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Session 17PD
Hot Topics in Group Short-Term Disability Income

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Summary: This session begins with a short presentation of current results and experience trends for the group short-term disability (STD) industry. Following that, panelists discuss issues of timely relevance to group STD actuaries. Areas covered include:

- *Voluntary products and other new product trends*
- *Statutory disability programs*
- *Integration issues with long-term disability, medical, and workers' compensation*
- *Additional hot topics to be announced*

Mr. David S. Mogul: I'm going to give some general thoughts about short-term disability. Ray Siwek will inform you of cash sickness plans or statutory disability plans as they're also called. Andy Baillargeon will discuss voluntary products.

It is probably not a surprise to many people that STD traditionally has been the coverage that has been somewhat neglected in terms of studying it. It has been treated more as a collateral line, a tag along type of coverage more than anything else. As a result, not too much actuarial study has been done. Also, it's not a product like long-term disability (LTD) where there are tons of different product variations, product features, or a lot of differentiation between products from one company to another. At least until the last couple of years, the rate levels haven't been as critical in short-term disability. The rate levels have certainly not been as critical as they've been on the LTD side. As a result of some of these things, you find that there very few experts, either individuals or companies, in the STD field.

The second point that I wanted to make was that it seems that there are almost two separate and distinct products. There are two separate and distinct products, what we call small and large, and the definition of small and large actually differs from company to company. But what I mean to be small are the situations where you're primarily talking about a manual rate as the largest component, and it's usually fully insured business. The large ones are those that are primarily based on the group's experience, and it's primarily administrative services only (ASO) coverage. The dividing line between the two from company to company varies, although it seems to be the case that most companies would start their experience rating somewhere between 50–100 lives, and consider fully credibility somewhere between 300–750 lives. One other thing about small versus large, it seems to be the case that most companies specialize in one or the other, and not necessarily both. There are a lot of carriers out there that are very expert and have large books of business in the small end of the market and not large and vice versa. There aren't that many carriers that, at least on the STD, are very good at both or at least have a large concentration of both.

It seems that on the STD side, insurers, including the actuarial staff, have become more sophisticated in terms of STD. There are many reasons for that increase in sophistication. There certainly are a lot more specialty carriers than we've seen five or ten years back. With a number of companies exiting the medical arena and now focusing on other coverages including STD, obviously they have to key on each and every product. Also, in the last number of years, and this hasn't really been restricted just to STD, there has been a lot more focus on profitability. STD is being looked at as well as any other coverage. For the carriers that have offered medical coverage in the past, STD had been pooled in. The increased competitiveness of medical carriers necessitates kind of breaking out each of the different products that, in the past, had not been really looked at separately. Each individual one, including STD, has been analyzed more as a result of that.

The results of these changes in the last number of years differs a little bit between the large and small market. On the large side, what we've seen is that either for the first time (or at least the first time in a long time) companies are starting to look at individual experience rating factors a lot more closely for STD (i.e. things like credibility factors, reserve factors, and expense factors).

On the small side of the marketplace, it boils down to improving the accuracy of the manual rating formula for STD. I think that breaks down into two major categories. One is increasing the number of factors that are being used to determine the manual rate for STD. The other one is looking at each of the individual factors in more detail.

One of the individual rating factors was area. If you looked at companies that had filed rates ten years or maybe even five years ago, a number of them probably didn't even include area as a factor in the STD manual rating. The majority of the carriers now are including that factor. I think a lot of that is recognizing that many of the things that drive LTD experience, like economic conditions and different medical conditions by area, also have an influence on STD experience. This is a good place to point out the fact that it tends to be the case that on STD versus LTD, the variation between the factors tends to be a lot less on the STD side. It seems like if a company's LTD area factors vary say from plus and minus 30, for the STD side it might be more like plus and minus 15.

Another individual factor was richness of benefit. You're starting to see more of that then you had seen historically. Again looking at what is done on the LTD side, where the more rich the benefit is, the more you expect both incidence and duration to increase, you should look at some plan design factors that capture that (i.e., things like benefit period and maximum benefit).

One thing I wanted to point out when I was talking about the small case market and manual rates is, I think, except for the companies that have been primarily small group carriers, there has been a lot less of an emphasis on manual rates, thinking that most of the STD business is experience rated or at least primarily experience rated. There has been a little bit of a push back in recent years to realizing or rediscovering that manual rates have other applications. I'm talking about things like having a tool for plan changes, for risk management for cases that had no prior coverage, and for looking at groups that either through acquisition or divestiture, or for whatever reason you can't get at their underlying STD experience separately. These are some of the things that are helping to push forward much more sophisticated manual rates.

One thing I wanted to spend a little bit of time on is how STD rating differs from LTD. I mean to go a little bit beyond the obvious differences. We talked a little about the fact that this is a simpler product than LTD, and really the big difference that jumps out is the fact that reserves are not an important part of the STD rating. It's the short-term nature of the risk, but it plays a pretty huge role in making one a lot more straightforward than the other.

