STD. The current formula is 5% of reserves. The proposed formula would increase RBC for small blocks of reserves, but larger blocks would probably get a bigger reduction to RBC. I assume that this is far from final, but I do think that it's interesting to note that neither RBC formula anticipates the amount of conservatism that's inherent in the 1987 table.

Chart 8 converts the RBC formulas into more real terms. All of the numbers shown here are in millions. What the chart shows is how RBC varies by block size in terms of millions of dollars. The bars on the left show the current formula. The bottom color on the bar shows the premium component of the RBC. The top part of the bar shows the reserve component of the RBC. You can see for a company that had a $10 million block size, the RBC would go up. A $25 million block size has a slight decline and the bigger declines in RBCs, the bigger the blocks.

When I looked at these potential changes both in the LTD reserves and in the RBC formula, I was curious as to what they might mean from a pricing perspective. What impact does RBC really have on how I might price a piece of business? To what extent do rating agencies drive what companies do as opposed to RBC, and how much are rating agencies influenced by RBC? I tend to think that companies are strongly influenced by rating agencies, but I'd also like to think that the rating agencies would be influenced by what goes into the RBC formula. I think there's a lot of talent that goes into putting the RBC formula together, and it would surprise me if rating agencies totally ignored that. Having made that big leap of faith, we developed a model to estimate what the distributable cash flows would be month-by-month for a given set of business. We looked at what capital and surplus would be needed to support that business, and we looked at what the emergence of income would be from that business. It ended up being a useful model for understanding the emergence of earnings, but the model also allowed us to solve for the premium a specified internal rate of return. It allowed us to change parameters such as the valuation table or the capital requirements, and given a change in parameter we could determine how much we needed to change the premium in order to achieve the same return, or if you leave the premium constant, how much the return would change.

CHART 8
LTD RBC



In order to do that, I found that I had to make many assumptions, more than I like to make in one sitting, but there was a unified theme to all my assumptions, and that was to keep it simple. I had to make assumptions as to how big a block the company has for LTD, the claim mix by age, sex, and elimination period (EP) diagnosis. I assumed everyone was my typical 47-year-old male. I had to make assumptions as to how statutory reserves are calculated, tax reserves are calculated, expense levels, incidence of expense, asset mix, etc. I needed to determine what non-LTD business for a company looks like, and what the RBC targets are. For this purpose I assumed the RBC target was 200%. Again, I did this simplistically. You can't really generalize from the numbers here. I think every company is going to view things differently and come up with different results, but nonetheless I took a crack at it just to get a feel for the numbers and to encourage you to do this type of analysis for your company.

What I did was put together numbers for a hypothetical company, using assumptions for the company and modeling what premium I needed to achieve an internal rate of return. Then I asked if I get a 15% internal rate of return using the 1987 table and the current RBC formula, what happens if I change the table or change both the table and the formula? What I found is if you change the table under these set of assumptions, results can vary widely. You can get a 3% drop in premium for changing the table to achieve the same return, or if you change the table and the RBC, you get a 3.5–6% drop in premium to achieve the same return.

Assume I calculated a premium to generate a 15% internal rate of return using the 1987 table and the current RBC formula using all the assumptions from my simplified hypothetical company. If I change the valuation table, the internal rate of

return changes from 15% to 17% for a small block or from 15% to 18% for a larger block. The corresponding changes in internal rate of return, if you have a table, and RBC changes are from 15% to 18% and from 15% to 23%. All these assumptions are hypothetical, results can vary widely, and none of this takes into account all the issues that Tom just talked about. I did want to throw these numbers out just to encourage you to do this type of analysis for your business.

Ms. Pamela J. Saunders: As Tom mentioned earlier, benchmarking is not an exact science, and what we do is conduct an annual study that allows companies to compare relative rate level. There are two parts to our study. It's relative rate level on STD and LTD, and then also a risk survey of different functional support areas, and so I thought today we might share some of that information with you. We're going to talk about the LTD piece of it.

