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Opportunities in "Under-Penetrated" Disability Markets

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Summary: The traditional markets for group and individual disability income insurance have become over-penetrated and profitability has suffered. This session investigates opportunities in three "under-penetrated" disability markets: the blue-collar market, the association market, and the integrated disability (i.e., 24-hour coverage) market. Panelists discuss new solutions to past problems and their prospects for success.

Mr. David E. Scarlett: We have three outstanding speakers for you. Fred Broers from Illinois Mutual will discuss the blue/gray collar market, Wendy Manners from The Hartford will discuss the integrated disability market, and Dan Skwire from Milliman & Roberston Inc. (M&R) will discuss the association market.

Fred Broers is vice president and chief actuary with Illinois Mutual Life. He serves also as valuation and illustration actuary for Illinois Mutual. Illinois Mutual has the fifth largest block of guaranteed renewable disability income (DI) premium and has long been regarded as an important player in the blue-collar market.

Mr. Frederic L. Broers: I'm a relative newcomer to DI since I joined Illinois Mutual five years ago. I think we can start out by defining what we are talking about. At Illinois Mutual, the blue-collar market primarily consists of the building trades: carpenters, plumbers, electricians, etc., including those who are self-employed in those occupations and those who may do contracting in that regard. This category

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†Ms. Manners, not a member of the sponsoring organizations, is Director of Integrated Benefits at Hartford Integrated Benefits in Hartford, CT.

also includes auto mechanics who are not employed by dealers, farmers, barbers, and hairdressers. We define these people as working-class Americans. The topic is underserved markets, so I thought I should get an estimate of whether we actually have an underserved market. Census bureau statistics show that about 38% of the market is blue collar; however, an estimate by Eastern Research Associates shows that the market penetration there is only 1.6%. In fact, based on Eastern Research Associate's information, the only market that we really have done a good job of penetrating has been the professional market. By far, the largest market is the blue collar market and it has the least penetration.

Why has the blue-collar market been so underserved? The focus of many companies has been on the upscale markets. Most companies have targeted people with incomes above $50,000 or above $75,000. The reason for this is easy: that is where the money is. These people have large needs and the ability and willingness to pay for the benefits. We have, by and large, not only in DI but in life, targeted those markets. Conversely, in the blue-collar market, we have relatively small benefits and less ability and willingness to pay for those benefits. Our salespeople are fond of saying that we are compensating with a new car or a new TV for the premium dollar. Small policies generate small premiums which translate into small commissions, so there has been very little incentive on the part of companies or agents to pursue this market. The economics simply haven't been there. There have also been some perceptions on the part of the companies and underwriters that this is a tougher market to underwrite, with less desirable risks and perhaps more abuse of the contract provisions. I think our recent experience with the upscale markets may lay that one to rest. There is no question that the relative needs in this marketplace are greater. For these people, missing a paycheck is a financial hardship, not a change in lifestyle.

Illinois Mutual has been in this market for quite some time, probably closing in on 30 years. We have gained somewhat of a reputation as being a blue-collar company. That did not come about as a part of any grand strategy in which we looked at the marketplace and saw everybody else was pursuing the upscale market, so we decided to go where everybody else wasn't. It came about as a result of a decision that our previous CEO made several years ago when he simply refused to chase the other companies by deliberalizing underwriting and contract language. That forced us to focus where we had already had some success and some presence in the market. We are a company that is concentrated in the Midwest. We are rural rather than urban, and we have never been licensed in California. We feel all these factors have helped contribute to our success in the market.

Our target market is clearly those under $50,000 in income. That is off the radar for most companies in their strategies. Most of our business is guaranteed renewable. As Dave mentioned, we are ranked fifth in guaranteed renewable DI in force, according to A.M. Best. Most of our policyholders prefer to get their coverage at the lowest cost possible, and they don't want to pay a 20% premium for non-cancellable business. Our distribution is basically all brokerage. We categorize it two or three different ways, but it is just brokerage business. We do have national marketing agreements with several fine companies, including some very large ones, and we have had a good deal of success there. About 25% of our new business comes from these national marketing agreements, companies that for one reason or another do not want to write business in this market.

The average agent produces only about two applications per year for us, and we may or may not get business from year to year, so it is a hit-and-miss kind of thing. Obviously nobody is making a great living selling DI for Illinois Mutual. However, the aggregate of these little pieces has enabled us to build a nice block of business. Our experience to date has been favorable. We have made money on DI every year when a lot of companies have been losing large amounts. To date, we have not had to increase the rates on our guaranteed renewable business.

Over 90% of our business is guaranteed renewable; we have very little non-cancellable on the books. Almost 60% of it is in the blue-collar market. The average premium in force is less than $400 a policy annual premium. New issues are running a little bit over $500 annually. The average monthly income currently is a little over $1,100 a month. The average premium per guaranteed renewable policy for our block of business is about two-thirds of the average annual premium for the non-cancellable. Our non-cancellable is well below the industry average, so these are relatively small premiums that we are talking about.

Blue-collar policies tend to have shorter elimination periods and shorter benefit periods. We believe policyholders are trying to balance their need for income with their ability to pay. They can't afford to be without a paycheck but, on the other hand, they can't afford to pay for long-term duration benefits, so you see a significantly higher number of policies with a shorter elimination period and more in the 24-month and 60-month benefit periods.