A compliciting factor is self insurance. As most of you know, for traditional LTD, it's fairly uncommon, except for the really large cases, to see an ASO or a self insured type of arrangement. On the STD side, it's not uncommon for larger cases and even some smaller and mid-sized cases to have some kind of self-insured arrangement. That brings in a couple different things that we're not thinking about

necessarily when we're talking about LTD rating. There are different categories of self-insurance arrangements. The first one I call salary continuation. What I mean is a situation where you're continuing 100% of someone's salary for a certain number of weeks, and that certain number of weeks is the same for everybody in a particular class. I try to contrast that with sick leave, thinking that sick leave is the same in that it continues people's salary at 100%, but it's for a certain number of weeks and those number of weeks are tied to years of service. The third simply is ASO; I kind of look at that as the all other category. That's the one where benefits typically are the same or at least similar to what you see on the fully insured side except for the fact that it's the employer's liability that you're talking about.

You also have the considerations of whether the plan is an Employee Retirement Income Security Act of 1974 (ERISA) Plan, or non-ERISA Plan for the self insured. In general terms, the ERISA plans are the ones where the benefits are being paid out of an ERISA trust; you have a plan document to support the plan with non-ERISA and the benefits are being paid out of either general assets, payroll fund, or payroll assets. Also, you have the differentiation of whether or not you're just calculating the benefits (and they're paying the benefits). There are a couple of things you need to think about there. When you're only calculating the benefits, you do have the additional complexity of trying to coordinate with the employer's payroll system. If you're calculating and paying, obviously you have the consideration of calculating the amount, cutting a check, and doing the actual mailings. Also, because you're only talking about the expense component on the self-insured side, it puts a lot more emphasis on that expense component, both for the expenses that are STD related as well as just general company expenses. Last, because we're talking primarily about the employer's risk, you tend to see a lot greater range of plan options available in the self-insured market. I'd almost say in the larger cases that you can be almost talking about "limitless benefits" where you can talk about things like an unlimited maximum. It's not as critical a situation or concern as in the fully insured market. For larger cases, you see a lot more variability in the self-insured market.

I talked a little bit earlier about product features. It certainly hasn't been the case that companies have been competing on the basis of differing plan features for STD. So both the number of variations and the types of variations have been a lot more limited on the STD side than for LTD. There's less potential liability on STD than on LTD. That has somewhat pushed the point that the underwriting rules, as well as plan designs, have tended to be less restrictive in nature than certainly they have been for LTD. Whether that's the motivating force or whether it was just the fact that these types of products have gotten less attention historically, I think you still have that same result. As companies have grown in their sophistication and the

attention they pay towards STD plans, I think that is changing. It probably will continue to change going forward. I mentioned earlier that STD has been less studied and less is typically known about these plans than LTD. What drives that point home is if you look at the amount of work that has been done by the Society on STD (versus LTD).

The last point I had in terms of differences relates to claim management efforts. Except for the case when you have both STD and LTD together with the same company, you see a lot less claim management on STD. Typically, if you have anything more sophisticated than duration management, you're probably a lot different than everyone else. I think that's usually the case on STD, instead of all the different efforts that go on with LTD. However, when you have the two coverages together, you're paying a lot more attention to your liabilities from day one.

I want to spend a little bit of time talking about STD experience. Historically, the profit levels for STD compared to LTD have been a lot more stable. STD tended to be a more profitable line. I think that this may change with increased competitiveness. I think that has already started to be the case. Some of the profit levels may slip a little bit going forward, especially on the small group side of the market. This has been a fairly unpenetrated market. As a result, there has been more market growth and more market growth potential in the STD market. Also, we've seen historically that both the closing ratio and the lapse ratios have been close to LTD, although we have seen higher lapses in more recent years on the STD side.

The last thing that I wanted to talk about was integrated products. I'm going to restrict my comments to integrated products where you have STD and LTD together because I feel they have been the most successful. I'm not so sure everybody would agree with that, but I think that's certainly the most prevalent of the combinations that have been tried in the market today. It is the combination that seems to make the most sense, at least from a theoretical point of view, and it seems like the one that's a natural fit. Questions are out there in terms of how successful carriers are and how much value there really is in terms of savings. The answers vary pretty widely. I would think, going forward, we're going to see this happen a lot more successfully as companies start to realize what works and what doesn't with this type of integration.

I think there is some difference between what companies are actually doing and what companies say they're doing; I think there is a lot of talk about this in the marketplace. I don't think you're going to see that many carriers, certainly not

major disability carriers, who won't say that they have an integrated STD and LTD product. As you go behind what's being said, I think you do see a lot of variation in terms of what's actually being done. I call it actual and apparent. For actual, in a lot of circumstances, companies either have one contract but even more importantly or more commonly, it's not necessarily one contract but it's separate STD and LTD contracts that fit together fairly well. Also, on the claims side, I think it's the case that a lot of these companies have a claims management office that is either located with or have their STD and LTD claims being handled by the same person. I think that's where some of the efficiencies that need to be gained are actually being realized. I contrast that with what I call a common front end. I think a lot of it appears in marketing and in the discussions that come up where people are just more or less talking about this. The question is, how many efficiencies are actually being gained? This is where you see the differentiation.

