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Session 123TS
Voluntary Benefits—Successful Approaches

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Panelists: WARREN M. COHEN
SEAN GILDAY†

Summary: This teaching session considers the marketing of voluntary benefits to employee groups and addresses key success factors for distribution, product, and technology associated with the work-site marketing distribution channel. Topics include:

- *Description of the voluntary benefits marketplace*
- *Distribution dynamics*
- *Product design and marketing considerations*
- *Technology impact on distribution*
- *Examples of successful execution*
- *Future trends*

Mr. Sean Gilday: I'm going to introduce voluntary benefits, with some background information as to the industry, and then go into some of the capabilities that are required to be successful in voluntary benefits. There's a new model that's being used now in the U.S. market for voluntary benefits that adopts some new methods of enrollment as well as some new methods of managing the data transfer between the carriers and the insureds. I'll talk a bit about that and then wrap up with some questions if there's time.

Moving along to the U.S. market, when gathering information on a voluntary benefits market in the U.S. there's not a whole lot of data. The Life Insurance Marketing & Research Association (LIMRA) tends to be the only main source of information. Conning & Company is another one. LIMRA has been trying to offer its carrier clients some information on the market. Fifty percent of all employers offer at least one voluntary benefit. A voluntary benefit is totally optional. It is not provided by the employer or paid for by the employer. A voluntary benefit is fully paid for by the employee. Ninety percent of all large employers offer at least one voluntary benefit, the large employer being one with 1,000 or more employees.

There's a movement to offer more multiple benefits, I'm going to talk about that a little bit further on, but there's definitely a shift. In the last five years companies are offering more than one voluntary benefit. It definitely offers the employee more opportunities to buy products, but it also adds to a few of the headaches that the employer has to deal with as far as administration.

† Mr. Gilday, not a member of the sponsoring organizations, is with Insource Limited in Toronto, ON.

One of the biggest things about the voluntary benefits market is it offers insurance companies access to the underinsured middle-income market. There's been a huge shift in the last few years of agents and brokers going to the top tier of the income earners because they see most of their commissions coming from whole life or universal life (UL) products, and the bigger the policies they can sell, the better. This has really been an opportunity for some of the niche and large carriers to go after the middle market and sell the smaller-faced life insurance and other type insurance products to the middle market.

But why are employers offering them? Employees are asking for those products. They improve employee satisfaction and morale. The enrollment process has changed over the last few years. Ten years ago it was very paper-based and face-to-face. Now they're incorporating a lot of new technologies: laptops, Web enrollment, and interactive voice response (IVR) system call centers, which I'll get into a little bit further on. But the method of explaining the core benefits to the employee and then offering them some options of voluntary products to supplement or add to or compliment their existing core products has been a trend of late.

A LIMRA survey, with a sampling of somewhere between 20 and 25 life insurers, tracking life and health personal lines premiums, from 1992-1997 showed U.S. worksite sales growth of about 15%. The survey showed a sales drop in 1996 because it actually lost a couple of the big carriers from its sample. It's hard to get a full number on what the market represents—somewhere between $10 and $12 billion is what we're talking about for work-site premium, and that's in life and health. In 1999 I think Conning & Company estimated that new annualized premiums would be somewhere around $2.5 billion. Once again, that's life and health. Unlike the traditional lines where we know what the market size is, companies are selling group voluntary, and sometimes selling individual voluntary, and it's hard to pull out the numbers and determine what the market really is.

LIMRA estimates that voluntary life and health products cover about 5.4 million individuals, and it estimated the growth at around 76% from 1994 to 1998. In a survey to assist the carriers, LIMRA estimated that about 120,000 employers representing 12 million employees would offer at least 1 voluntary product in the next 5 years if they were approached, and LIMRA estimated that at about a $12 billion market opportunity.

A couple of the large work-site carriers or voluntary benefit carriers use captive agents, but there has been a shift away from the captive agency to the independent broker. One of the main reasons is the fact that they have more control over what products are sold, and clearly they can seek out products that'll give them better commissions and offer better benefits to the employees that they're trying to sell to.

