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Product Trends in Group Long-Term-Disability Insurance

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Summary: This panel discussion addresses recent developments in group long-term disability product design. The specific subjects include integrated disability programs and voluntary disability programs.

Panelists address the issues involved in the new long-term disability product offerings, including contract design, pricing, administration, and profitability. They also present their observations on the market acceptance of these new programs.

Mr. Frederick R. Brown III: We have a group of panelists who will talk about issues regarding new disability product offerings. What I'd like to do is introduce them, go through a short lead-in, and then have each of the panelists in turn talk about their particular topics.

Let me introduce the panelists in order of their presentations. The first is Mike Fish, who is second vice president and actuary at UNUM and currently head of group long-term disability (LTD) pricing. He has seven years experience in the group arena. Mike is going to be talking about cost containment provisions and alternative funding arrangements regarding group LTD.

Our second presenter is Fred Yosua who is vice president of long-term care at UNUM. He is most recently working on alternative distribution systems and association disability as well as long-term care. Fred is going to talk about critical illness insurance. Paul Barone, our third presenter, is manager and associate actuary with PMA Insurance Group, which is a property and casualty company. He is an associate of the Casualty Actuarial Society. He has 12 years of property and

casualty (P&C) experience, including workers' compensation, managed care, and third-party administration, and three years of experience with an integrated disability product. Paul will be talking about integrating short-term disability (STD), LTD, and workers' compensation.

I'd like to just take a moment and tee-up this topic. John Hewitt & Associates does an annual profit study for us that covers 80% of the marketplace, eight of the top 10 writers of disability, and 31 companies overall. It's a very large study. I'm going to give you a very brief, high-level overview.

In group LTD, margins are improving. They improved in 1998, compared with 1997, and 75% of respondents reported that they made money in group LTD in the year 1998, which is up from 55% last year. In STD, though, margins continue to decline.

Group LTD required equity, and GAAP equity is approximately 100% of premium. For STD, because the reserves aren't such a driver, required GAAP capital is about one-third of premium. These are very capital-intensive lines. With the level of profitability that I indicated, the result is that returns on capital are nowhere near the 15% hurdle rate that most companies aspire to.

If you look at the drivers or the components of that profitability, we see, in group LTD, new business written and the margin on business written. As it contributes to the bottom line, it's zero. In other words, claims are being incurred with reserves at the tolerable loss-ratio level and the source of profitability really is excess net investment income. By "excess," I mean net investment income because of rates higher than valuation rates, investment income on capital, and investment income coming from capital gains. In fact, on a morbidity basis, claim termination rates do not appear to be adequate to run out adequately on the GAAP morbidity basis that insurers have in aggregate. For STD, the product or the components of profitability are actually pretty similar.

As we head into a period of time where interest rates are lower and portfolio rates decline, the implications here are that earnings from excess interest could get smaller. This, in turn, means that the challenge to attain a 15% return on required capital is going to even get greater.

One of the questions we asked the respondents was, "What are the factors that have had a positive impact on your results and a negative impact on your results? What are the things that are driving your results?" We focused on responses by those companies that appeared to be more profitable than other companies.

Companies that had a good, positive bottom line and improvements in their bottom line were focusing on renewal and rating actions; strengthening their rating base, benefit management, and risk management efforts; and tightening their underwriting

and their risk selection. You have pricing, claims risk management, and underwriting selection. That is no surprise. This is basic blocking and tackling. The things that were a drag to the bottom line related to sales and what it took in today's environment to acquire business. Net investment income yield rates were falling and expenses were rising. The flip side of aggressive benefit management was the impact of claims reopening in today's environment. The companies that are improving their financial situation are focusing on the basic elements of blocking and tackling, such as pricing and risk management.

As insurers continue to rate traditional disability products or develop the new product forms that the panelists are going to be talking about, they need to address elements of product design, pricing, and how to manage profitability. Our panelists are here to discuss the keys to success in that area.

Mr. Michael Jeffrey Fish: The sources used to construct the new contract were broker and employer focus groups. We talked to the brokers and employers regarding what they would like to see in a disability contract. Some of the feedback we received is that they'd like contracts with fewer bells and whistles and more provisions addressing the disability risk. We also did file reviews and claim experience analysis, drilling down to certain segments that were performing poorly.

On a policy-level basis, where we had some very large policies, we also looked into what was driving the poor results. Was the case priced too low or was it too liberal a plan design (for example, a 70% plan sold with unlimited mental/nervous and lifetime occupation coverage). Or was it some of the external forces that we've seen around the rising self-reported type of claims? Was that driving it? Once we did this analysis, we could try to address some of these issues in the contract and some in the plan designs that we're selling.

I'd like to discuss some of the standard changes that we have put into our new contract. "Maximum capacity" language is one example. This addresses claimants who are out on disability but who are partially disabled, so they're earning some income. We try to define in the contract and specify what is the maximum capacity that person could be working towards. If someone has a loss of earnings, we are making sure that the loss of earnings is due to the disability and not due to a lifestyle change. For example, a claimant might decide he or she doesn't want to go back to his or her old job because it's too stressful. The person would rather reduce his or hours. We would be able to point to the maximum capacity language to say the change is an employee choice and is not due to the disability.