Allmerica, BMA, Canada Life, Fortis Benefits, Guardian, The Hartford, Met Disability, Mutual of Omaha, Paul Revere, Principal Financial, The Provident, Prudential, Reliastar, Standard Insurance, TIAA, Union Central, and Union Fidelity participated in our most recent study, which was conducted over the period of December 1996 through March 1997. Ninety-three percent of the companies indicated that they had some form of rate change over the 1996 year, and 40% of those companies indicated their rates went down 1–20%, just over a half of those companies indicated that they went up 1–20%, and 7% said no change. Some disparity existed among the companies and what their strategies were, some of them slow to react to changes. Others having done it in previous years had not as big an impact this year, so that's why we believe the change took place as it did.

When we look at the benchmarking, what we've done on a rate basis is ask for two rates on each given case. We provide standard plan design, the standard industrial classification (SIC), the geographic location, and a census spread with occupations assigned. We then ask them to rate it on a claim-cost basis and on a street basis. What I'll be talking to you about are claim costs, because as Tom said, who knows what they're doing competitively on the street. We feel this is a much better measurement.

Using a general industry distribution, in other words, a group that tends to be at a factor of one for SIC, occupations that are not substandard, we have been rating for the last few years—in this case we compared our 1995-96 study to our 1996-97. We have kept exactly the same detail so that we could do that comparative trend line. In fact, that group of companies and plan designs rates had approximately a 17% rate increase overall. We then looked at it and asked them to use the center as our traditional mix of census, the demographics that you would tend to see in a group of these kinds. We then asked them to rate it as all male and all female, and

we found that the trend line was the same, that about a 17% increase had been confirmed overall.

We got into some specifics by industry group. Physicians, we were very surprised, seemed to have leveled off in 1996-97 for the companies that participated. Going from 1994-95 into our 1995-96 study, there was a 135% increase in rate, but this year only a 2% increase was indicated by these companies.

We had about a 13.5% increase in rate for a hospital group in 1995-95 and 1996-97, and this was consistent across plan design.

A law firm, we were very surprised, actually went down this year for those companies that were participating by about 5%, and we didn't have the similar census plan design in our 1994-95 study, so we weren't able to bring it back to that point as we did physicians. But assuming that there were increases with the attorney groups in earlier years, that's why we didn't see as great an increase this year. Some companies actually dropped rates.

There are some other factors coming into play. Companies have stopped offering extended own occupations consistently, and specialty own-ccupation wording has changed, and so that could also be impacting.

We then asked on our risk survey within different plan design elements, geographic areas of the country, and industry occupational groups wether they had become more conservative in the 1996 year in underwriting. We found, in fact, that the majority of companies indicated extensive own-occupation had been tightened up, the availability of that, and specifically said that for attorney groups a good majority of the companies said they are not extending own-occupation beyond the two years. Maximums in excess of 10,000 had been tightened up—70% benefit, and then to a lesser degree 70% all sources.

For physicians and hospitals, underwriting was tightened up. Even though we did not see a significant price change, they were tightening up the available maximums, etc. Then in California, Florida, and New York, the specialty own-occupations, the extended own-occupations, they indicated that they had tightened up their underwriting as well.

Let’s discuss maximum monthly benefit. We heard that standard issue maximums are limited by the majority of companies to less than $15,000. Upper limit maximums, where you calculate based on top 3 or 5 salaries and what a group will qualify for, have been limited within certain industry segments, such as physicians,

attorneys, and municipalities, and in those segments to $15,000 upper limit for the most part. Not all companies, but a good majority.

We asked about the removal of mental and nervous, drug and alcohol limit and we did some comparisons for the top five sales leaders relative to the whole of respondents. The companies, in total, were not any different from the top five on removal of drug and alcohol, 1–4%. However, regarding removal of mental illness, we found that the group as a whole was looking at a 5–10% difference as opposed to the top five which was 8–20%. Much research and analysis has gone into what the actual cost of removing that mental and nervous rider and limit is on the contract, and so those carriers that have done some of their analysis have found it's much more significant than we might have thought a few years back. Also incidence and percentage of claims open and new relative to that mental and nervous diagnosis are growing.