Because of the problems that have occurred in the upscale markets in the last few years, there has been a renewed focus on the blue-collar market. At the same time, we have had two companies that we have always considered significant competitors in this market, BMA and Fortis, exit. Those two companies, I believe, exited due to strategic considerations rather than the fact that they were dissatisfied with the blocks of business. On the other hand, I hear and read a lot about companies that

are refocusing or rethinking their strategy about this marketplace, so I think we are going to see more activity. In fact, I am concerned that this market has not had a lot of competition in the past, and we may see more from some of the larger players now.

To service the market, you need to have a good balance between cost and benefits and straightforward coverage with low cost and a good benefit structure. However, we have found that our clients are willing to pay more when they perceive that there is more value in the contract. For example, about 20% of our policyholders opt for the cash surrender value rider which repays premiums less benefits paid. Of course, that is sold as a win/win situation. If you have a disability you will get paid, and if you don't have a disability you will get all your money back. It is one of the benefits in our industry that I refer to as a "free lunch." It's very appealing.

You can't pick up an industry publication without reading at least one article about work-site marketing. Successful work-site marketing should increase penetration in all these markets. The appeal of work-site marketing is that you are able to aggregate a group of policyholders that all have small premiums and produce a large enough premium that makes the economics work. The average premium, based on my experience on the life side, is somewhat less, possibly as low as $6 a week. It is a very small premium, but if you get enough of them together it is enough to make it worth your while.

The market generally requires some underwriting concessions and/or premium discounts, and is characterized by high lapse rates. It is not unusual to see first-year lapse rates 35% or higher, and in the second year 25% or more is not unusual. So you lose about half the business in the first two years. I always struggle with this because the salespeople always want to pay the same commission on this as they pay on the individual business. I have a hard time reconciling that kind of persistency with those front-end commissions. I think that argues for a level or levelized commission structure, but I have not been able to convince our salespeople that is the way it ought to be.

There are currently a lot more people today moving into home-based occupations either by choice or by chance. They are becoming entrepreneurs, and we see this as an evolving market. We segment these into two categories, home-based occupations where the work takes place primarily outside the home such as self-employed carpenters and plumbers, and those home-based occupations where the work takes place primarily in the home. Most of the Class B risks would fall into the former category. The latter category is a little harder to underwrite, but we still think there is some potential there.

Women are underserved across the occupational classes. Certainly there is an additional factor in the blue-collar market due to the heavy presence of males there, but we are starting to see more females moving into those occupations as well. More effort needs to be made to market to women.

Given the demographics of the market, it is obvious that anybody who is able to solve the problem and penetrate this market effectively is going to have some great rewards. The challenges are not easily overcome. There is a great deal of sales resistance in this market, and the basic economics with the small premium structure is a problem that has to be overcome if you are going to be successful. The rewards will be great, if you are able to solve that problem.

Mr. Scarlett: Wendy Manners is director of workers' compensation and employee benefits integration at The Hartford in Hartford, Connecticut. She is a Certified Employee Benefit Specialist. She is head of The Hartford's 24-hour initiative including the planning, development, implementation, sales, and marketing of integrated health and disability plans.

Ms. Wendy Manners: All of you work in group disability. I am told by Fred that you have a separate association for property/casualty actuaries, and that none of you actually participate in that side of the house. Just to show a little bit about my world and to demonstrate the value of the product that I bring to the market, my challenge is to get all of you working with all of them. The product bridges two worlds that are distinctly and historically different. They think differently. You think in terms of blue-collar, white-collar, gray-collar, age, sex, and employee demographics. You say that to a property/casualty actuary and they just look at you with a blank look. They don't think that way. They think in terms of industry, work-place incidence, and standard industrial classification codes. And their pricing is regulated to a large extent so there are limited things they can do from a pricing perspective. It varies by state what they can do with the pricing. So you have different worlds. My work bridges those two worlds, and I think your world may start to go there at some point in the not too distant future.

Our customers, *your* customers, have a problem. They have a problem with productivity. We all know about the global economy. You know about competition, and that it is having an impact on business. Employers are needing to squeeze out more and more productivity. The problem for them is that productivity is fragmented. There are pieces of it that are covered by you. There are pieces of it that are covered by things like the Family Medical Leave Act, vacation time, or any absence away from work. There are pieces that are covered from work-related incidents by workers' compensation. Our employers are saying they need that fragmentation to stop. They need you to stop thinking about just group disability

and think more globally for them. They need a more proactive and comprehensive return to work for all absences. Some of the programs that have been historically in the workers' compensation arena (such as disability management) are filtering over into the group disability area. They are asking for those programs to be treated more from a productivity-oriented perspective.

The integrated product is essentially bringing together group disability with workers' compensation. There are a couple components to workers' compensation. Workers' compensation does include the medical component. The market is struggling with how to deal with that medical component right now. Integration is primarily focused on the area you work in, disability. Integrated disability management is a trend that you probably have seen developing in the marketplace and is the focus of the problem that I work on. To give you a little background on the nuts and bolts of the program, it is primarily focused on the service end. All states have restrictions on being able to combine contracts. People once thought that if you couldn't combine the contracts, there was nothing you could do—there was no integration. Well, that really couldn't be farther from the truth. Essentially, integrated programs today are written under standard contracts. There are some states in which there are pilots where you can apply for the ability to write under one contract. Those have "sunset" provisions which make it somewhat less appealing to even try to do that, and those have not really seen a lot of results at this point. Most are really writing in the integrated services end of the business.