We also specifically defined gainful occupation. Once again many of these changes are specifying clearly how our benefit specialists are adjudicating claims. During the any-occupation period, you would be defined as having a gainful occupation if you're earning at least 60% of your pre-disability earnings. If you're earning 60% or higher,

we determine that you are no longer disabled. It's putting a number on the gainful concept. The new contract language also specifically addresses fraud and proof of claim. Those are pretty straightforward provisions but we are making sure they are specifically addressed in the contract.

We have also introduced "prudent person" wording into the pre-existing exclusion wording. The wording states that, if you're under care or have symptoms for which an ordinarily prudent person would seek medical care, then the pre-existing exclusion would apply for claims due to the same condition. The prudent person language is aimed at situations where people would suspend medical coverage for several months prior to the effective date of coverage so that the pre-existing exclusion would not apply. There are some other carriers out there who use reasonable person language in their pre-existing language, which is a similar concept.

In our standard contract, we have a 24-month limitation for self-reported disabilities. This limitation does not name specific disabilities. In other words, we do not exclude chronic fatigue or muscle tissue. Instead, the wording states that if your disability is due primarily to a self-reported condition that cannot be verified by the medical profession, that claim would fall into this 24-month limitation. There are also a 12-month limitation or unlimited coverage available as options. We have a standard mental/nervous limitation, which is a 24-month duration. We also offer a 12-month or unlimited coverage as well. Both mental/nervous and self reported limitations could have potential regulatory issues. Our self-reported limitation is approved in all but two states, so the issue is, what is going to happen in that arena in the future? We've all been waiting for the mental/nervous limitation to disappear, and I think that, if that happened, the self-reported limitation would follow as well.

We also have some optional features that the employer can purchase. A 40-hour work week definition is one of them. This states that claimants are deemed no longer disabled if they can work at least 40 hours. This will primarily impact high-wage earners. For example, let's say someone was previously working 80 hours a week and becomes disabled. If the doctor releases the person for a 40-hour work week, he or she would be deemed no longer disabled. However, in our standard contract, the person could still get a partial disability payment if there was a loss of earnings, even if the person was working 40 hours per week. Third party and auto and liability offsets are another optional feature that can be included in the new contract. Finally, gainful occupation equal to the gross disability payment is available as an option. Under this provision, the claimant is deemed gainfully employed if his or her post-disability earnings are at least equal to the gross disability payment, rather than the 60% level. This also impacts the high-wage earners because of how the benefit maximums work out. For example, if there is a $20,000 max on a plan, and 60% of the claimant's salary is $30,000 a month, then under a standard contract, the person would be gainfully employed if he or she were earning at least $30,000 a

month. But, with this provision, the gainful amount drops to $20,000. The first and the third provisions mentioned above will have the largest impact on higher-wage earners.

We have had some issues with trying to analyze the experience on these contracts due to system constraints. We rolled the new contract out in late 1996. Fifty to 75% of our 1997 sales premium was sold with this contract, and all of 1998 sales were under the new cost containment contract. We have not had many years of experience to examine. We can only look at the early duration of claims.

A couple of issues have surfaced around data capture from the benefit specialists. There has been some improper coding on our administrative systems. For example, the benefit specialists should enter 24 months in the duration if they believe a claim is going to fall into the self-reported category. This is similar to the process for mental/nervous claims. However, this has not been happening for the majority of self-reported claims. Also, new benefit codes are available on our administrative systems to capture the features of the new contract. For instance, there is a 40-hour work-week closure code. Unfortunately, there has not been consistent use of these new codes. We need to stress the importance of entering the correct data into our system, so we will be able to conduct detailed claims analysis in the future. Even with these procedures in place, it is too early to determine the effectiveness of these provisions because they have not been in force very long.

With the limited amount of data to analyze, our preliminary findings have indicated mixed results. The good news is that overall recoveries have improved under these contracts. However, we do not know if this is due to the new contract provisions. We need to make sure that the discounts offered for these cost containment features is warranted from the savings in risk. We also need to make sure that the contract provisions are sold to the right customers. The 40-hour work week and the gainful equals gross should be sold only to an employer who has higher-income employees, otherwise the claims savings will not offset the reduction in premium.

Many of these contract changes are an attempt to clarify further how our benefit specialists will adjudicate claims. We are trying to get consistency across the benefits area such that, when two similar claims come in the door with two different benefit specialists, the process used to adjudicate them will be the same.

We also need to make sure that the brokers and the employers understand exactly what they're buying. This was an issue when we first rolled out the new contract. We received some feedback that the brokers and employers didn't quite understand all the contract provisions that they were buying. They just knew that they were getting a good rate in comparison with that of the competition. We've worked very hard with our sales reps so that they will describe to the customers exactly what provisions are being purchased, and what the differences are between our contract

and the competition's contract. The employers are then able to look at the different rates and features and choose what would be best for them.