Mr. Raymond A. Siwek: I'll be discussing statutory disability. First I'll go over what statutory disability is exactly. Then I'll go over some of the high level features of each of the various statutory disability plans. I'll also touch upon some instances where you might be asking yourself if your customers are in compliance and exactly what are the rules surrounding these plans. I'll touch a little bit on plan design considerations when designing a disability program. Finally I'll get into some examples of the regulatory requirements of these plans. They are extensive and problematic at times.

What is statutory disability? Simply put, statutory disability is mandated STD. The coverages are for nonoccupational disabilities and complement the workers' compensation benefits. Statutory disability is often referred to as state plans or mandated STD in the industry. Five states have legislation requiring these benefits. They include California, Hawaii, New Jersey, New York, and Rhode Island. Also, the Commonwealth of Puerto Rico mandates these benefits. It is up to the employer to provide benefits for their employees actually working in these jurisdictions. The cost is borne by the employer and the employee. The coverage is available through state run funds, private insured plans, or self-insured plans. Minimum benefit levels are set by law. Many of the states automatically increase these weekly benefit maximums each year based on statewide wage averages. Some states require legislative enactment to raise benefits. Jurisdictions enforce various forms of administrative requirements. Some of these requirements become volumes dealing with claims to benefit levels to the actual wording of the contracts. They also include filing of claim forms. Some states require annual experience reporting. There are also time service requirements with regards to claims in some of these states.

Now to take you through some of the nitty gritty of most of these state plans. California's program is the Unemployment Compensation Disability (UCD) Benefits Act that was passed in 1946. The Employment Development Department in Sacramento is the regulating body of this plan. Benefits are paid per a schedule. Benefits simply run 48–52% of weekly wage. The maximum weekly benefit for 1998 was $336 per week, and there's also a $50 minimum weekly benefit. The waiting period with this plan is seven days; benefits start on the eighth day. California has the longest duration, 52 weeks of all the state plans. In California, most of the employers insure with the state fund. It is possible to insure the employer through a private insured plan, but it is a complicated process to take a plan private and take it away from the state. It is possible, but we think it's pretty close to impossible to get it done. In California, employees contribute 1% of their first $31,767 of annual wage. Employers may contribute to the cost, but it is not mandated in California.

Hawaii's program is the Temporary Disability Insurance (TDI) Law, and it was passed in 1969. The Department of Labor and Industrial Relations in Honolulu is the regulating body. Benefits are calculated at 58% of weekly wage to a maximum of $357 per week in 1998. In Hawaii, there's a $14 minimum weekly benefit. As with the California plan, there's a seven-day waiting period. The benefit duration is 26 weeks during the 52-week period. There is no state-run fund in Hawaii. All plans are privately insured, self-insured, or else they're collectively bargained sick leave plans. Employees contribute 0.5% of wages, not to exceed $3.07 per week. Employers may pay the entire cost or the balance of the cost.

New Jersey's program is the Temporary Disabilities Benefits (TDB) Law which was passed in 1948, and took effect July 1, 1949. The Department of Labor in Trenton is the regulating body. Benefits are calculated as two thirds of average weekly wage to a maximum $364 per week in 1998. There is no minimum benefit in New Jersey. The waiting period is seven days; however, after three consecutive weeks of benefit, the waiting period is reimbursed retroactively. The maximum benefit duration is 26 weeks per disability. In New Jersey, the state fund is the dominant insurer. It covers an estimated 85% of the work force, and the rest of the employees are covered by private insured plans. Employees contribute 0.5% of wages up to their first $19,300 of earnings in a calendar year. Employers pay the balance of the cost. In New Jersey, benefits increase every January 1 based on a calculation of a statewide wage average, and the calculation is prescribed by law.

New York's program is the Disability Benefits Law (DBL). That was passed in 1949 and took effect January 1, 1950. The Worker's Compensation Board, headquartered in Brooklyn, is the regulating body. The benefits are 50% of weekly

wages to a maximum of $170 per week. The minimum benefit is $20. The waiting period here too is seven days. The maximum benefit duration of these plans is 26 weeks per disability within a 52-week period. Most employers are covered by insured plans. The New York state fund covers most smaller employers with somewhere around 5% of the market. Employees may contribute 0.5% of their first $120 of weekly wage with the balance paid by the employer. In New York, it's pretty common for the employer to pay the entire cost. In New York, benefits do not automatically escalate by some index. They were last increased in the late 1980s. A wage of $170 a week doesn't really buy much in New York these days. Legislation must be proposed and passed to raise benefits.