These programs generally have traditional underwriting and pricing. As I mentioned, when group disability products and workers' compensation are priced, they are totally different. They do not interact in even the same sorts of data. Pricing has continued to retain some separateness. That is a developing issue as you start to merge the administration of these programs. As employers start to seek some combined funding of those programs, continuing to keep the silo the industry likes to talk about between these two programs becomes more problematic. We have more employers coming to us saying, "We want a combined funding arrangement on this." As you are working both sides of the business together, it is the "squeeze the balloon" analogy where, if you are going to pay under workers' compensation, it is not going to end up in group disability. If all of a sudden you put the squeeze on the workers' compensation side, you are going to start to see your group-disability incidence go up. So if you start to bring those two programs together for more comprehensive management, there are pricing implications. This is what takes me to the doorstep of our actuaries on both the property/casualty side and the life company side. We need to look at this on a combined basis. That is when we sit down with the blank stares and wonder how we even talk to each other.

Integrated disability management is a cross-selling initiative. What generally occurs is rather than trying to place both pieces of business simultaneously, one will often find an existing block of business. For instance, a company will take its group-disability clients and try to cross sell the workers' compensation, or take the workers' compensation clients and sell group disability to bring the two together into a single package. These kinds of initiatives are offered by companies that have both property/casualty and group disability, as well as in companies that are joint venturing to bring those together to cross sell.

As I mentioned, where the meat is in today's product is primarily in the administration. But again there is an evolving need that is growing more real and louder every day to bring together the funding, the underwriting, and the pricing side of this business.

To review the service components that are primarily included in these types of programs today: (1) Almost everybody can fairly easily give the customer a single point of entry into the system. They can give them a single toll-free number to call to report both their group disability claims and their workers' compensation claims. Single point of claim reporting is pretty prevalent in the market. (2) They usually will have a single nurse case manager to receive claim information. If you are not terribly familiar with workers' compensation, you may not be aware that often while you are paying benefits in group disability, workers' compensation may be paying simultaneously. That would generally happen in salary continuation plans which wrap around the workers' compensation (or offset it) or the long-term disability plans where there is generally a workers' compensation offset. It generally is not both plans paying at once when there is an short-term disability (STD) plan. Here, there is usually is a work-related exclusion. But in the other two situations you do have both plans paying simultaneously.

If you have ever experienced that kind of situation yourself it can be somewhat frustrating because there are two nurses generally working that account—Two nurses contacting the doctors, two claim representatives, two of everything. There is redundancy throughout the entire system which causes some disconnect. Employees may be getting different messages about their return to work, their treatment planning, etc. Put one nurse on it to make sure there is consistent management throughout the claim. It also can be a benefit even when there are separate coverages, when there is no redundancy in paying the claims such as in the STD and workers' compensation. In the workers' compensation world (and I hope you have not experienced it), if you submit a workers' compensation claim, usually the claim is denied. There is a reason for that and it is primarily regulatory based, in that workers' compensation must pay or deny a claim within a certain number of days, usually about 14. The reality is that very rarely is a claim submission

comprehensive and detailed enough that a claim representative would feel comfortable committing to a lifetime responsibility for that claim based on the limited information received with the initial submission. Unlike group disability, it is a lifetime commitment.

Depending on the nature of the condition, on a workers' compensation claim you generally have liability for the rest of the life of that claim. So, they will often deny that claim. However, that doesn't mean it will be forever denied. It just means they are going to investigate it, but by law they have to deny it. In the event that the person needs some income to pay the bills, it will go to the group disability side. Again with two nurses, claims are bouncing back and forth, and employees get frustrated. Sometimes the claim doesn't even get submitted for a disability but goes to the attorney. If you bring these two programs together, you can ensure that, if it is not paid under compensation, the same information can be used to pay it under disability. We get a reimbursement agreement signed so that once it goes back to compensation they can just repay the group disability benefit. There is a tremendous incidence of litigation in workers' compensation primarily because claims are usually initially denied. Integration can assist in that area.

Combined claim handling; again there is redundancy in the system. There is no reason, if information has already been sent in to workers' compensation, that the same information should be requested again for disability. You don't need two individual medical evaluations, you don't need dual contacts with the provider, the employer, or the employee. You don't need to harass those parties with multiple contacts. All of that could be done efficiently through one process.

The area of combined claim reporting and loss analysis bridges over into your world of numbers.

We give comprehensive loss analysis of workers' compensation and group disability, and the combined result, so that employers can start to see the total impact on productivity. With integration, while somewhat young in its evolution of reporting in terms of volume of data available, we are starting to see some results. Most of what we are seeing is that employers want only one thing when it comes down to the final analysis, and that is productivity. They want to know total lost days, and they don't really care a lot whether it was work-related. They do care about workers' compensation experience because the Occupational Safety and Health Act is after them if they have hazardous work conditions. Their interest is getting people back to work and keeping them at work, and that is what they really want to know about. They don't necessarily want to be focused on your data versus

workers' compensation data versus some other data. The world is starting to move toward providing that kind of information on the employers behalf.