Finally, I mentioned the level of discounting associated with the cost containment provisions. It's going to take many years before we know how that plays out, so a conservative approach is warranted. It is also very important to have the proper tools in place to be able to monitor experience as it emerges and make necessary price adjustments.

I'm going to shift gears and go into a different subject alternative funding arrangements. The focus of these contracts is to find some creative ways to break into the first-time buyer marketplace, especially among the very large employers. Currently, many large employers use ASO arrangements. There are several reasons why we do not want to be in the ASO market. It's very costly to have a benefits area, and we want to be able to participate in the risk. In the Hot Topics in Disability session, the large increase in expenses for disability carriers was referenced for both individual and group. I think a big amount of that is driven by investments in the claims area. It is very costly to have a benefits area and we don't want to be in the fee-for-service type of situation. We want to take on the risk and have the potential to earn some underwriting gain from that risk. Therefore, some of these alternate funding arrangements are ways to talk to the employers about different options and give them alternatives to consider if they are reluctant to go purely traditional fully insured.

It can also be used as a means to differentiate your product offerings in the large-case market. These arrangements can be used by the sales reps when talking to the brokers regarding a very large employer that currently self-insures its disability coverage. This is something that the reps can use to start the conversation. Maybe the employer should think about going fully insured for at least some of the disability coverage.

Here are some of the funding arrangements that we would consider. Demonstrate that the insurance company at least can be flexible. You could have fully insured premiums in excess of $15 million or $20 million, and that's a tough thing for employers to hand over the first year they go fully insured.

A fully insured contract forms the basis for these products. In other words, the insurance company is taking over the insurance risk. However, a side agreement is drafted that specifies what the funding arrangement is and what billing rate is charged to the employer. The key point is that the fully insured contract is still present, so the insurance company is on the hook for the risk.

What are some of the advantages to these arrangements? For one, the policyholder realizes potential cost savings. I'm not sure it's an insurance company advantage,

per se. What I mean here is that, in the large marketplace, when you have disability coverage on a 20,000+ life group, it would be very difficult to get the standard profit margin on that group. It is unrealistic to expect that you'd be able to get, for example, a 15% pre-tax margin on a group of that size because, on $20 million of premium, that amounts to $3 million of profit. To write the case on a fully insured basis, we would lower our premium to be able to sell that case, and so unfortunately we lower our profit margin anyway. However, we may not recognize this. In these alternative contracts, it becomes clear what margin is built into the premium because some of the components are unbundled.

Another advantage is that the large employers are allowed to participate in the risk. On some of these contract provisions they will participate in the risk as it emerges or, in some cases, prior to the experience emerging. This is different from standard experience rating, which stipulates that, when good experience unfolds, future premiums are lower than the current or past premiums.

The disadvantage of these arrangements is that they can be complex to sell and administer, and that is an issue. The complexity problem is very important because disability insurance is complex to begin with, especially from the employer's standpoint. They often don't understand the whole concept of disability insurance and the different contract language from the insurance companies. To add another layer of complexity may not be attractive to the employer. However, the target market for these offerings is fairly astute. They are employers who have a higher degree of understanding than your average small employer.

The administration is also more complex, especially regarding the premium owed to the insurance company. There will be fluctuations in the premium coming in the door rather than a standard contract that has a guaranteed premium level for a certain number of years. There will also be accounting issues that need to be addressed due to the irregular premium stream. The legal department should be contacted when drafting the side agreement that specifies the funding arrangements. It should review the wording to make sure there will not be any legal issues.

Compliance and regulatory impacts should be addressed with these arrangements. You may need to do a single case filing for some of these plans. Generally, though, we've taken the approach that a filing does not need to occur on these plans because the overall premium remains virtually the same. The difference is more a matter of how the premium is collected. In other words, the funding arrangement as to how the premium is collected is different. Instead of the employer paying a level monthly bill to the insurance company, it may be a little bit lower up front and then higher toward the end.

What are some of the offerings that we're doing? The retrospective premium arrangement is one example. This is a situation where the policyholder pays a

discounted rate up front in anticipation of a better-than-expected experience. A standard experience rate is calculated and then a discount is applied to that rate up front. This becomes the billed rate that is charged to the policyholder. There is usually a two-year rate guarantee period for these contracts. At the end of two years, the actual claims experience is compared to what was originally priced. If the claims experience is higher than priced, the insurance company can make a retrospective premium call to collect additional premium. In other words, it can capture some of the discount that was given to the policyholder up front.

The arrangement will also specify the maximum amount that the insurance company can collect. Therefore, the employers know how much risk they are taking. This type of contract is offered to employers with at least 2,000 employees. You are looking for employers who are going to have credible experience because the claim costs can be very volatile. These experiences can be used as an incentive for employers who are ASO to go fully insured because the premium charged up front is lower than a standard contract.

The retrospective contract is similar to placing a bet on the outcome of the claims experience. The employers are betting that their claims experience is going to be better than their experience over the past several years. The insurance company is giving that bet in the form of the 15% discount up front, but it has the recourse make a retrospective call if needed. If this contract were not offered, some of this discounting may occur to write the case anyway. For example, it could be a situation where there is a positive claim trend. When the experience rate is generated from experience over the past three years, there may be a tendency to only use the last two years of experience to get a better rate. If this were done in a retrospective contract, you would at least be able to collect more premium if the experience did not play out that way.