I think the carriers found a bit of a restriction when they could only sell one company's products, and it's not uncommon in the voluntary benefit market to have one employer group with as many as 6 to 12 carriers' products on a case. It definitely offers the broker more control over what they can bring to the market.

I think one of the other things that we've seen in the voluntary benefits market is there's a core group of brokers who are specifically focused on selling those voluntary products such as individual UL, individual YRT, and cancer products. The brokers are not necessarily concerned

about the group products; they are just going into the employer trying to sell these voluntary products. They have an understanding of the processes involved in selling the voluntary products, the enrollment processes, or the licensing issues with the agents. They understand how to deploy the enrollment capabilities for each employer, and they're definitely specialists when it comes to that.

There has been a bit of a shift lately; we've seen a few large group brokers who are trying to adopt a voluntary benefit capability. They have a large in-force block of group accounts where they were just selling group products, and now they see a lot of potential commissions on the table with respect to the individual voluntary benefits.

I'm going to talk about some of the key capabilities that are required for work-site success. Clearly, products and sales enrollment are important, but a couple of the key issues are technology, administration, and billing and reconciliation. There are a lot of administration issues that come into effect here to make this whole package work, and a lot of carriers in the life and health area are definitely struggling with some of these issues. I'll go into these in a little more detail.

When it comes to products, the successful products tend to be simple, easy-to- explain, and easy-to-understand. For example, when I'm talking about a UL product it's not a high-market complex UL. It's a very simple UL. They're usually guaranteed or simplified issue. Provident has a guaranteed-issue UL. It's one of the few remaining guaranteed-issue ULs. It's basically guaranteed-issue. But most companies have a simplified issue with maybe four to five knockout questions that they use. A joke among brokers is, if you can fog a mirror you can get the insurance, but they're tending to get a little stricter now with the underwriting. But the key thing is most of these products are individual, and they're usually portable. Once the employee leaves the company, he or she can take the product with him or her.

Another big thing, as I've already mentioned, is the employers are usually offering products from multiple carriers, and some of the typical products could include UL, LTD, and dread disease, which I mean to be cancer. That's been sort of the traditional product, but now we've seen a pretty big trend in critical illness (CI). CI has really been picking up in the marketplace as of late. Dental is another product. A lot of employers now are not offering that as a core group benefit. Now, employees are seeking out coverage on their own. That's an individual-type product that's being sold in the market.

We've seen some mini-meds and major-med plans that are also being sold in the marketplace. But, once again, if you're looking at life and health I'd say the key driver in the market has been UL, and that's predominantly because of the high commissions that can be gained by the broker.

Products are definitely tailored to the market. I'll just throw out a couple of the key issues that carriers have to think about. There's higher than normal lapsation, somewhere between 20% and 25%. The carriers don't have programs in place to keep those clients after they leave the employer. If people leave, generally that policy will fall off the books.

Another issue is carriers have to be constantly aware of participation levels per employer, and in many cases carriers won't offer their products unless the enrollment or broker says they're going to meet with every employee face-to-face to do a presentation and have a minimum participation on that group of somewhere between 20% and 30%. That way they can avoid antiselection issues. But the veterans in the work-site market tend to be able to look at groups, look at the demographics, and look at the other products including voluntary offerings through the group and they're pretty good at estimating what kind of participation they can get.

There are a great number of sales involved in voluntary benefits. Probably the most important is the sale to the employer. There has to be some demonstrated value to the employer. Many brokers will go to an employer and say, "I'm not here to replace your group benefits, but what I will do is free of charge explain all your core group benefits to each employee in a presentation that's on a laptop." And it's a very nice feature offering this to the employer because it'll save time on human resources (HR), and also in many cases employees don't even know what benefits they have and they've never been given a thorough description of those benefits that they do have. It's seen as a value-added process to the employer. Usually what happens is at the end of the description of the core benefits there's a pitch for the voluntary benefits, and I'll get into that in a little more detail later on.

One of the key things we're seeing with employers is that there has to be seamless administration. Payroll deduction is probably one of the biggest issues. Most of these voluntary benefits are payroll-deducted, and when you have one, two, three, or four carriers that are offering payroll-deducted products at one employer's site, it becomes a very big issue as far as managing that payroll deduction process for the employer, not to mention products that tend to be more dynamic.