Puerto Rico's program, the Disability Benefits Act (DBA), was passed in 1968. The Department of Labor and Human Resources is the regulating body. Benefits are 60% of weekly wage to a maximum of $113 per week, but only $55 for agricultural workers. The minimum benefit is $12 a week. The waiting period is seven days unless hospitalized. If you're hospitalized, then the waiting period is waived. The maximum benefit duration is 26 weeks per disability within a 52-week period. Coverage may be obtained from either the state fund or through a private insured plan. Employees contribute 0.5% of their first $9,000 of annual wages, employers match the employee contribution.

Rhode Island's plan is the Temporary Disability Insurance (TDI) Act which was passed in 1942. The Department of Employment Security in Providence is the regulating body. Here's where it gets a little tricky. Benefits are 4.62% of wages in the base quarter to a maximum of $441 per week. Additional benefits are paid for each dependent child up to the age of 18. Usually the benefits are 70% of wages per week as an approximation. The waiting period is seven days, and it is reimbursed retroactively after 28 consecutive days of disability. The maximum benefit duration is 30 weeks per disability or until benefits equal 36% of base period wages. In Rhode Island, the state fund controls all the statutory disability. You can't write a private insured plan. Employees contribute 1.2% of their first $38,000 of annual wages.

The question is, are your customers in compliance? I've just given you an overview of what the requirements are by state. When you get into claims practices, contract wording, and all the other nitty gritty stuff that goes with it, it gets complicated. I'll share with you some of the experiences we've had. Large national employers, for instance, headquartered out of these states often are not aware of these mandated state plans, or are not fully aware of all the details. They generally try to cover all employees across the country with a typical insured STD plan. However, many times the STD plan doesn't meet the requirements in these states, and are found out

of compliance. What we typically run into are employers that try to use longer waiting periods than are allowed under the statutory requirements of these states. We also run into instances where the brokers and consultants aren't quite up to speed on these plans because they don't deal with them on a regular basis or they're from outside of these states. Many times, the broker does not let the employer know these requirements and as a result, a plan that's not in compliance is installed.

We also run into problems where contracts don't comply with the laws. Take New York, for instance. If you file an STD contract in New York, it could be approved by the Department of Insurance, but it doesn't pass for a DBL contract. To be certified as a DBL contract, it has to be approved by the Workers' Compensation Board after it has been approved by the New York Department of Insurance. You know you have approval because, with the approval, you get your carrier number that you use on your annual experience report and assessment filings. An insured STD plan just doesn't fly unless it has all the key provisions required under DBL.

Regulatory bodies are also getting more sophisticated. They are catching more employers out of compliance. What they do is they cross reference with their unemployment insurance numbers, and they find that the employers haven't notified the regulatory body of the coverage in effect, and departments are getting quicker to levy fines. Another instance we came across is where an employee assumes he's covered by the state, sends a claim form into the state department only to find out that he's covered by a private plan. The state checks to see if the plan's on file. If it's not, they fine the employer. Sizes of fines can vary. In New York, for example, fines can be 0.05% of total weekly wages up to $500 per occurrence. The fine can even go higher for plans that are greatly out of compliance. It's very important to really understand these plans. When designing an insured plan, talk to your broker and your employers and go over the details with them. You need to check to make sure that the current plans are in compliance and also the proposed plans are in compliance. Again, it's a great way to demonstrate your disability expertise.

I will briefly touch on some plan design considerations. As I already mentioned, insured STD plans don't necessarily mean that they meet the requirements by state. Just because you have an STD contract filed and approved, it just may not be in compliance. In Rhode Island, you can't issue an insured private plan, so please don't try to do this. Enriched plans. That's another term in the state plans niche market. Enriched plans simply means you've enriched the statutory plan to a greater level. You can be either offered a shorter elimination period, a longer duration, or a higher benefit maximum. That's pretty common. Wrap plans are

another plan type I run into every now and then. Generally what happens is we'll see a request for proposal and the employer will be asking for a higher benefit to be written over a statutory plan. What generally happens is one company or state fund has the statutory coverage and you'll be asked to provide an excess layer. It sounds nice and looks nice, but it's very difficult to adjudicate claims on that basis. You can have one company or a state fund approving a claim, and your claims department is denying the claim. The conflict can cause a lot of trouble. You may wind up in a hearing in that state. So if you're going to write a wrap plan, it's basically better for you to issue a statutory contract, and then write an insured STD plan for the excess coverage and put all the coverage under one carrier.

A consideration when integrating LTD plans with state plans is to make sure your contracts include wording allowing you to do this. Also, your claims department must have the correct mandated benefit method levels that it is integrating with. The mandated benefit levels do change often. New Jersey updates on January 1, and I believe California updates on July 1. I just want to make sure the claims people are integrating with the right level and again, it's demonstrating their disability expertise.