We asked for some voluntary LTD plans to be rated. We also asked some questions relative to their rating and in our risk survey as well and found that 67% of all companies reporting will offer a voluntary group down to a participation level of 25% or 35%, and 100% of the top five will get down to that level. Pretty much those that were not willing to go down to 25% or 35% were at a 45% or 50% voluntary level.

With incidence rates, we found that 56% indicated that their incidence rates had gone down in the last 12 months, the 1996 year. For the 90-day EP, about half of the group said that their rate was 4–5 per 1,000 lives exposed. For 180-day EP, only 43% were at the 180-day, and then looking at just top five, we had an interesting distribution. On the 90-day elimination period, three of those top five players indicated their incidence rate was 4–5 to 5+%, and then on the 180-day, two were at 2.1–3.3, two were at 3.4–3.9, and one at 4–5 per thousand.

Reasons for LTD claim recovery outside of normal benefit duration expiration. Most significantly work return was indicated, and work return represented 25–50% of all recoveries as reported by the companies. Among the top five companies, three indicated that work return represented 26–40% of claim terminations, while one indicated 60–65%, and then as far as the other causes, own-occupation transition was next in line, death was 10–25% of terminations, and settlement actually ended up being at 1% or less for most companies.

Average monthly benefits seem to have grown for companies. We heard that 88% of them had seen an increase and that on an average gross basis the monthly benefit for the majority of companies was $1,000–1,999. On a net basis it was $500–999,

and it was interesting because on the net basis we had a split. Thirteen percent also indicated that it went up as high as $1,499, and 12% indicated less than $500.

For distribution of LTD claims, these were the primary categories that were consistent: muscular and skeletal, cardiac and circulatory, mental and illness (M & N) drug and alcohol, and cancer. As a percentage of open claims, muscular and skeletals for the majority of companies represented about 11–35%, and 83% of the respondents indicated that for new claims it was in that same range. For cardiac and circulatory, we saw very different numbers. Ninety-three percent of respondents indicated that cardiac and circulatory represented 11–24% of their open claim block, but only 58% indicated that it represented 11–24% of their new claims, and 33% of companies on new claims indicated that it represented less than 10%. That was a shift downward for that particular category, whereas all the other categories went upwards. For mental illness and drug and alcohol, 53% of companies and 58% on an open basis and 58% on a new basis indicated 10% of their overall block of claims. Cancer was interesting. Seventy-one percent of respondents indicated that on their open claim block, cancer represented 6–10%, but on their new claim block, 11–24% of the block was represented by 83% of the companies, so it was growing significantly as a piece of incidence on new claims.

Regarding integrated coordinated products, we asked questions around this issue to get to what companies were actually doing. We found that 87% of companies were integrating or coordinating a program, primarily STD/LTD, and the STD/LTD might be packaged with other products such as ID, life, medical, or worker's compensation. That varied by company.

Self-reported and subjective illnesses have been picked up by some companies, but not as many as we had thought. Thirty-five percent indicated that they limit benefits for subjective or self-reported illnesses. Sixty-seven percent indicated that they actually provide a list. Some companies will simply say that if it's not clinically diagnosable and it is considered self-reported as they define it in their language, then that's the extent of it. Others actually go into a great deal of detail as to exactly what qualifies as subjective. Another 47% indicated that they intend to begin to limit benefits for subjective illnesses going forward, and those that were indicated that they were limiting to 12–24 months of benefits typically. About a third of them actually wrote the limit within their mental and nervous limitations, and there were four states consistently represented as problem states for subjective illnesses—Maryland, New Jersey, Oregon and Iowa.

Activities of daily living (ADL) is something that UNUM introduced within the last year, and some other companies have been looking at it. When we asked the question is anybody using ADL to limit their duration of benefits or their definition

of disability, none of them indicated that they had. However, 1 company did indicate that it was planning to do so over the next 12 months, and even though nobody indicated that they had, 1 company indicated they had problems trying to file it in the state of California, so there is some activity there.

For physicians and attorneys groups, we found that 100% of the respondents had removed the own specialty option from the definition of disability. In the marketplace we know that's not consistently true. They are probably doing this on a standard basis. Twenty-two percent did not offer a T65 or an extended definition of disability, and more than half of them are limiting the maximum to $15,000 or less.