If there are premium changes—for example, property and casualty (P&C) products are being sold at the work site, they tend to change through the years. People buy a car or a new house or change their coverage. That payroll deduction is quite dynamic over a 12-month period per employee. Employee communication is also a big issue. When you start offering products at the work site, those employees are going to have questions: "How do I change my coverage? How do I change my beneficiary?" And there are more questions involved than there would be normally through a core group benefit.

One thing about the process that many of the brokers are pitching is that it offers the employer a census update. As the employee is sitting through the presentation, changes in address and phone numbers are added into the system, and then it'll be fed back to the employer at the end of process.

One of the things that is sold to the employer over and over again is that it is a morale builder, and it can improve retention of employees. Once again, the voluntary benefit specialist is definitely critical here because there are a lot of objections that the employer has that you have to deal with when you're actually selling the case, not to mention managing the enrollment process.

In the last two years, there's been a big shift among the work-site and voluntary benefit carriers to using TPAs. I guess three years ago carriers were thinking that they could do everything, and now they're realizing that in order to compete with the other carriers they have to be able to move quicker on certain things. One of the biggest issues is application processing. A lot of carriers say they can do a 5-day turnaround on an individual application for UL, but it tends to actually take longer, more like 10-15 days, maybe 20 days. One of the things that we found in the market is that the longer that insureds don't have a policy in their hands, the more likely they are to cancel their contract.

It's very important to get that policy out quickly, and there are some TPAs now that do the application processing for the carriers, and they work directly with the enrollment companies to download those applications and process them. In some cases the TPAs have the policy papers of the carrier, and they can print out the policy and send it to the insured.

Underwriting is being outsourced now. I know there are a few large carriers in the U.S. that are outsourcing the underwriting for different products. One of the big things is the information that travels from the electronic enrollment, but when I'm looking at application processing for a life application the cost for that processing can be anywhere from $10 to $20 U.S., and it tends to speed up the process and improve persistency.

I'm going to talk about three key areas: enrollment, application processing, and payroll deduction. Once again, the key pitch in the market has been the education on the core group benefits, and it offers the broker the opportunity to sell the voluntary benefits because the voluntary benefits presentation is sort of built-in. It's usually quite homogenous. It looks like it's all part of the same package, and it is endorsed by the employer. The approach has been a soft sales approach—that if you visit every employee face-to-face with a presentation, the law of numbers will show that you'll get 25-35% participation. A lot of enrollment companies tend to make sure, and they enforce the fact, that they don't want their agents selling hard because that'll get back to the employer, and it could jeopardize the case.

They tend to use more of a teaching methodology. They just walk through it, describe it, and then usually the employee will say yes or no, and it's usually based on picking a premium amount—$5, $10, or $15 per pay. The employee will say, "Yes, I'll take $5 per pay." The presentation will calculate the amount of coverage, say it's UL, and it'll show them the coverage they'll get on that UL contract and then ask, "Are you happy with that?" The employee will say, "Yes," and he or she basically signs up. It's a very simple approach, but one of the things that has changed is the method that they're using to sell. Face-to-face has always been the most effective way to get the highest participation, but now there are a lot of companies that are asking for different methods, for example, live call centers, IVRs, are being used a lot now. Probably one of the areas that companies are looking at for the future is the Internet, where they actually have some sort of web-based enrollment.

For example, a large bank might have many offices throughout the U.S., and it's virtually impossible for an enrollment company to meet face-to-face with every employee. They have to have some other methods of enrollment to lean on to make sure they can cover the entire country and all the employees. The live call center tends to be quite effective. IVRs are not as effective. The Internet's still pretty new. We're not exactly sure how that's going to work, but

companies are using the Internet and their Intranet to do the core benefit enrollment and also to select voluntary benefits.

One of the key things about enrollment is that it is done on company time. The carriers tend to be very tough on the enrollment company saying, "If you don't get face-to-face meeting with every employee, we're not going to let you use our products," because the carrier knows they have to have certain participation levels on that employer. There are probably about five to ten really neat enrollment software companies in the U.S. that are developing software for this market, and now they're all Web-enabling that software. There are a few players there that have the neat packages, but enrollment is the key. Having a successful enrollment is important to everybody involved because there's a lot of money put up front, somewhere between, say, $50 and $100 per person visited. They want to make sure that they get a lot of commission out of that case.