Combined underwriting is relatively rare in the industry today. There have been a couple of initiatives that have experimented with bringing underwriting together. The Hartford is also still relatively young in that area. I think we will start to see that evolve over the next few years.

In terms of combined billing, sometimes one bill tends to be an undesirable feature for larger employers that have separate risk managers and benefit managers. However, some employers who have a combined function or are integrating their own operations do prefer a combined bill.

There have been a number of studies over the last few years about what is expected from this type of program, and the number one answer is always cost reduction. When I go to the group actuaries and the property/casualty actuaries to get them to come up with one combined number, that is not a small challenge. We do need to get there. Sedgwick did a study in 1998 that showed 83% expect a reduction in workers' compensation cost, 78% expect employee satisfaction improvement, and 78% expect no duplicate claims. (If you have both claims handled in the same place, you are going to see patterns of abuse. As soon as you cut them off from benefits on one coverage, they will file under the other.) Employers also expect increased quality of care. (If you have one message going out about treatment, you don't have mixed messages that are somewhat counterproductive.) Seventy-two percent expect reduced disability cost, 71% expect enhanced data collection, and 71% expect administrative cost reduction and reduced litigation. I think from what I have described to you already, you can see where those expectations are formed from bringing processes together.

Towers-Perrin did a study in 1997 on employer expectations of integration, and again reduced cost was number one. Other expectations were ease of access to benefits (you don't have to submit a claim twice, etc.) improved productivity, and reduced absenteeism. This concept has really been evolving over the course of many years, but has picked up steam over the last 3–4 years. In 1995, 82% were expecting reduced cost, 72% improved human resource planning and productivity, litigation reduction, and performance management. These were the same issues.

Who is doing this? The Integrated Benefits Institute (IBI), an organization in San Francisco, surveys the industry every six months and gives an update on who is doing what in integration.

If you talk to employers, they are planning to add integration and making purchase decisions around integration. Some surveys have been done on our national account business. About 50% of our requests for proposals coming in on national-size business were only going to carriers that were quoting integration, and 75% of them were asking about integration capability. You really can't run away from this one. It is coming, and it is starting to trickle down into the smaller markets.

On the integrated medical side, CIGNA is the only carrier with a national medical program. It has zero accounts on the books, given that it is just one HMO. In your own benefit selection package you probably have numerous HMOs to choose from. One of the problems is that the locations and the number of HMOs CIGNA offers doesn't deal with the national needs of employers medically. Medical is a regional issue.

If you look at a group-disability plan it tends to be administered more on a national basis, as it is federally regulated. You don't have the state-by-state issues. That is a little easier to link up than group medical, where there are vendors across the entire nation.

In 1998, Sedgwick did a study of 500 employers. Fifty-nine percent of them said they had some form of integrated disability in place, and 12% said they are likely to add it. Obviously, based on the numbers from the carriers in terms of who has cases on the books, they haven't necessarily enrolled in integration yet. They are aligning their own internal organizations to integrate first before looking to bring in a vendor for integrated claim administration.

Towers-Perrin also did a study on what they call total health management. Of the vendors, 50% felt that the market is strongly interested in total health management, and 57% said they believe there is a strong market interest. In 1997, Towers-Perrin studied 200 employers with 2,000 or more employees. Ninety percent said that programs should be integrated and in the future this will become "the way they do business." Of the 90%, 25% said that they will integrate immediately, 75% said they will do it in the next 3–5 years. In 1996, Watson Wyatt talked to 251 employers of all sizes. Twenty-five percent said they have some form of integration or coordination in place, and 40% of them intend to add it.

So the studies are indicating that market interest and the intention to integrate are there. We are actually starting to see that movement in the requests for proposals and in the number of accounts we write. We are writing probably four to six accounts a month at The Hartford at this time. They are ranging in size anywhere

from 50 lives up to thousands of lives. Again, much of our national account activity is in this area.

Why is this market under-penetrated? I think it is pretty self-evident. It is a new thing. It takes some time to build, and when you are building within your own shop it is a little bit easier. You control the resources when your hierarchy is structured to support building and you can get that product out. If you only control 50% of the process, and you have to work with an organization that doesn't even talk the same language, this makes it very difficult. So it is a slow start. Additionally, employers also need to re-engineer their own internal processes to align with this. It is going to take some time, but it is definitely heading in this direction. Employers are re-aligning their own internal processes.

One other barrier to integration is how we distribute our products. When you sell your business, you are going to a producer that works primarily in the group life and health area. When workers' compensation sells it goes to a property/casualty producer. You are going to two different customers in the employer's place of business. Workers' compensation is going to a risk manager on the property/casualty side, and you are going to a benefits manager. To make the cross-sell successful, you have to bring all those parties together into a joint decision. That issue goes away to some extent when you have a smaller employer with a combined risk/benefits manager function, but you still generally have two producers. Convincing the distribution world that it is time to change (when that change is somewhat disruptive to their lives, and there are licensing issues involved) and become cross functional in their selling is very difficult. Asking them to work with another producer who may have a property/ casualty or life connection makes it a little threatening to them, and is not an easy challenge. Often you get some static in the distribution system in trying to get the cross-sell.