When we asked generally what types of things were occurring and changing relative to having managed their disability, a consistent message came through that the claimants' employability is becoming a major issue on how they're managing their claims and assessing their risk. With that, such things as safety, wellness, loss prevention in total, notification of absence to supervisors as well as formal procedures for how that is performed, training for the supervisor on how to handle and refer absenteeism cases when there is medical attention needed and it appears there be a prolonged absence, job demands analysis and transitional work programs, and work return policies within that employer entity.

In the area of contractual language, this didn't come from our study, but we monitor the marketplace relative to what's happening and dissect contracts and packages that are offered. These are some of the things that we've seen of late that have come into play within contractual language as a way of better management. For instance, gainful employment—the employment that you were performing or any gainful employment that you might be able to perform, and a distinction between that and any as to which is which. For field of employment versus work setting, this is a scenario where we're not going to provide you coverage for your particular work setting with your particular job with that employer. What we're going to be looking at instead is your field of employment and returning you back to gainful employment. With regular versus own, and occupation versus job, this gets back to the same issue as work setting. Treatment and care has become explicitly defined in contracts whereas we now require that they see a specialist in the field relative to the diagnosis of their claim. We have tightened up on exactly what that specialist's credentials are. For mandated participation in treatment, and rehabilitation, we found that a number of carriers have mandated that participation and if the individual will not participate, then the benefits will cease.

Let's look at management activities on the contractual side. Work incentive programs have become second standard programs within the product and expect to

be there 12–24 months. For objective clinical diagnosis, if you look at proof of loss within a contract these days, some carriers put a limit on subjective illnesses. They require proof of loss to be objective and clinically diagnosable. For catastrophic limit for benefits to continue, we're seeing programs where if after 2 years of benefits, the individual is continuing to receive their 60% benefit level, they have to have suffered 2 or more ADL's, and if they do, they're entitled to benefits. If they don't, their benefit may drop to 40% replacement or it may cease.

Contestability and fraud provisions, as we've seen in individual programs, association policies, and franchise programs with two-year contestability are now showing up in group programs, as are subrogation clauses and arbitration. We're seeing arbitration more frequently. It's binding arbitration, so they don't have an option to then take it to the courts. We have seen some with nonbinding, but we recommend binding.

Regarding the hybrid, in the early 1960s and 1970s what we were trying to accomplish with disability plans was to protect the event that should a person become disabled, a reasonable replacement of income would occur. Then over the 1980s and 1990s, we took on a different approach, lifestyle protection. If they had an income loss, we would replace that income, but we would also add to that different variables that would enhance, improve, and increase their benefit level. Where we are mid-1990s is at an income protection level focusing on ability and replacing a reasonable portion of a person's lost income, but also focusing on returning that person back into gainful employment. That's it. We'll open it up to questions at this point.

From the Floor: A question for Tom. Regarding the closing ratios over time, I believe 1 in 9 in 1988, 1 in 11 in 1992, and 1 in 14 in 1997. I'm unclear on the attribution. Which survey gave rise to those statistics? Was it based on a small or a large sample? Was the sample representative of the industry? Is there much variance from company to company?

Mr. Corcoran: It was a closed study that Tillinghast did. It was a small sample and it's based on companies that are in the medium to small group range. Their results were consistent.

Mr. John D. Dawson: I've got some comments on short-term disability, and I'm looking primarily at employers up to maybe 2,000 lives. For the most part, most of the employers that my firm talks to, at least in Wisconsin, say short-term disability is not a huge risk, so they're not interested in insuring the risk. ASO is interesting to them, however, and there are many of medical TPAs that will provide short-term disability administration cheaply, but their real focus is on asking the doctor if

somebody is disabled, so they don't perform good managed disability in my opinion. When we asked the long-term disability carriers who do have that knowledge, they tend to tell us we'll do the short-term disability administration, but only if we can have long-term disability, and that's puzzling to us. We feel if you are in the short-term disability administration business, you should be able to make money on that alone and you don't need the long-term disability to subsidize that line. Can you help us understand?