Finally, I'll touch on some of the regulating and reporting requirements. First is an annual assessment filing. New York, New Jersey, and Hawaii require an assessment filing. The laws in these states allow private carriers and employers to be assessed for deficiencies in their expenses and their experience. In New York, for instance, their experience reporting or their assessment filing requires very detailed expense. Experience reporting requires claims by male, female, maternity, and claims duration; they want to know what the average benefit is, what the average payroll is, and they also require loss ratio calculations and expense levels. In New York if your group has 50 or less lives, if it runs below 60% on an accrued earnings loss ratio, the department will catch you on this filing and they'll be quick to challenge you to object to your rates. We've been ordered to lower rates a number of times. They never order you to raise the rates, but lower them to below 60. For groups with 50 lives or more, the minimum loss ratio in New York is 65% so you have to also meet that. You'll be able to split your plans at the 50-life level.

In New York, claim time service is also mandated. Claim time service is really time service. You have four days to turn around a piece of mail, and that includes one day for mailing. So if you have a valid claim in, you have three days to make a decision and issue the first check, or else issue correspondence stating why you're requesting more medical information and explain why you're not paying that claim. It's a very tight time constraint. You need to file in a number of states when the coverage is effective. In New York, for example, you have to file a form DB 820

with the Workers' Compensation Board within 30 days of effective date of coverage. In New Jersey, you have to file a DP-1 with the state prior to the effective date. With that you also have to file the employer's application and the signed employee's consent forms. (For a plan to be private in New Jersey, 51% or more of the employees have to sign consent forms agreeing to take it private). Also when coverage cancels, you have to file with the Workers' Compensation Board in New York notifying them that the coverage on an employee is cancelled. The employer in turn has to secure new coverage. In New York, the cancellation form is DB 829. Finally, there are minimum loss ratios. In New York, with 50 lives or less, you must meet a 60% loss ratio. You have to meet a 65% minimum for groups of over 50 lives.

In conclusion, you can see that there are a number of details and administrative requirements that go with writing statutory plans. I would suggest obtaining copies of the laws, brochures, and pamphlets issued by the states and the regulating bodies to make sure that you are aware of all the nuances. I know in New Jersey, for instance, there's a booklet that's probably an inch-and-a-half thick that deals just with claims protocols. So it's really up to you as a disability expert to be up to speed on these things, and demonstrate your expertise to your employer, customers, and brokers.

Mr. Andre C. Baillargeon: I'm going to talk about three significant trends that are currently continuing the marketplace expansion for insured STD. By law, if you do hot topics in disability, you have to talk about voluntary products and integrated disability management. I will indeed do that. Another topic I'd like to address is the movement of self insured and self managed cases to insured STD.

Historically, a lot of large cases, generally over a thousand lives, have self insured the STD risk, basically due to the low risk, high credibility nature of the product. They've just assumed that risk on their own, and perhaps decided on a TPA for either advice to pay or perhaps administrative services. The recent trend has been moving entirely to insure all case sizes and getting completely out of the claim decision and administrative process. I'm going to talk about what that means to the industry as well.

There are certainly a lot of issues in developing a voluntary STD product. With enrollment and reenrollment, you can have individual choice within your plans, replacement ratios, and various other plan design features. I'm going to address three of what I think are the very important issues: participation, the maternity risk involved in voluntary plans, and the use of a pre-existing (pre-ex) conditions limitation in those plans.

Certainly there are a lot of questions regarding participation. The first one is, how low can you go with your plan? Certainly, it becomes much more individual in nature as you get down to low participation levels. You've got to weigh the cost and marketability of the coverage as you lower those participation levels. There are certainly other variables to consider: whether the plan has a pre-ex (and we'll address that), what percentage of the group is female with high maternity risk (and we'll address that as well), and whether an individual choice is involved in the plan. My feeling is that, for a group plan, certainly if you don't have a pre-ex on your plan, I wouldn't recommend going lower than about 25% (and perhaps even with a pre-ex). There are certainly a lot of risk issues as well so I'm not sure I would recommend going below that level even with a pre-ex. That seems to be somewhat the norm in the marketplace.

Certainly STD is a relatively easy product to select against in terms of a lot of the types of disabilities that you see. You can expect incidence to easily double per 1,000 enrolled lives at 25% participation. You might even expect it to quadruple if you were down at 10% participation level. I've definitely seen that in the past. Establish rates by participation level. Before you enroll, a nice feature would be to rate appropriately for the selection risk that you have, but setting rates before enrollment is difficult. You can bet that your sales representatives or brokers are going to anticipate a higher level of enrollment than what you may actually see, particularly if they're getting a better rate for that. You have to ask yourself what you're going do if you don't get that enrollment. Are you going to turn the case away after it has been enrolled? That isn't going to make you terribly popular with the broker. Are you going to accept that risk at a lower rate than what you need for the participation that you've got? That's certainly an important aspect of pricing that actuaries are going to have to figure out to make their voluntary product viable in the marketplace. One final point is age-based rates versus composite rates. Composite rates are nice; they simplify the enrollment process. Age-based rates are certainly better with risk, but you can get some kind of funny shapes to your step rates due to that maternity risk. I would not recommend forcing your step rates to be monotonically increasing. I wouldn't drive down those lower age rates to make your rates look smooth because you certainly got a lot of risk from the maternity side.