Integration is about employer productivity. It is about integration of all those things that impact productivity. This is viewed as the next piece in the evolution of managed care. We have managed each of the separate components; now bring it together. This is the next step toward what is talked about as total health and productivity management. It is moving there. Given that there are probably less than a couple of hundred accounts written right now, you tell me what the market potential is. We can make employers lives easier and improve their savings results and their pricing if we can bring these together. It is a huge opportunity, but a difficult challenge to get there. Claims can be managed better. The bottom line is that it is not in the best interest of our customers to keep these programs separate at this point.

With respect to savings projections, Watson Wyatt with Washington Business Group on Health conducts a study each year and recently announced its 1998 study results. It found 25% savings on direct costs. That is not even touching the indirect costs that impact productivity. Mercer also did a study. Its estimates are 15–20%. Towers-Perrin estimates, based on accounts it has integrated, is 15%.

I think the message is clear. The world is moving in a direction that is going to take down some of the barriers for disability. Eventually the medical component will probably be the driver of disability duration. That means thinking about management information systems, reporting analysis, and pricing in a way that will meet the customers' productivity-driven needs. That may not be white-collar, blue-collar, age, sex, and employee demographics. It may be about lost days and productivity issues that address the employer's business needs. I think that ultimately will mean you will work more closely with the property/casualty actuaries and start to develop a common language.

My advice to make this work for you is, find the "yin" for your "yang." If you don't know a property/casualty actuary already, get to know one. Start to talk about how his or her world. Talk about productivity. I like to call it the "take an actuary to lunch" program. Find somebody who knows the world that you don't yet know, because there is an emerging trend in that direction that would be beneficial to know about.

Mr. Scarlett: Dan Skwire is an actuary with the Portland, Maine, office of M&R specializing in disability insurance consulting. He was previously second vice president with UNUM Life Insurance Company. In that position, he was responsible for a variety of financial functions in the individual disability division, including pricing, reinsurance, financial modeling and regulatory compliance. Dan is currently the head of the Disability Special Interest Group of SOA.

Mr. Daniel D. Skwire: We have quite a bit of variety on our panel. We are talking about three very different markets. I will discuss disability sold to professional associations. One way to think about association disability is that, in many ways, it is a combination of traditional group disability insurance and individual disability insurance. Unfortunately, that means it is twice as hard a product to deal with.

Those of you who have written business in the association market may be a bit surprised to find it in this session of under-penetrated markets. In fact, I think Fred explained that disability sold to professionals and particularly to white-collar professionals was more highly penetrated than other types of disability markets. So

this is a difficult question, and I think the answer really depends on your view of the association marketplace. I will come back to this in a few minutes.

I thought we would start out by taking a look at the association disability channel and how it operates. To a very large extent, people's behavior is motivated by money. So when we take a look at this channel, we should take a look at how the different players are paid and the way in which that focuses their motivations for their jobs.

The first link I want to talk about are the purchasers of the insurance products, the members of professional associations. For many years, the traditional buyers of association disability products were not financial experts. They were not very sophisticated financial consumers. They were members of professional associations, frequently self-employed, and frequently not at a very high-income level. This meant that products that were marketed to them on a fairly simplistic basis with a direct-marketing approach had a great deal of appeal, and were very easy for them to purchase. That has changed a bit in the last five to 10 years. Current buyers of association disability products are much more educated financial consumers. They have higher incomes and, in many cases, more layers of disability coverage. By this, I mean they may have group disability coverage through their employer, they may have a separate individual policy, and they may be looking for some additional coverage on top of that.

This is an important shift in this marketplace and one that some companies have been somewhat slow to recognize. It is a shift that affects not only the marketing of these products, but also the risk profile. Just as one example, consider the new importance of financial underwriting for this channel. When you are selling to a population in which a very high percentage has other coverage, it becomes very important to get the detailed information on what coverages are available and the taxability of those benefits. When you are dealing with people who are self-employed, it is important to have a good understanding of the revenues of their businesses and how they operate, and how that relates to their income. This is an important step, especially for companies that have previously focused on group disability. This can be a very new concern for them on the financial underwriting side.

The next link consists of the association itself. The association makes its revenue from membership dues, which means that the primary concern of the association is to keep its members happy. One of the ways that associations do that is by offering an attractive package of benefits. Of course, the people at associations who make the decisions on insurance benefits are not, by trade, financial experts. If it is a medical association, they are probably doctors running their own practices. They

may be lawyers, accountants, or whatever profession you are dealing with, and therefore, insurance is not really foremost in their minds. That means that the traditional way that insurance decisions are made is for associations to contract with a third-party administrator (TPA) to help them run their insurance programs.

The TPA has a primary role in this channel. For the most part, TPAs are paid by commission so they get their compensation from a percentage of premium on the case. Traditionally, the commissions in this business are a completely level, flat percentage of premium but usually quite high. In fact, a 20% commission level is not uncommon at all for this business. That commission stream means that the TPA has a very significant interest in keeping things running smoothly. On these products, the traditional premium structure is a banded attained age rate which increases with age. Due to that, the renewal commission stream stays very stable even if the number of lives who are insured is declining. This increases even further the administrator's desire to keep the case in force and moving along, even if sales have not been growing rapidly.

Once the TPAs have been contracted by the association to help administer the insurance programs, it has several primary functions that it performs. The first is to seek out insurance carriers to provide those benefits, which is usually done by putting in place a series of endorsements with companies. The association will offer a particular disability product, usually just from one company, and the company in exchange will say that you are going to be the sole representative who can sell to this association from our company. We are not going to send our other brokers and agents into this same case with a different product. This will be your case.