The second offering is called a flexible funded arrangement. In this situation, the front end of the claim benefit period is fully insured, but the claims are paid on a pay-as-you-go basis, and the tail is funded on a traditional fully insured basis. The premium that's collected on a standard fully insured contract has to cover incurred claims, all your expenses, and your profit margin. In the flexible funded offering, we carve out the premium associated with claims in the first few years of the benefit period.

Let's walk through an example of a five-year flexible funded plan. In the first five years, the incurred claim cost is carved out of the fully insured premium. The billed rate charged to the policyholder is going to cover the expenses and the profit in the first five years and all of the incurred claims and expenses in the tail beyond five years. As claims are incurred, the billed rate is going to increase to cover the actual paid claims in the first five years. A contract rate is also calculated, and it is equal to what would have been charged under a traditional fully insured case plus a

contingency margin. This is the maximum amount that the insurance company can charge the policyholder. The employers are participating in claims experience for the first five years of the benefit period. Also, the maximum that they're on the hook for is equal to the contract rate so the downside risk is capped. One way to think about this is that the policyholder is taking on the incidence risk. The severity risk is covered by the insurance company by fully insuring the tail on a traditional basis. If policyholders have a higher frequency of claims, they would end up having to pay more than they would have if they were covered by a standard fully insured contract.

For flexible funded cases, a supplemental premium arrangement is required to cover the reserves on the front end in the event that the policyholder terminates coverage. This clause states that, upon termination of coverage, the policyholder owes the insurance company the reserve amounts needed to cover any claims with less than five years of benefit duration. This is required because the insurance company is ultimately responsible for paying these claims due to the fully insured contract underlying the funding arrangement.

The market appraisal for these types of contracts is that they should have wide appeal. The risk-sharing component is an attractive notion for the employers. They can participate in the risk, but they also have the coverage in the form of the contract rate that specifies the most they will have to pay. These arrangements also lower the cash-flow strain when employers go from a self-insured to a fully insured status. They get some relief up front because they don't pay a higher premium rate until actual paid claims start incurring. This is a timing difference because, over the long run, they will be paying close to what would have been paid under a standard contract. From the standpoint of the premium collected, it starts out low and eventually increases to some steady state as the claims experience matures. Upon termination of the contract, there will be a lump sum supplemental premium amount paid to cover the reserves on any early duration claims.

The third arrangement is called split funded. It is basically the same concept as the flexible funded plan. The major difference is the benefit duration that is covered on a fully insured basis. These contracts usually have short benefit duration plans, such as five years. The employer, on a self-insured basis, covers the risk on claims beyond five years (the tail). The premium for the first five years of coverage is exactly like the flexible funded arrangement, where the billed rate is only covering expenses on the first five years and claims are paid as they actually develop. For claims that go beyond five years, the employer has the option to use an ASO arrangement or do a reserve buyout, where an insurance company takes over the liability for those claims. Similar to flexible funding, there is a contract rate that sets the maximum amount the policyholder is liable for, and a supplemental premium arrangement is also needed to cover the reserves in the early duration if the employer terminates coverage with the insurance company. These arrangements

are only for the very largest employers that have a high tolerance for risk, because the entire tail of the liability is covered by the policyholder.

The fourth alternative funding arrangement is to use a captive reinsurance model. In this situation, we write the insurance coverage like a standard fully insured contract. However, the employer may own a captive reinsurance company. We then reinsure the risk to the captive company on a quota-share basis, up to 100%. In this situation, the employer is able to regain use of the funds that would ordinarily be tied up in reserves in the insurance company. The employer also directly participates in the risk.

The details of these arrangements will vary from case to case because of the number of parties involved. You have the employer, the captive reinsurer, and the insurance company. The actual flow of funds is going to be negotiated between these three entities. These arrangements are only limited to the very largest employers that have a captive reinsurance company set up mainly for their health coverage. We haven't written any of these products, but we have had discussions with employers that were interested in this approach.

Finally, there is the full reserve transfer model. It is similar to the captive reinsurance arrangement but is more of a straight financial transaction. A fully insured contract is written and then the premium backing the policy reserves are loaned back to the employer for the employer's use. The reserves are calculated on an annual basis, and a letter of credit needs to be obtained by the policyholder in this amount. You need to make sure that the letter of credit is updated annually to cover the liability because the reserves are going to grow for a number of years. If the employer terminates coverage, it will owe this amount to the insurance company. Once again, this is only available to the large employers that want use of the premium dollars backing reserves. They must have a high internal rate of return because it is costly for them to obtain this "loan." From the insurance company's standpoint, you need to be aware of any admitted asset issues. In many states, a letter of credit is not an admitted asset, so you will need to allocate surplus to back these reserves.