The single biggest type of disability risk facing voluntary STD in my mind is maternity risk expanding to older ages, i.e., women bearing children well into their forties and even early fifties. I've seen low participation on voluntary cases with no pre-ex where 75% of the claims that we saw were maternities. It certainly isn't because there wasn't any other sorts of disabilities happening, but there was tremendous selection. So pre-ex will prevent you from buying existing maternity

cases, but it takes minimal planning to overcome a pre-ex from that standpoint. You can certainly expect repeat claims with women in child bearing ages starting their families. Unfortunately, pricing for maternity risk can keep away the best risk from an incident perspective, which is actually young males. They basically are just hurting themselves, a lot of injuries, and basically are not a high risk for claims. You may want to consider using a composite rate for a high female group. Using step rates for a largely male group might be one alternative to managing that. For high female groups (50–60%), you may also want to consider in addition to a pre-ex, which is very important, raising your minimum participation requirements for the group.

Finally, pre-ex provides some advantages, but has a clear down side as well. It does help with the immediate issue of maternities and other existing conditions. It may allow you to lower your step rates at younger ages and improve that spread of risk, but it's extremely difficult from a benefits administration perspective. The high incidence nature and the short-term nature means you'll be doing a lot of expensive, time-consuming investigations and potentially interrupting benefit payments which start soon after the disability and probably before you've had time to do your pre-existing investigation. That's obviously a significant customer dissatisfier. Also, if you've got the same pre-ex for your STD and LTD, you may be potentially accepting the LTD risk by accepting the STD risk. It's not like you really short cut that pre-existing investigation process. One possibility might be to use something like a delayed pre-ex. The pre-ex takes effect either two weeks after disability payments begin or 30 days after the disability. You'd be accepting the risk for the first part of the claim without the pre-ex coming into play, but then beyond a certain duration, the pre-ex would take effect. It provides you time to do that investigation, and has minimal impact on the early disability payments. It definitely provides significant risk mitigation to help your rates.

To have a successful long-term product, you need a spread of risk that comes from high participation, which requires a successful enrollment. A successful enrollment comes from a simple, cost-effective product that offers a spectrum of choices that meet the needs of most of the individuals eligible for the plan.

When customers think of integrated disability management, I think they have some sort of ideas on their mind. They're looking for a single claims-paying system. I'm going to focus primarily on STD and LTD here. They're looking for a single claims paying system that all claims are on perhaps one claim form, one contract, even one bill for that. They expect a single benefit specialist throughout the duration of a claim, and maybe even a nurse touching every claim. Now I don't necessarily feel that all of these features are necessary conditions or necessarily sufficient conditions

to providing a true, integrated disability management program. I think you can deliver the above features without necessarily having to provide true, integrated disability management that is similar to what Dave was addressing earlier. However, those often are aspects that the customer is looking for. You're either going to have to provide them to meet those expectations or you're going to have to manage those expectations and lead customers to what you feel is important in an integrated disability management program. I don't think that all of these features are necessary. Keep in mind that approximately 1 out of every 20 STD claims ultimately becomes an LTD claim. So you really have to consider if it is worth really overhauling how you're managing your STD claims for that 1 in 20.

I think this program should include a smooth transition of claims from STD to LTD which likely will mean one claim system. It also means a clean and informed handoff at the point where the claim transitions from STD to LTD. You should have integration of contract elements and forms where appropriate. For example, the maximum STD duration should integrate with the LTD elimination period. You should have the same definition of disability, the same definitions of earnings, the same eligibility, and those sorts of things when that makes sense. I do think the benefit specialist should actually have a separate focus on short-term claims and long-term claims, but there should be early recognition of which claims are going to be which. The severity in nature of disabilities between STD and LTD is very different. Again, only 1 of 20 STD claims becomes an LTD claim, but all LTD claims were once STD claims. So STD benefit specialists should really be focused on managing those short-term claims and managing those durations and appropriate back-to-work dates. LTD benefit specialists can deal with more complex claims, more complex issues, rehabilitation, and financial things like getting Social Security offsets for claimants. I do feel, however, that the earlier you can recognize which STD claims are going to become LTD claims, the better. It makes all the sense in the world to get specialized people on those claims, not necessarily wait until they become LTD claims. You can have your short-term people looking for claims that will become LTD claims and bring in the LTD people very early on in the process. I think that's completely appropriate.

The final topic that you don't hear quite so much about is this transition from self-insured or even self-managed to insured. Again, customers have a list of expectations when they're going through this process as well. First and foremost, they're expecting lower claim costs. If they're a self-managed plan or using a TPA, they expect those costs to go down. That's a major reason that they're going fully insured. In addition to wanting to get out of the decision-making process, out of the fiduciary responsibility, and out of the claims administration process, they want to focus their resources on their core business. They may also be looking to eliminate

expensive sick leave plans. At this point, they're willing to set up a plan that supports solid risk management. However, one knows that they may expect to maintain certain benefits. They may consider these differentiators in terms of attracting or retaining employees. They may simply be popular with the employees or they may be part of a union contract.