Once those relationships are in place, the TPA's role includes such functions as marketing the case to the individual members which is usually, although not always, performed through a direct-mail type of marketing approach. In almost every case, the TPAs perform billing and collection functions. They send out the premium bills, bring the money in, take out commissions, and remit the remaining premium to the insurer. In some cases, although this is declining somewhat, the TPA also provides the individual underwriting support for the cases and the claims management or claims-paying support. There are a lot of different roles that fall to the TPA and they really boil down to communication. The TPA is the link between the association and its members and the insurance company. So, if the association has a concern about the types of benefits that are getting paid or the types of products it needs, the TPA needs to relay that. Likewise, if the insurer finds itself in a position where it needs to make changes to the program, it falls on the TPA to explain to the association why that has to happen and why it is in their interest to play along with that.

The final issue that complicates things for the TPAs is that a great number rely on just a few cases for their entire livelihood. For example, you may have a TPA who has all of its business in one state. It might have the state medical, the state dental, and the state bar association. That is an awful lot of premium volume and it is coming from different lines of business. It is not just disability, but medical, and liability, and so on. But it is a lot of premium tied up in just a couple of cases. That makes it doubly important for them to keep things running smoothly. They don't have to lose too many of these cases before their entire livelihood is threatened.

The insurance carrier is compensated by the bottom-line results of the business. That means that they need to balance all these challenges of sales, profits, and persistency. Those are tasks that they take on by working with the product design, the underwriting rules, the rate structure, and so on. But there are a couple of real challenges in measuring the profitability of association disability business. I think there are two particular areas that are difficult for companies to get a handle on.

The first one is the data on your in-force business. The challenge here is, in part, the role of the TPA. Because the TPA is responsible for collecting most of the initial information at the time the policies are sold and because a company is dealing with a variety of different TPAs on its association disability business, there are a variety of different types of data coming in. Some may be very good at collecting individual policy level information on the plan design, on the underwriting techniques, and on the premiums. Others may be set up only to collect very high-level data at the group level. You may know only how much premium there is on this one case and how many covered lives are there. The amount of data that you have plays a very great role in your ability to measure the profits on a particular case.

Another challenge in measuring profitability is the fact that many large association cases are managed through retention accounting, by which I mean experience rating through the use of a premium stabilization reserve. A stabilization reserve can be used to return favorable experience to the association if profits are greater than expected or to provide a cushion for the carrier if profits deteriorate in the future. The challenge is that the assumptions that are used to compute the stabilization reserve may differ significantly from the actual experience of the insurance company. For example, the insurance company's actual expenses might be quite different from the expenses that are charged to the association for the purpose of administering the case. Likewise, the interest rates may be different. There might be different reserve assumptions that are being used for calculating the morbidity experience. All of these differences cloud the picture of how profitable a given case is. It is necessary to look very closely to understand how a specific case is performing.

I think the buyers, more than any other link, typify the shift that we have seen in the association disability market. The buyers today, as they have been for years, are concentrated in a few specific professions. They are doctors, dentists, lawyers, and CPAs. In fact, those four probably make up 85–90% of the association disability business that is sold. But over the years they have become more sophisticated buyers and have more in-force coverage, as I had described before.

As a result of that shift, these buyers are demanding more generous and complex products than they ever have. They are looking for long-term benefits, residual coverage, and own-occupation definitions. As these products become more complex, the insurers are saying that to sell you these products they need to have significantly tougher financial and medical underwriting, and it is going to cost more money to buy the products. The result of all of this shifting has been that the association disability market is no longer as clearly defined a niche of the disability market as it has been in the past. The offerings have become similar to individual disability insurance. Due to the mechanics of the distribution channel that we have just described, there is less tolerance in this market for the type of underwriting and rates that are typically required in the individual market. They are really the most challenging aspects of the individual and the group market mixed together. The result has been a market that has a little bit of an identity crisis. The professions are the same as always, but the underlying risks and marketing issues have changed significantly.

We have touched on many important issues, so I will summarize them very quickly. Some of the risks/challenges of this market are the overconcentration on a few specific professions which, tragically, have been the ones that have suffered the most in the last couple of years from the disability downturns. I think the underwriting performed on association disability business has somewhat lagged the changes in the products. The products have become richer, and the underwriting is gradually tightening. That is a big change in a lot of ways, but has been a little slow to pick up. You have to think about your underwriting very differently if you are writing a $1,000 a month on a two-year benefit period versus $7,500 a month on a to-age-65 benefit period. Finally, for the reasons we have described with the TPA, it can be difficult to place rate increases on these cases. The TPA, despite the opportunity to earn a higher commission from the additional premium, may be more concerned about the risk of the association deciding to seek out another TPA who can bring them a better deal from another insurance carrier. That can be a tricky situation.

At the same time, the marketing hasn't been easy. Many of the potential buyers of this product are asking, as long as they need to go through medical underwriting

and financial underwriting, why not go all the way and buy a big face amount of individual coverage that is guaranteed renewable or even noncancellable instead of this association business, which has some specific renewal conditions and some other complicating factors? Likewise, because of the additional amounts of group disability in force, many buyers are eligible for less coverage and many carriers find themselves relying heavily on a couple of large cases, which makes it that much more difficult to take some of the steps that are necessary to manage the risk.