What we're trying to do with many of these arrangements is to bring the employers to the table, especially large employers that do not want to fully insure their disability coverage but would like some degree of risk protection. Our goal is to demonstrate that we can be very flexible. In the end, we would hope to persuade the employer to elect standard fully insured coverage. We also realize that some employers are not going to go that route, so these contracts are a way to get them to take a first step toward fully insuring their coverage.

Sound financial underwriting should be done for these arrangements. This is very important because many of these situations involve the employer owing the company a sizable amount of money in the future. The company should have high Dun &

Bradstreet ratings and have been in business for at least five years or longer. Having a letter of credit also mitigates some of the financial risk. Finally, you need to be aware of the impact on your financial statements. The premium that is collected is not level in proportion to the risk assumed. You may need to book a receivable for a large due-and-uncollected premium amount. You also will need to be aware of any profitability issues because, in some of these situations, you may be giving away some underwriting gain. Finally, there should be a risk charge applied to these cases to cover the added financial risk associated with this business.

Mr. Frederick J. Yosua: I'm going to talk about critical illness insurance. As Fred said, my background is more in long-term care, although I have been doing some work in alternative distribution. The critical illness contract came up because some of the alternate distribution channels we're looking at want simplified products. How many people really know how much money they would get if they became disabled? Nobody knows that. But, if you get cancer, you know you're going to get a lump-sum payment. This is a very simple product for the consumer to understand, so it lends itself to some of the distribution channels that we've been looking at. This will be an overview. I'll talk about the need, the market, various products, underwriting, pricing, and regulation.

The first question really is, "Is there any need for this type of product?" Modern technology has done some wonderful things for people when they get critical illnesses. The probability of surviving a critical illness before age 65 is twice the probability of dying before age 65. Disability insurance, unless you have, like Mike said, a $20,000-a-month benefit, replaces the income but is insufficient to pay for other items that you might need for care. For instance, the American Cancer Society found that the cost of cancer is $69 billion a year, two-thirds of which is not covered by medical insurance. That's a huge number.

The market for critical illness insurance in the U.S. is in its infancy; very little coverage is written right now. In Australia and the U.K., however, the market is much larger. In Australia, the product was introduced in 1990 and 31 out of 33 companies now offer the product. In the U.K., the critical illness market is twice the size of the disability market. There are 70 companies offering coverage, and $72 billion of in-force business.

The market has grown tremendously. It's a very easy product to understand and, as a result, it is a pretty easy product to sell. Japan is another place where critical illness insurance has been recently introduced. Once again, sales in Japan have taken off. We're hopeful that in the U.S. a similar thing will happen.

The basic product is, if you get a critical illness, you get a payment. That's pretty easy to understand. Most products have a survival period of 30 days or so. If you're diagnosed with life-threatening cancer and survive for 30 days, then you get the

lump-sum payment. The covered conditions can vary tremendously. There's a real temptation and marketing pressure to add more and more as time goes on. Most policies cover things people are afraid of, which makes it easy to sell. Cancer, heart attack, stroke, kidney failure, a major organ transplant, paralysis, and Alzheimer's disease are usually covered under this product.

In the U.S., we have not seen a lot beyond that, although some contracts also cover bypass surgery. In Australia, there are many conditions covered—up to 30 critical illnesses. One little complicating factor is that the amount that's paid on an event can vary. Generally, if you're covering bypass surgery, you'll pay less than the face amount. Or, if you're covering HIV, you might pay 25% or 50% of the face amount of the insurance. I mentioned the 30-day survival requirement, although some policies will also pay a reduced amount if you become ill and then die within the 30 days.

Because this product is in the early stages of the product development cycle, there are a tremendous number of variations on how this product is sold. It's sold on a standalone basis. It's sold as a group voluntary product. And I've also seen it sold as a rider to a term insurance policy, a universal life policy, or a whole life insurance policy. The duration of the coverage varies as well. The standalone products may cover events for life, up to a specified age like 65 or 75, or they may cover a full amount up to age 75 and a reduced amount thereafter. Many people are trying a lot of different things at this point.

Underwriting also varies tremendously based on what you're trying to accomplish. On a group voluntary product, the underwriting requirement may be actively at work. You might be selling this as a rider to a life insurance policy. There are companies that are issuing policies up to $1 million or $2 million. If you have a heart attack, you get paid $2 million, and that requires a decent amount of underwriting.

Generally speaking, because this is a new product, and people don't want to get locked into the rates, the standalone products are priced on a guaranteed renewable basis. I've seen very different rating arrangements, depending on the market you're serving. Rates might be five-year or 10-year age banded, where you pay the rate at attained age, in which case your premium will increase as you age. Or rates might be level premium. The most difficult thing at this stage of the product development cycle is trying to find out where you get specific disease information. If you have 30 diseases, you need to have information on each one. Then there's the question of how you adjust the data because when you get the data, they are not going to be based on an insured population.

I put down some sources of data that I found very helpful. Medical journals contain tons of information. You can find them on the Internet or from the doctors in your medical departments. The *Cancer Statistics Review* and *Heart and Stroke Facts* are great because cancer, heart attacks, and strokes are very common. Heart attack,

stroke, and cancer are going to be the biggest incidence items. The *U.S. Renal Data System* and the *Organ Sharing Scientific Registry* are good sources. You may have specific information as a company or you may have subsidiaries in foreign countries that are already offering this insurance, and you can tap into them. Actuarial publications in other countries can also be a good source. I recommend *Pricing Dread Disease Insurance* written by a couple of Australians. That's very interesting. It also has some good data. It's all Australian data, so you need to adjust it, but it's a very good source.