Insurers can expect a surprise or two in this process as well. This is maybe the most important thing that I'm going to say; you can expect higher claims experience in a lot of situations than indicated by previous self-insured and self-managed experience. Depending on the situation, it could be 10–20% or even higher claims experience than what is tracked in the previous plans. Self managed, salary-continuation plans are the worst example of this in terms of how adequate their tracking is. There's no incentive to have perfect tracking if you're managing your own claims or really not managing them at all. You get significant underreporting of what their claims are. While customers are looking for savings, you're delivering a rather tough message in the marketplace that the costs that they're going to see are higher actually than what they've been tracking. That's a real tough message to sell. Meanwhile, a competitor is going to be cutting their experience by 10% for superior risk management. It's a real tough message, but it's going to be a real tough message to deliver to management when you start writing these cases at a significant loss. Another tough message to deliver to the customer a year or two down the road is when you have to give him or her a significant rate increase (and it's definitely happening). Finally, you will need to be flexible in terms of certain provisions, now that you need to match on behalf of the customer. That could mean a difference between getting the case or not and satisfying the customer or not.

Mr. Stephen J. Rulis: There isn't as much STD industry experience, certainly no Society tables for us to look towards. Is the Society planning on doing any STD studies, either for incidence rates or claim durations? In lieu of that, what do we have now that we could point to when a customer is asking us for benchmarks, when they want to know how their own experience compares to typical benchmarks?

Mr. Mogul: In terms of whether the Society is planning on doing anything, I've had a couple of conversations with Tom Corcoran about this very topic. Tom has shown some interest in getting some people together and getting some companies to start putting something together. We've talked more of not necessarily claims in the sense of claims duration, but something that shows, over time, how many out of 100 claimants are going to be around day one, day two, and so on? It would be more of a continuance table than anything else. Beyond the talking stage, I don't

think anything really has been done. It's really at forums like this that we start to see some interest to see if we can pull enough people together to do something like that.

Your second question related to sources of information. From my experience, it seems like most companies have relied more or less on their own experience, certainly with the larger carriers. There's not really too much else out there to rely on. What seems to be a primary source for data is a company's own book of business.

Mr. Baillargeon: It's definitely an important question, particularly when thinking about the issue of transitioning self-insured or self-managed cases. If you get a hospital that has 800 lives and they say they had $9,000 in claims last year, how do you explain that to them? That doesn't quite add up. It is definitely an important part of educating the customer. You at least have to get some kind of benchmarks for your own company, or your high-level averages and utilize them to that extent.

Mr. William J. DeCapua: I've got a question that relates to what Andre was talking about regarding participation. I've heard a lot about this 25% level and selection occurring if we go below that. I get these questions from my superiors, from underwriting, and from clients. Why can't we offer 20% participation? Why does it have to be 25%? What statistical analysis do you as an actuary have that supports the 25%? I'm caught in a bind with no data to support that underwriting guideline or that actuarial rule. What I'm trying to do is get that kind of information. When you say 25%, is that from your own company's experience or are there some studies or something that I can go to?

Mr. Baillargeon: The comments that I made were from my own experience. I tend to think of it in terms of a certain number of claims that are just going to have essentially 100% selection. You've got 60 claims per 1,000, 70 claims per 1,000 that might be your typical average claims on a group, and you're going to get a big chunk of that right off the top. If you get down to something like a 10% participation, you're running the risk of getting essentially all of those claims or a large percentage of those claims, and virtually no spread of risk at all. At least at 25%, you're starting to get some sort of spread of risk. The other thing is that it's a marketplace norm to the extent that voluntary STD exists. I'm not sure it's anyplace anybody's willing to sort of be out on the limb. If you're the only company out there offering 10% or 15% minimum participation, then you're probably going to get a lot of those cases, and I don't think anybody's willing to bite the bullet on that at this point.

Ms. Joy A. McDonald: Are you are seeing higher incidence rates in states that have statutory plans?

Mr. Siwek: With regard to incidence rates on the statutory plans, generally we see rates lower than our normal insured plans. As mandatory coverage, there isn't any selection occurring. As a rule of thumb, we see incidence around 30 claims per 1,000 for the smaller groups under 50 lives. That grades up to maybe 50–60 per 1,000 across the overall block which I'd say is a pretty good mix of industry and probably 60% male in content. No, generally we see lower incidence in those plans.

Mr. Mogul: I would just add two follow-up points to that. One of the things that we've seen based on our experience is we definitely see some variation by state. A lot of it goes to the fact that these plans are fairly limited, but some of the states actually have relatively rich benefit coverage. Another part of it is it seems like a lot of employees don't even necessarily realize they've got this coverage. Some groups are more well educated on disability coverage or maybe insurance in general, and you actually see some antiselection in some cases. I agree with what you say, it's certainly lower than a standard plan or a nonstatutory plan.