These are all the methods of enrollment for an employee. There's IVR, the Internet, mail, fax and face-to-face. And there is the enrollment software. A lot of large enrollment companies that have nationwide coverage and a lot of capital, some of which are publicly traded now, have built a database that interacts with the enrollment. Whatever method of enrollment there is, whether it's paper-based or electronic-based, Internet or face-to-face with a laptop, that information is sent to the call center that has a database, and that database is the central repository for all the information that's derived from the case.

All the application information is sent to that database. And what tends to happen on the other side is that the carriers have access to that database, and they can pull off that information. What the enrollment companies are doing now is bypassing the carriers. In the old days all the applications would go directly to the carriers. They'd have to process them in 10-20 days. Now the smart enrollers are putting all that information together, and they're giving access to the carriers via a firewall with a log-in, and they can go in and pull off that information they need to update their own administrative systems. And what that does is it allows the enrollment company to have better access to the information to start the billing and also to begin answering questions of the employee, but it speeds up the fulfillment. It's a neat model that's being used now, and a lot of companies now are trying to tie in not only the voluntary but also the core benefit management.

A call center can answer questions on the core benefits as well as the voluntary benefits, and it can fast-transfer any calls at the policy level where the carrier has to answer the question. If there's a claim issue, that type of thing, it can pass on that call directly to the carrier that's responsible. And one of the things that it does at the employer level is that when they're selling the case the enrollment company and a broker can say, "Look, we're going to give you a 1-800 number for all questions related to your core benefits and your voluntary benefits." It's a very nice, easy way for the employer to outsource all those responsibilities. It relieves pressure on the HR department, and in many cases employers will pay to have this service done for them.

Billing and reconciliation is probably another big issue, and typically cases feature multiple products and carriers. What has happened in probably the last two years is that a lot of employers have said, "Look, this is getting crazy. I'm getting eight to ten bills per month from

different carriers, writing all these checks. I'm having trouble reconciling. Employees are leaving. They're dropping the coverage. It's all messed up. I'm not really sure what's happening." They really are asking for a consolidated bill.

There are a few companies that sprouted up in the last, say, two to three years that are offering this service. Now, I'm not talking average deferred percentage, like a payroll company. I'm talking about a specialized TPA that understands both the insurance business as well as the billing business. It is offering employers one consolidated bill, and it can be an unlimited number of carriers or products. The employer only has to write one check per month or per pay period, and they actually now can consolidate on the employee level because when an employee has three or four different products their paycheck was getting all messy and it was tough for payroll. Now they can actually consolidate it. They have one deduction per employee for an unlimited number of transactions or products. It's cleaning up the whole process, and what it does ultimately is it allows the broker to bring in more products and also allows the employer to do a little more cost sharing on the other benefits, and it makes the whole process much simpler.

One other thing that's a key aspect of this is the companies are offering communication to the employee. For example, if an employee buys a new product, and their deduction goes from $20 to $25 per pay, and they have a question as to why it's gone up, there's usually a call center or some sort of paper communication giving the employee that information prior to the deduction so they understand what's going to happen.

One of the things about payroll deduction is it definitely has the highest persistency because you're getting at the money very quickly before it goes anywhere else, and in the middle market, too, another factor is that a lot of people don't even have checking accounts. A preauthorized check system or a pension administration plan is not really an option. And direct billing, you don't want to do that as well. It definitely gives you for that middle market the best way to get the premiums collected. One of the things about this whole consolidated billing issue is that accuracy is very important, and deduction mistakes can definitely cause the case to maybe fall off the books.

Carriers have been trying to develop systems. TPAs both in Canada and the U.S. are developing these types of systems to do the payroll deduction. This a very simple case where you have a TPA that's on the case, and basically how the process works is a TPA will get the information from either the enrollment company or from the carrier as to what to deduct. They have an interface built with the employer, and the employer will load in that information into their payroll registry, make the initial deduction, and send the premiums to the TPA who reconciles them. When I say reconcile let's say there are 100 employees at the company. Say, 99 totally match up in terms of what was supposed to be collected and what was collected, and, say, one is at 50% of what should be collected. The TPA in most cases will send the 99 people's premium to the carrier. They'll hold out that one person's premium till they can figure out why it's not at 100% of what it should have been. Maybe that employee went on holiday or maybe they left the company, but it's up to the TPA to figure out what happened to that premium. They'll hold that out till they figure out why, and then they'll send it on to the carrier once they've collected what's missing or they've determined why it stopped.