There are some pricing considerations. The first one is event definition. You have to be very careful about event definition because people are going to claim they had an event so they can get paid. I'll give you a sample. We, in the U.S., probably would not use the U.K.'s definition of a heart attack: "A heart attack is the death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by an episode of typical chest pain, new electrocardiograph changes, and by elevation of cardiac enzymes." You need to have a definition similar to that, though, or you're going to be paying a lot more claims than you planned on paying.

Reliability of data can be a problem. If you're using hospital information on a specific disease to find out how often it occurs, how long people survive, and those sorts of things, you need to be sure that you capture all the incidence type of data. For instance, if you're going to use that source with stroke, you would be greatly understating the incidence of strokes because a lot people who have strokes don't end up in a hospital. Adjustments to the data are usually necessary. You have to adjust the data for your definition of incidence. For instance, if you include transischemic attacks in your definition of strokes, then you're going to have a very different incidence rate than if you don't.

Going from population data to insured lives data requires another adjustment. One of the things that you need to be aware of is that you might want to leap to the conclusion that, "I'll just compare insured mortality data to population mortality data and make that adjustment." But, if you look at it in detail, you'll find that, for instance, the underwriting effect and the insured lives effect for things like respiratory conditions is far bigger than it is for these dread-disease type of conditions. If you use ratio mentioned earlier, you will be overstating the effect on insured lives for that adjustment.

Similarly, the underwriting effect will be shorter for dread disease than it is for life insurance simply because, in the sequence for life insurance, you start with a clean population. Then you either have a dread disease or death. If you suffer from a dread disease you can recover or die. There's a three-step process for underwriting death in life insurance, but there are only two steps for dread disease. As a result, the underwriting effect doesn't last as long either.

Trends are also very important for this insurance. The trends are based on underlying trends. What is really going on in the health insurance environment? There's also a huge diagnostic effect. If you have dread-disease insurance that pays if you have an event, then you're going to be looking more for the event. Examples here are bypass surgery, which has increased tremendously over the last few years, as well as things like breast cancer detection and so on. You will need to make an adjustment for smokers and nonsmokers if you want to do smoker/non-smoker rates.

Finally, your target market is also going to be an important consideration. If you're distributing through the same channels that you've traditionally used for distribution, then you probably have a good idea of the mix of people that you're going to get. If you're going to distribute through the Internet, you're going to have a much different population than you traditionally have had. All those things need to be reflected in the pricing.

Standalone insurance products are usually filed as A&H products, and, as usual, some states are difficult. Because there is no definition of critical illness insurance in most states' laws, it falls under whatever regulations the person you apply to wants to put it under. If you pay with after-tax dollars, then the benefits will be tax-free, and if you pay on a pre-tax basis, you need to talk to somebody because that's something that's not clear yet.

A product that does not cover cancer would never sell. Nobody would buy that at age 67. The male rates would be very different because there's very different incidence for heart attacks and cancer at those ages.

Mr. Paul C. Barone: My topic is a little bit different from the previous two presentations. It is about integrating workers' compensation, STD, and LTD. How many of your companies are integrating those products with another insurance company or in-house? There's not too much competition for me just yet. That's good. Our company began the process about three years ago and looked to integrate the products. The first thing we did was to try to understand the product. We learned that integration means different things to different people. When the insurance industry hears of an integrated carrier, most people think of the STD and LTD as being integrated. The next logical step would be to integrate it with workers' compensation. Another logical connection would be integrating with the medical industry. Then, finally, you'd have the 24-hour coverage policy, which is integrating all the pieces.

There has been a difference of opinion as to which one is going to work best. My company, being primarily in workers' compensation, felt that its best avenue into this arena was through the disability management portion of a claim. That is our niche market. We're trying to take those types of ideas into the disability marketplace, which leads me to ask, why will this product will work? The general goal for disability

insurance is to return the person to work when he or she is physically able, and you want to make it administratively easy on that person. As everyone knows, when a person is out on claim, you're struggling with a lot of different issues. These issues occur in workers' compensation, STD, and LTD. And you don't want that person frustrated by the claim process. When someone first files a claim we know that sometimes it is unclear as to whether it occurred at work or at home. By putting those two policies together, you can take a little of that burden off the claimant. The insurance company can, based on the facts of the claim, determine if it is occupational or nonoccupational. There's not a struggle back and forth about who's going to pay the claim, and there's not a financial hardship on the claimant. A short-term financial hardship may occur for the claimant while compensability is being handled through the court system.