Ms. Saunders: What we've heard from carriers is that the STD is on a fully insured basis. The STD product is quite profitable, but on administrative services only it's also labor-intensive, and because of overhead, and of a number of other reasons, we've heard from different insurance companies that they're unable to make money on STD claim administration, and for that reason have pulled back and chose not to, unless they can pick up the LTD as well.

Mr. Corcoran: That's consistent with what I've heard. There is a definite movement in the STD and the LTD market where they're interested in insured business because they make money on the risk margins, not on the administrative margins.

Ms. Saunders: It does make the sense to manage the two together, and, assuming that it's positioned appropriately, you can certainly change your results because of it.

From the Floor: Pam, you mentioned that 87% of the companies surveyed integrate or coordinate product programs. What does integrated or coordinated mean? Is it in the marketing, the underwriting and pricing, the claims of some of these, or what?

Ms. Saunders: We asked that question as well. All of them that indicated that they were integrating and coordinating, did it with their contractual language. Some of them with their claim forms, but not all of them. Enrollment had been combined by some, but to a small degree relative to those that responded that they had integrated. We also heard that their back room, their claim management, had been integrated. Some still kept the STD and the LTD separate, but had a referral protocol program for certain types of claims and diagnose that would be referred off for the longer term management, and to the RNs in many cases. As far as premium billing and accounting, we didn't see any integration at all. That was still separate unless it was a composite rate.

Ms. Tania L. Newton: A follow-up to Tom's question. When you talked about integration you talked about STD/with medical or STD/LTD. Have you seen any integration with individual products or have you begun asking that question?

Ms. Saunders: On our survey we were told by two of the companies that they had integrated individual disability income (DI) insurance. They tended to have individual as a primary product line and that would account for that, but what they were doing was integrating the STD, the LTD in most cases, and the DI.

Mr. Corcoran: I've seen a lot of interest by the individual DI writers in integrating with the disability. Their experience is much better on DI written through an employer tie in. That is the hot market in the individual DI business nowadays. People are looking for ways to leverage their way in.

From the Floor: Is it in the contract language again that you're seeing the individual and group integration, or is it in claim management? Where within the company itself are they integrating?

Ms. Saunders: What we heard on our survey was that it was not contractual language in the case of the DI. They in fact were packaging it, so it was marketing. Behind the scenes they were trying to coordinate and communicate more effectively in the claim management aspect.

Mr. Corcoran: That's the way I've seen it done as well.

Mr. Justin N. Hornburg: Pam, referring to voluntary LTD plans, you mentioned that a number of companies, or actually 100% of the top five, were offering quotes. Do you have any kind of a feel for what types of group sizes they're willing to quote, and if there are any industry restrictions?

Ms. Saunders: It varied by company, but for the most part what we're seeing is 50+ lives. Some actually indicated 500+, some were at 100+, some went down to 10, but the majority were in excess of 50.

From the Floor: Any industry restrictions?

Ms. Saunders: No, we didn't see that at all. We saw that wide open. Does anybody else know of any industry restrictions?

From the Floor: I would guess that the industry restrictions follow the normal underwriting guidelines.

Ms. Saunders: Right. Actually we see more voluntary quoted on what might have been traditionally ineligible list of industries on a traditional block of business. They tend to be more eligible on a voluntary basis because they can be managed differently.

Mr. Wayne V. Roberts: You indicated that based on the new table there's a potential of a 3% rate reduction, and then for the larger companies with the new RBC, it would be potentially another 3%. You didn't talk about interest rates going down. Because of the decrease in interest rates, what effect would that have on your LTD premium block? Do you have a ratio for every 1% decrease or 3% in premium, or have you done any work in that area?

Mr. Galenda: The rough rule of thumb that I tend to think of is that 1% or a 100-basis point change in interest rates is like 5.5–6% on reserves.

From the Floor: That's on reserves. Have you done that over into the premium level? I agree with the reserve number, but if you model that on overall premiums what would that be?