I have explained the many challenges in association disability, but there are also opportunities. For companies that want to explore association disability, the critical first step is to stabilize in-force business, if there is a block of in-force business. To begin that process means getting a good understanding of the experience on the in-force business. That means cleaning up the data, getting some of that information that we talked about before on an individual policy level, and understanding the types of coverage in your business so that you can look at one segment at a time and figure out if you have problems and from where those problems are arising. Is it limited to the shortest elimination periods that you have? Is it limited to a particular definition of disability? That can lead you in certain directions to make the appropriate changes in your portfolio.

Once you have an understanding of the experience, you can move ahead and start dealing with some of the other risk-management practices. Examine the claims and underwriting practices that you are using. If you are relying on a TPA to perform some of these functions, you may need to think about how that TPA is compensated. For example, if you are relying on a TPA to perform the individual underwriting and make the decisions about whether policies are issued or not, and you are paying that TPA on a commission, which means the TPA only gets paid if they issue the policy, you want to make sure that you have some kind of component in that compensation to encourage the TPA to issue only profitable business. It is sort of aligning the interests of the different parties that we have looked at. There are a lot of other steps that can be taken as well, such as reviewing the product offering and taking the appropriate rate actions. It is not necessary to try to do all of this at once on a particular case, because that is where you can sometimes get into trouble with cases picking up and walking because they are getting a little bit too much change at once.

I really think that the key to taking a lot of these steps is being candid and communicating very clearly with the TPA because the TPA is going to be the one who has to walk into the association and explain why its rates are going up or why a certain benefit is no longer available. If you are able to sit down and explain the experience and present a good argument for why having a financially healthy case will benefit not just the company, but also the TPA and the buyers of the product,

you will be much more successful in trying to get some of these changes put in place.

It is a little more fun to talk about future growth in a market than about solving past problems. I believe that the association disability market is one that is ripe for growth if it is tackled in the appropriate way. I think that the key to growth in this market is to look beyond these four traditional professions that have built up so much of the in-force business. For the reasons I have described, those buyers have changed so much in recent years that they are no longer being well served by the association products. The key for the association market will be to find those potential buyers who do not have other options for disability coverage, people who work at home, who are newly self-employed, are entrepreneurs, and maybe even those who are temporary workers. There are a number of segments like this. Every study I have seen suggests these are the most rapidly growing segments of the work force. New jobs that are currently created, to a very large extent, are people going into business for themselves or working in small businesses and startups. It is not easy for these people to buy other types of disability. Traditional group doesn't work because they may be too small or may not have traditional employment relationships. Individual writers issuing policies that have long-term guarantees and generous definitions have a lot of trouble figuring out ways that they can offer those types of products to these markets.

The challenge is that selling to these markets will involve designing new products to specifically match the needs of the market. This is a fantastic opportunity for innovation because the key is to design the product to match the market, not to try to find a market that matches your existing product. That is the approach that has been taken in the past and it is reaching the end of its life span in this particular market. This concept of selling products to people who do not have other options for disability insurance is not that big a change. In many ways it is the same niche that the association market used to serve. It is the uneducated financial consumers who don't have the other options. It is just a different collection of workers and professions. There is a lot of potential here. It is going to take a little bit of research and some creativity to approach the markets, but I do believe there are significant opportunities. If you focus on the traditional occupations, then the market is not underpenetrated. If you are going to concentrate on physicians, for example, physicians have a very high amount of disability insurance in force, and I can't by any means call that an under-penetrated market. If you can look beyond those traditional markets, there is a lot of potential and a lot of marketing opportunity in other areas.

I wanted to give you a head start on your research into under-penetrated markets. The public library has volume after volume of directories of associations. I pulled one up the other day. It has a list of about 25,000 associations from the AAA Foundation for Traffic Safety to the ZZ Top International Fan Club.

Mr. Thomas K. Penn-David[*]: Dan, how many companies are playing in that market, how many TPAs, and roughly how many associations or what percentage of them have been written?

Mr. Skwire: I think a fairly small percentage of those 25,000 associations have actually been written. Of insurance companies, I would say there are about six that have a really significant presence in the association-disability market. There are probably six others that have some cases in force who specialize either on the group or individual disability side but have gotten a few of these that have come in from time to time. Of the associations themselves, there seems to be a fairly high level of penetration on the medical, dental, and legal side, but I think when you associations that are more general in nature, it starts to fall off very dramatically. There are associations, for example, of self-employed professionals as well as all sorts of affinity groups by which I mean associations that don't focus on a profession, but on some other connection, like an alumni association. Those, at this point, are almost zero penetration. A few companies are beginning to explore that. That is really a new market.

Mr. Richard H. Magro: Fred, you discussed the guaranteed reversible distribution of benefit periods, and there was an emphasis toward the shorter benefit periods. You suggested that part of that may be due to income or what they can afford. I was curious what your opinion is as far as the percentage of that that might be controlled by issue participation limits or underwriting guidelines. Are there occupation classes where that is all you will offer?

Mr. Broers: Most of it has to do with selection on the part of the individuals. In these occupations, we feel that they easily understand short-term disability. If you are a carpenter and you break an arm, you know you are going to be disabled for a short period of time before you are going back to work. They don't have a long-term perspective on disability. We feel that it is the nature of the beast and the selection is primarily on their part and not on ours.