In integrating the products, I tried to break it down into the five particular areas that we tried to grapple with as we first entered the market. There were general administration, marketing, rating and underwriting, claim adjudication, and other issues we had to struggle with that just popped up along the way. First and foremost, in general administration, I'd say the biggest issue is the statutory versus the contractual language. Workers' compensation is nice from the perspective of a statutory type of benefit. It's defined. When you buy that product from PMA, CIGNA, or any other P&C carrier, you're getting the same coverage. When people get hurt on the job, they're going to get the state-mandated benefit. You're going to follow the rules that apply in that state, as opposed to the STD and LTD contract, in which the contract is the force that governs what type of benefits people get.

An example would be, how do pre-existing conditions apply? That was difficult for us. We had to make sure that those few things were in sync. As we entered into the STD and LTD arena, we designed a simple contract that we felt was understandable to the client. We defined the things that Mike was talking about, especially where you tighten up some of your contract language.

The second area we addressed was not to be an administrative burden on any company. We tried to look at the billing of the premium in two different channels. STD and LTD typically goes to a human resource benefits area of a company. Workers' compensation is usually purchased by the risk manager and has a completely different flow in terms of who writes the check. What we tried to do was make that administratively simple in the process.

Finally, for statistical reporting, in the P&C world, I'm very accustomed to reporting my data to rating agencies. They take that data, segment it by the different types of classes of business, and develop rates from it. There's a large body of information that actuaries can access to get a lot of information as to the duration of claims, how expensive claims can be, and what the split of costs are. I haven't really gotten that body of information outside of looking at some Commissioner's Group Disability

Tables (CGDT) and seeing that they've been updated. But there is no place to go to find out how to break it out into the different industries or different segments that we insure.

The next thing that our company looked at was the marketing. The distribution channel is different for STD and LTD versus workers' compensation. What we found was that, even if our P&C agents had an employee benefits broker in-house, those two sides didn't talk to each other, which I think is very similar to what happens to the buyer of the coverage. The human resource person and the risk manager don't typically know of each other's role or interact as much as we'd like them to. One of the things we're trying to do as we continue to go into these different companies is get those different entities together. What we're generally finding is the companies that are most interested in integrating those policies are starting to integrate those functions within their own shop. They're starting to talk about the common goal, which I still think is a return-to-work type of atmosphere. It's trying to break down the walls that seem to occur. When the person's injured on the job, there seems to be a lot more of an effort to get them back to work than when they file a claim through the STD and LTD arena.

Finally, as for marketing, there is a difference in the way a sales presentation is prepared. As we added sales staff in our own company to help us sell the STD and LTD policies, we definitely had different approaches when it came time to present in front of a client. One of the biggest things that I noticed was, when you go to sell an STD and an LTD policy, the contract features and the different bells and whistles seem to be the focus of the presentation. Discussion surrounds what this policy can do for you in this type of an injury or how it works, as opposed to in the P&C industry, because it's statutory and mandatory. Companies distinguish themselves by service, and that is the key component of those types of presentations. We tried to take the best of both worlds as we put together presentations and go after clients. You are going to have that mix of buyer. You're going to have the risk manager who wants to hear what you can do from a servicing side, and you're going to have the human resources representative who wants to know what benefits he or she can tell employees that they're going to get under this contract.

The next thing that I want to touch on is the rating and the underwriting. I think there are a lot of things that can be drawn from both industries, but they are similar. The only differences are where the data came from and how we can ultimately come up with the final price that we want to take to the market. The exposure base is very similar. In workers' compensation, it's gross wage with only a minor wage limitation. It's captured at an aggregate level by class. You're not looking at each individual from a census perspective. You're looking at aggregate payroll data broken down by class, which is how the insurance product is priced out, as opposed to the STD and LTD arena, where it's broken down by covered salary. Again, you're using payroll as the base. It's just that we're limiting coverage relative to the maximum wage.

They are trying to do the same thing with the experience rating formulas. They're trying to apply credibility to this insurance policy that we're trying to write. Although they don't take the identical approach in the workers' compensation arena, what we use is something called an experience "mod." An experience mod takes expected losses, and says, "Based on this particular number of insureds, we can apply this amount of credibility." It splits losses between primary losses and excess losses and applies a different set of credibility to a primary loss versus excess. Just to expand a little bit more on that, primary losses are frequency-based; excess losses are more severity-based. The credibility formula tries to blend those two pieces and comes up with an overall modification to a manual premium. In the STD/LTD arena, it's the number of covered lives and the credibility you give relative to that block that you're underwriting.

Finally, we'll compare loss cost versus the CGDT as being the main source of data that we have to underwrite the policy. Loss costs are typically calculated on an expected loss basis. They are adjusted by state and include a hazard group differential. In workers' compensation, there are four hazard groups utilized in the rate-making process. These groupings would be similar to grouping STD/LTD into white collar, all the way down to blue collar. In disability, we utilize the CGDT and modify the base rate by a series of loads and discounts to reflect the industry and any other particulars relative to the case to come up with the final price.

From a claims perspective, when comparing workers' compensation and disability, I think this is probably the place where the two products have the most similarity. There is the most similarity because returning the person to work is what we all want to do. We want to do it when it's appropriate. Through the integration of those policies with STD, LTD, the workers' compensation, we're mainly providing a wage replacement mechanism. Workers' compensation has that extra component of the medical losses, but it is really designed to cover lost wages while a person is out on claim.