Mr. Corcoran: The modeling that I did held the interest rate constant, looking at the impact of those changes without regard to any change in interest rate. I don't have any numbers here to say how much the premium changes. It's going to be a function of a given company's expense parameters, and many of other factors are involved it if I understand the question correctly.

From the Floor: You looked at the change in reserves to end up being worth about 10% of reserves, is that correct?

Mr. Corcoran: It was 5–10% and that was at the durations for older claims. I looked at claims from 24 months and out. I really didn't look at duration from the onset of claims.

From the Floor: Pam, you showed that some of the companies were indicating that incidents rates have gone down. I know that in the past many companies have indicated or publicized the fact that incidence rates are going up. Is that a one-year period or has there been any other information? My concern is trying to segregate the professional marketplace. Also, I think there's a trend from noncontributory to contributory, which tends to have higher incidence rates, so we try to look at specific blocks and what the trends are in that area.

Ms. Saunders: Over the last three years our study indicated for 1994/95 and 1995/96 incidence rates were climbing. This is the first time they've actually reported that it had been reduced and that's overall.

Mr. Corcoran: In the survey that I performed, we did ask companies what their trend had been over the last four or five years and the indications were mixed, if not basically flat. Some were up, some were down, and most were essentially flat. For incidence rates, it's a volatile number in terms of the small magnitude swings you see, so I think you'd want to see a trend over several years before you recognize that as such.

From the Floor: A question for Pam. At one point you were talking about the distribution of open claims by diagnosis versus new claims. I think you stated that cancer was representing a higher proportion. Was that a comparison of the reported percentage that they represented as new claims, such as the last year of survey versus this year, or was that just an attribution that's a higher percentage for new claims, so it must be going up?

Ms. Saunders: What we asked for is a snapshot and at the end of the 1996 year for cancer, what percentage of open claims did it represent and what percentage of new claims did it represent. The majority of companies were indicating that 6 to 10% of their block were cancer on an open basis, but 83% of the companies indicated that 11 to 24% of their new claims are cancer related.

From the Floor: I think that may be more driven by the shorter durations rather than an increase in prevalence of that diagnosis, but it could be some of both.

Ms. Saunders: Yes, that's a good point. We hadn't asked it last year. This was the first time.

From the Floor: I thought I saw a contradiction or at least a discrepancy in your presentation. You said that 45% of the companies had cut rates and 53% had raised rates, yet later you said that the pricing claim costs went up 17% overall.

Ms. Saunders: There was a distinction. One was a risk study in which we asked specific questions from the actuarial department as to what they're doing. The other piece was from our rate study. We would give them plan design census and geographic location and ask them to rate 75 plans for LTD, and in that situation they were indicating that the rate increase was on average 16.7%. But when we asked the actuaries what was going on with their pricing the actuaries indicated something different.

From the Floor: A 17% rate increase is substantial. I would have thought we would see more movement in profitability.

Ms. Saunders: It was consistent among the groups for both male and female and a traditional demographic mix. It was surprising to us as well.

Mr. Galenda: The new case rates have gone up, but the in-force block probably hasn't been changed that much yet, so it's going to lag. The other thing is the effect of rating pools.

Ms. Saunders: This was claim cost, so the rating pools didn't come into play.

Mr. Galenda: Right. You can raise claim costs 100%, but street rate may not have changed at all. I had a question Pam, about the contractual changes in LTD nuances contractual language, which you said didn't come from the survey. What percentage of companies in the market have made changes to contractual language, and how would you characterize those companies?

Ms. Saunders: We have not been able to keep up with it. Diane is our compliance review and product development person here and she tracks market intelligence for our software, so we've been pulling filings, and over the last two years, the majority of players have changed their contracts drastically and continue to about every three months. This has surprised us.