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[*]Mr. Penn-David, not a member of the sponsoring organizations, is Assistant Vice President of Munich American Reassurance in Atlanta, GA.

Mr. Barry D. Eagle†: Dan, you mentioned a lot of the opportunities at different associations and you also cautioned us to clean up our act before we get into trouble. Do you see us presently or likely to repeat with the association business that is in force today some of the mistakes that we did on the individual side?

Mr. Skwire: Some of the mistakes have been repeated already and many of the problems that have occurred in the association disability business are similar to those that have happened on the individual disability business. There are a couple of advantages because the business on the association side is largely conditionally renewable and has nonguaranteed premiums. It is a little bit easier to step in and try to fix those problems than it is on the individual side, where it is either guaranteed renewable or non-cancellable and tougher to solve. In moving forward, one of the keys to avoiding repeating those errors will be to have a good understanding of the market itself. To the extent that the market is a different risk than companies have done before, both the products and the underwriting will need to reflect that. For example, if you are writing people who work at home, it may be more difficult to offer an own-occupation type of disability definition because it may be very tough to define the specific occupational duties that are involved. The right type of contract for that market may involve a wholly different approach to the definition of disability, but I really think being in touch with the market is the key to avoiding those mistakes.

Mr. Thomas M. Ciha: Fred, given the nature of your business's lower incomes and shorter maximum periods, are your financial underwriting guidelines significantly different from those in the companies that sell to professionals?

Mr. Broers: As I said, I am a newcomer to the disability market and all I know is what we do. I don't think that they are. Our underwriter comes from Lincoln National Reinsurance so he has seen a lot of companies, and in my discussions with him about what we are doing differently, he hasn't indicated that there is any significant difference.

Mr. Michael V. Koopersmith: Fred, you commented earlier on work-site marketing that you have a relatively low average premium and very high lapse rates. I wonder if you might comment on the economics of that business. How you actually make money in that kind of environment? What might you be able to do either through employer selection or agent training or whatever to improve the persistency in that block of business?

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†Mr. Eagle, not a member of the sponsoring organizations, is Second Vice President of Marketing at Cologne Life Reinsurance Co. in Stamford, CT.

Mr. Broers: Do we have anybody here that does a lot of work-site marketing that could address that better than I could?

Mr. Koopersmith: I can tell you that I come from a company that used to do a lot of that and stopped for those reasons.

Ms. Sue Rynearson: The average age really goes down and I think part of what we have seen is you are going to have a real hard time getting the lapse rates very low in that market just because people change jobs. If they change jobs, they don't keep their coverage. You said your first year was 35–40%. That actually sounds pretty good. I would like to know how you did that.

Mr. Broers: I guess better case selection. I feel that if you are paying individual commissions and have those kind of lapse rates, the economics are not there. Some things you might do about it, if you can sell this to your sales or marketing people, would be to select companies that have lower turnover rates. Try to avoid new companies because the failure rates on new companies are very high, and if a company goes out of business or if an employee leaves the business, he or she generally do not keep the coverage. Again drawing on my life experience, we found that about 85% of the people who leave the employer do not keep their coverage, and this is one of the big misconceptions in the sales approach. We argue that this is coverage that you can take with you wherever you go. It is not a group coverage that ceases when your employment ceases. The fact is that the employees typically view it as group or associate it with their employment and when they leave their employment they terminate it. When the payroll deduction stops and you find out that they are gone, it is too late to do anything about it.

Ms. Manners: The purchase decision is made by the employer. The offering is similar to workers' compensation, which applies to all employees obviously, and the disability may be on a voluntary basis, so it need not involve all employees of the firm.

Ms. Rynearson: You only integrate for those who selected? It is not automatic for everybody?

Ms. Manners: Right. There may be employees who only have workers' compensation coverage and aren't eligible for disability. Those who do elect disability coverage receive integrated claim services.

Ms. Rynearson: So you can't really combine the underwriting, can you, if it is a different underwriting process?

Ms. Manners: There is a totally different underwriting process. One of the things the market has been looking at is, if you write multiple lines of business with a carrier, do you tend to have better results overall? There have been carriers that have found that they do have better results when they have multiple lines with a particular employer, but the specific results vary by carrier.

Ms. Rynearson: You were talking about integrating the claims management. Have there been differences in the past between managing claims from workers' compensation and claims for group disability?

Ms. Manners: Handling claims for workers' compensation and disability are very different from a regulatory perspective. Workers' compensation has very specific requirements about what you can and can't do. You can't stop benefits without going perhaps through a hearing, or having the doctors concur that the person is no longer disabled. It is more a voluntary stopping of benefits on the carrier's behalf on the disability side. The underlying piece that is very similar is how you manage a disability: how you get a person back to work, the medical protocols, and the treatment that would be used to treat the person most effectively.

Ms. Scarlett: I was taken by the statement that Illinois Mutual has never had to increase rates on its guaranteed renewable products. What is a typical incurred loss ratio for this kind of business?

Mr. Broers: We are creeping up a little bit. We are about at 75% now.

Mr. Scarlett: Is 75% enough to cover expenses and profit margin and not think about increasing rates?

Mr. Broers: I didn't say that.