Definitions of disability and benefit durations differ between workers' compensation, STD, and LTD. Workers' compensation can be payable until death if a person remains disabled—it is a lifetime benefit. Disability policies typically cover a claim up to retirement age. One other main distinction between the two is in the wage replacement. Worker's compensation is a tax-free benefit as opposed to disability, which can be taxable. Another factor to consider is limitation of benefits. That doesn't really occur in workers' compensation. You get your benefit while you're injured and off of work. An offset to gross benefits occurs under both arenas, although I see much more of an emphasis on it in the LTD market.

Finally, we incorporate return-to-work programs into the claims process. I've heard at different sessions the issue of return to work, and how we get the person who's

injured to return. Most companies with a workers' compensation perspective have a light-duty program. When you ask whether the companies apply that same philosophy to the disability claim, they typically respond "no." What we've been trying to do is reeducate them on this issue. Although the person is out, there still seems to be a hands-off approach to the nonoccupational type of injuries, and companies don't utilize this as a method to get them back.

The issue of confidentiality requirements cropped up along the way as we entered the marketplace. When someone gets hurt on the job, the company knows about it. Obviously it happened in the work place. Then there is the issue of how badly the person is hurt and his prognosis. That can all be freely discussed with the insured with workers' compensation, as opposed to with the nonoccupational injuries. Insureds don't have that right to know.

From the company's perspective, this is probably one of the reasons that return-to-work programs haven't been as successful. On the occupational side, there seems to be a view that, "This person got injured at my work site." Therefore, there's an ownership of that claim in that the company in some way feels responsible. Had the company not engaged that person in that particular role, and if that particular incident hadn't occurred, the person wouldn't be injured.

This view does not carry over in the nonoccupational side. In this case, the event that caused the disability was just a happenstance of life. It was not job-related. This translates into, who is the ultimate buyer of the insurance? As I've seen in a lot of different cases, companies buy the workers' compensation insurance because they have to. Even if they are providing a fully insured STD and LTD program, they look at that as a benefit that goes to the individual. When a nonoccupational claim occurs, the person receiving those benefits seems to be at the individual level more so in the STD and LTD arena as opposed to the workers' compensation arena, where the company seems to be taking a much more integral role.

I'll mention a couple of things about integrating the policies and procedures. From the contract perspective, there is not one workers' compensation/STD/LTD product or one contract for that. We do sell through separate contracts, although we put them together and package them together. From a billing perspective, we found that we didn't want to recreate the wheel. There is a comfort in having the STD and LTD flow through the human resource department and having the workers' compensation go through its normal P&C agent perspective. One of the big differences about billing is that, in workers' compensation, billing is based on an estimated annual premium. At the end of the year, there's an audit performed, and you true-up all experience, as opposed to in the disability marketplace, where the billing is monthly accounting. It is either self-administration or list bill. One of the things that we were successful at integrating was the reporting of the claim. We developed a combined claim report, so the client can report either the workers' compensation injury or the

disability. There is no choice of which claim form to use. There's a section for both. We had to get the form approved by different states, depending on the first report criteria, but that makes it administratively easy on the company to file that claim.

The claims adjuster role is a key area for integration, and it has been very successful. At least we see some early success in it. The client likes having the same person handle STD, LTD, and workers' compensation because he or she has one point of contact. The claimant likes it because, if he or she has both a workers' compensation and an LTD claim, they are both being handled at the same time by the same person. You don't have to get two sets of information or send it to two different people to have them evaluate the claim. It also helps when you have the person file multiple claims. Once his or her benefits run out on the workers' compensation side, he or she tries to file a claim under the disability marketplace. With integration, is easy to discover that the claim is of an occupational nature and has been resolved.

The need for integrated reporting of claim experience seems to be arising from the marketplace and has come back to us. They want to be able to measure how much time somebody is out of work due to occupational or nonoccupational injuries. I think it is important to integrate the reporting and develop a loss analysis based on that so that the clients can take all these different types of injuries, analyze them, and decide what would be the best method to help improve their own loss experience.

In summary, I do see the integration of the different policies continuing to grow in the marketplace. Companies that will be most successful are the ones that can write the product most simply and with the most administrative ease. I do think that there are some educational issues. You have to get both your human resources and risk management departments talking to each other, but once that occurs, I think the product can be extremely successful.

Ms. Jena A. Breece: I have a question for Paul about the workers' compensation claim adjuster. You mentioned that you have one person dealing with one claim as it comes in, and that could be medical, STD, and potentially LTD. Is that correct?

Mr. Barone: We handle the medical within the workers' compensation arena, but we don't have a group medical policy.

Ms. Breece: Is it really just disability?

Mr. Barone: It's just disability.

Ms. Breece: I was wondering how you would have effective claims management if somebody was trying to learn the ins and outs of those three different kinds of claims.

Mr. Barone: You're speaking of the group-health arena. We have explored that area only peripherally. I think that industry has a large volume of claims, and that presents it's own logistical issues. One very important issue would be systems.