Mr. William P. MacLafferty: Can you comment on the applicability of the elimination period, and the way it coordinates with sick leave? I've seen everything from requiring all employees to use their sick leave before the STD benefits start to making it optional, some of them can bank part of it, and the different rating characteristics of all of those options. What have you seen in the marketplace from employers?

Mr. Baillargeon: It's a great question because you're seeing so many plans where you're taking over that sort of thing. Many are grandfathering those plans. Otherwise they're discontinuing things like accruing for those sick leave benefit credits. What we've tried to do is try to keep it relatively simple. We've primarily stuck to grandfathering a case. A recommended approach might be to just estimate what the ultimate elimination period becomes on those sorts of cases, and then give a price credit accordingly. It's pretty difficult when you start getting into situations where the elimination period changes at the option of the employee. We've avoided that, but honestly we're seeing it come up. That's something which must be addressed in our company, and it certainly sounds like in a lot of other companies.

Mr. Delaine B. Hare: Andy had mentioned using a delayed pre-ex on STD claims on the voluntary plans. I was wondering how such a pre-ex would work. It seems

like if you accepted the claim after the elimination period, it would be difficult to come back two or three weeks later and say, "Oh, I'm sorry, this is a pre-ex condition. You no longer have a claim."

Mr. Baillargeon: The way it would work would be that the claim would be payable for those first few weeks, and the pre-ex would take affect after that. So you would certainly never go back and try to get any dollars back or anything like that. In terms of when you make that initial approval of the claim, it would have to be very clearly stated that you're approving it through a certain duration and that continued benefits will depend on a pre-existing investigation. It seems to me from a benefits perspective, as long as you set those expectations very early on in the claim process, then you can still actually do a good job of satisfying the customer, even if, ultimately, you're denying that claim. They probably have a pretty good idea at that point whether or not they're going to be approved or denied so I think it tends to work fairly well from that perspective.

Mr. Hare: Is it handled from an administrative perspective, or is it contractually set up so that the pre-ex occurs at a certain date?

Mr. Baillargeon: It would be contractually set up that way. You'd follow that up at the time of your initial approval that it's only approved through a certain date.

Mr. Paul D. Hitchcox: Some states, especially those with no-fault auto insurance, are not letting you integrate with the STD. I was curious what your thoughts are on that. Also, what are your insights with regards to the integrated product and features like residual and partial that are available on LTD that are being pushed on to the STD product?

Mr. Baillargeon: Partial and residual features are available on STD as well as LTD. Now I think most companies are willing to offer at least partial if not residual as well. I don't think I can state with too much authority how much of an impact that's having on the claims process. I know I said it here kind of anecdotally that it's tough to get involved from a STD perspective. I don't consider the no-fault piece to be that much of a risk from an STD perspective; it doesn't usually affect much in the way of claims. A relatively small portion of premium would ultimately be affected.

Mr. Mogul: I think the types of questions you're asking shows how STD is a product that has been changing over time. The question about partial and residual shows that we are taking something that's reasonably straightforward in the type of coverage and actually adding some new twist to it. The no fault brings up the question (or probably the necessity) of really kind of keeping your eye on STD as a

separate product and being aware of some of these emerging trends whether they are legislative or not. I agree with you. At least up to this point in time, it certainly hasn't been too much of a risk issue but if we see that trend continuing, I wouldn't be surprised if we've got to be a little bit more aware of it going forward.

From the Floor: Does anybody have a real good feeling for how much the partial definition of disability impacts their STD claim cost positively or negatively? Probably most folks have a load for it, but does anybody have a good sense for what it really costs or saves?

Mr. Jerry J. Brown: In order to provide the statutory benefits, could an employer piece together a STD plan and a LTD plan that together provided the statutory required benefits, or does it have to all be in one benefit plan with let's say an LTD plan above and beyond that?

Mr. Siwek: I guess the correct answer is yes, as long as the specific contract that's covering the statutory part of the benefits needs to meet the minimums. If your LTD, STD contract was a single contract, yes, I think it would exceed that. If you have a separate contract for STD and LTD, then the STD contract would have to exceed the minimum statutes.

From the Floor: So if there are two contracts, then the STD contract would have to exceed the minimum standards, and you couldn't have two contracts together exceeding the minimum standards. I'm thinking of California, for example. There is the 52-week benefit period. If you had a six-month elimination period on the LTD, but a six-month benefit period on the STD, could you get two contracts together that would satisfy the requirement?

Mr. Siwek: I think the catch there is that the LTD contract can be terminated. It's really the STD contract that they're looking for compliance on. So if it was a combined single contract, I think that would work. In California it's a little tricky. I think the most requested plan design you see there is a 90-day limit on the LTD to integrate with their UCD plan. That makes it more interesting.