It gets a little more complicated when you have a couple carriers, and that's why the TPA becomes more important in the process, because once again, as I said, the employer is getting tired of writing all these checks to the different carriers. Being able to write one check to a TPA and having a TPA do all the reconciliation helps the process.

It definitely becomes a more critical issue when you have a lot of different products that are being deducted. There are a few cases that I've worked on with TPAs in the U.S. where there are somewhere between 10 and 12 carriers offering products. I can give you an example of this, there might be LTD product that's tailored to the lower-end income and maybe there's a different carrier that has one that's more tailored to the higher-income employees. There are two products from two different carriers that the employer's offering.

Now, this is probably the most important part of it, and if you can follow the numbers, we'll start at the bottom. The employees will cancel their contract. Say it's a UL contract. They'll send their notice to the carrier that cancels the contract on its administrative system. The changed data is sent to the TPA who, in turn, will do two things. The TPA will send the billing update to the employer so it can update its payroll registry. What they're doing now is they also send a change letter to the employees instructing them as to how their deduction is changed. In this case it's a cancellation, so their deduction will be reduced. But a lot of TPAs now are also doing the same type of process if a new contract is added. It'll give the employee an early indication as to an increase in the deduction before it comes out of their paycheck.

Effective communication of premium changes is a critical part, and now they are using call centers so the employee can call in. Those are getting tied into the billing TPAs as well. On-line access to billing information is the next step. The employees can log on and track their last year or two years' worth of deductions to figure out how it's changed over time. It works like a budgeting tool for the employees, they can track and see how they've budgeted for their premiums for insurance, both property casualty, life, 401(k) (if that's being deducted), and other products.

Basically I've touched on some of the key success factors, but I think that coordination and implementation are critical. There are a lot of different capabilities and tasks that have to be done to be successful, but what we've seen is that there are some successful companies—AFLAC, Colonial, and American Heritage and some big companies like Transamerica and Met Life that are making money at this. There are a lot of small carriers that are able to react quickly to technology changes and product changes, and they tend to be very successful in this market.

Mr. Warren M. Cohen: I'm the vice president of financial planning and market intelligence for Cigna's group voluntary business, and I'm going to build upon Sean's presentation by focusing on the group voluntary benefits market. Along the way I'll be comparing and contrasting the group market to the individual products market. Many of my examples are going to focus on life insurance because that's the most common product between the two areas, but the principles apply across most coverages in general.

First I'm going to go over some basic definitions—what we mean when we talk about group versus individual and group voluntary benefits versus individual work-site marketing. Then I'll move into some of the distribution, pricing, and underwriting dynamics, again comparing and contrasting individual versus group. Then I'll finish with some thoughts of what the future may hold.

In terms of group insurance, in my mind when you talk about group insurance the main distinguishing factor is what the employee gets is a function of the group profile. The coverage they're offered depends on whom they work for. And this is the dominant model in the large case market—the 500 lives and above. Later I'll go into some reasons why. In the individual market the product isn't a function of which company you work for. By way of example, I actually like to use myself. I have two group UL certificates issued by Connecticut General Life Insurance Company, exactly the same group contract in terms of the words, but one I have as a former employee of Ernst & Young on a direct bill basis. The coverage is portable.

And when I went to work for CIGNA I got additional group life insurance coverage again through Connecticut General, the same contract. But despite the fact I'm obviously just one individual, I pay two different cost of insurance rates because of the two coverages being with two different employers. Two different interest rates are credited on the side fund. They're administered in two different places. I actually have to call two different call centers if I want to get service. As far as Connecticut General is concerned I'm two different people as far as this coverage goes, and that's because it's two different employers. It focuses on the employer, and that's the basic difference. That wouldn't happen with individual coverage. If I had bought two individual UL products, one as an employee of Ernst & Young and one as an employee of CIGNA, assuming it was the same product, all the bases would be the same.