From the Floor: Maybe it's my imagination, but when I see Chart 1, I see three distinct periods and two clear-cut turning points. When looking at the four-year period from 1983-86, you can almost draw a horizontal line through those four years. Then from 1987-92, you can draw another horizontal line, but at a distinctly lower level. Let's focus on the last years, 1994-96. That's in the neighborhood of zero earnings. Let's call 1993 the transition year from the second period to the third period. You have three distinct periods and two rather clear cut turning-points. Why? I've heard many explanations, kinds of reasons given for the down turn, and I believe that there's a lot to be said for all those explanations. But the problem I have with that is those explanations do not convince me why things had to turn so bad so suddenly at precisely those points. Many of forces had to work in the same direction at the same time for the changes to be so abrupt at those two points. Does anybody on the panel or in the audience have a comment on that phenomenon?

Mr. Corcoran: I think what happens when you see the changes is that, of course, the underlying trends are smoother than the demonstrated trends. I think what happens with companies is that they tend to look at things as fluctuations and stabilize them in their mind and in their actions. When things are turning bad and

they think it's a fluctuation, they'll try to draw down on their reserve levels and wait for the good times to come back. What happens is that they realize it's a bad turn, and this is where they have to catch up with their reserves again. In the 1991-92 period, you may have companies who are implicitly releasing conservatism in their reserves to maintain the earnings that they think are the long-term trend. Come 1993 or 1994, they're saying what we really have is a disaster on our hands, the market has turned out to be much worse than we thought, we actually have to strengthen reserves at this point. What's unusual is that it happens in concert like this. If you look at the individual DI marketplace, it was a smoother trend than the aggregate. I think much of this happened at the same time. People recognized the problems and reacted at the same time.

In terms of the high level in the 1980's, I think that was driven by the spike in interest rates earlier. People had this huge amount of investment income that was carrying them for a long time and that naturally went away. There was not too much resistance because it was looked at as excess profits at that point, so people wanted to be more competitive. People concentrated on the competition rather than maintaining excess profit levels.

Ms. Saunders: I would say that some of the driving forces to why that experience went bad would be the combination of downsizing, unemployment, and other factors related to the recession.

Mr. Corcoran: The downsizing was a sudden shock to middle management who have been the traditionally insured LTD group.

Mr. Andrew S. Deitch: With respect to these subjective claims limitations that we see coming out now, from what you're able to tell from the language that companies are using, are companies attempting to overlap the mental/nervous limitation with subjective as in one provision that has everything in there, or do they have separate provisions for the two? or do they intend to have any overlap and are pricing it that way? What do you see as the future challenges because of 1988 to this type of subjective provision?

Ms. Saunders: About a third of them actually write it into their mental and nervous limit. The rest of them actually separated it out as a duration of benefits clause and talk about specific subjective illnesses. My personal opinion on what's coming about with the ADA and the challenge of the Equal Employment Opportunity Commission (EEOC) against insurance carriers is that the EEOC is determined to find a way to prevent insurance companies from limiting benefits. They've tried different bases, and at this point in time, they're attempting it on an employability issue and saying that if you are limiting benefits while a person's continuing to

receive disability benefits, he or she is still employed. If you cut benefits at a shorter duration because of specific causes, you are saying that individual is not entitled to employment so they're getting into it on that part of the way the title is positioned at the ADA. I think they're going to continue to pursue it, and they're looking for opportunities. Diane spoke with some of the EEOC attorneys and they seem adamant on going forward and looking for other avenues to make sure they can do this. I would say that by putting it in your M & N, subjective illnesses could be a later issue. What we've recommended to some carriers is to put it in your proof of loss. If you ask for clinical or objective findings to be utilized in the way that you're assessing whether somebody's entitled to your claim, that's another way of getting at it without specifically indicating that it's an exclusion relative to a certain illness.

From the Floor: I want to counterpoint that. It's interesting to note that the EEOC has already lost this twice, once against CNA, and I don't know what the circuit was. There they used Title I, I believe, and they lost on that. Title I specifically says you can have M & N limitations. They then tried Title III against Met and we know they lost that one. It's strange how they're pursuing it, employability and whether you can get back to work.

I would think that a far easier route for them to take would have been to go to Congress and change the law. I suspect they realize that Congress didn't intend specifically for M & N limitations to be restricted; therefore, they wouldn't win, so they're going to continue to try to win it in the courts. Even if they do win it in one circuit, that doesn't necessarily rule in all circuits.