The group-benefits market has approached the voluntary market by extending traditional core employer-paid benefits. The focus is still on the employer. Our efforts in the group market are in selling employers and retaining employers. That's our measurement focus; it is very employer-centric. And there's a social insurance perspective to it. It's a benefit. Everybody's supposed to get it. You see very liberal underwriting. If anybody wants it, they should be able to get it. There is less focus on precise rates for the right individual and what their fair share should be. There are a lot of cost subsidies. It's more of a social insurance concept.

On the individual work-site marketing side, the focus is on the channel. The carriers, as Sean said, simplify the products. They're basically the same types of products, as you would have in agent-based, kitchen-table-type sales. The focus is on the channel, the employee, and building consumer relationships. The perspective is different.

In terms of some successful companies, I have a couple examples in the group area and some numbers that I got through analysts' reports (that's the level of accuracy I can commit to). Metropolitan has reported to analysts over $2 billion of voluntary insurance premiums with life being the dominant product. Interestingly, in terms of another product line, they have group auto and homeowners which they sold to more than 1,000 employers worth over a half billion dollars of premium. At CIGNA we have over a half billion dollars of voluntary premium: life, accident, and disability coverages, including group UL and group variable UL. In the work-site marketing arena, and Sean mentioned these companies, the two leaders are AFLAC and

Colonial. AFLAC has reported over 130,000 payroll accounts, 75% of which are for under-50 lives. As I mentioned, the individual work-site market is concentrated in the smaller firms. With over $1 billion of annualized in-force premium and double-digit margins, they are making good money on this. Colonial has more than 40,000 accounts and a half billion dollars of annualized premium in-force with similar attractive margins.

In terms of distribution in the group market, as Sean mentioned, it's a two-step process: the employer and the employees. Again, in the group market much more attention and much more energy is put into acquiring employers. Eighty-five percent of the business comes through intermediaries, not direct sales from the companies, and it's a very reactive process, which I'll describe. There are two primary types of distribution, one through commissioned group-benefits brokers (Marsh and Aon are prime examples), who are paid level commissions. In the smaller end of the market typical commissions might be a level 15%, but when you get into 1,000 lives or more, you get into single-digit commissions. These are obviously much lower commission levels than in the individual market.

Fee-based consultants dominate the larger case market. The employers pay on a project basis. They pay benefits consultants such as Mercer, Towers, and Hewitt to go out and run a project and get coverage. The carriers generally have company representatives who are a liaison to these intermediaries. They don't sell directly in general—like I said, maybe on about 15% of the business. They are the link to the intermediaries, and they're generally paid on a salary plus group-sales-incentive-compensation basis. Now, the process is very reactive. The carriers aren't going out and trying to sell coverage. They're somewhat sitting back and waiting for the intermediaries to come to them with requests for proposals (RFPs). Say your company is invited to bid on a group voluntary life program. Please submit your bid by a certain date, and here are the bid specs. The carriers are reacting to RFPs.

Now, after a case is won, somebody's a winner of this bid process, and then they have to go about enrolling the employees. Again, the emphasis is on the group and cost-efficiency. You see very little one-on-one- and face-to-face-type enrollment in the group-benefits market. The primary method is large group enrollment meetings. The objective is to keep the cost as a percentage of first-year premium down in the single-digit range. Again, the focus is on cost-efficiency.

The enrollment meetings can be run several ways. Some of the larger players do have their own salaried enrollers to run the meetings. Sometimes the intermediaries themselves run the enrollment meetings. Sean mentioned there are specialized enrollment firms. They run the meetings. Sometimes the employers run the meetings themselves. They say they can do it themselves. It's backed up by communication support, material describing the benefits, sometimes payroll stuffers, things of that nature, or an employee benefits booklet. Now, obviously without the one-to-one contact the employer endorsement is critical for participation success because you don't get that opportunity to solicit one-on-one.

Today, paper is still, unfortunately, the dominant method of enrolling people with people filling out enrollment forms and submitting them. This is obviously a very expensive process, prone to error, with a lot of data entry. There's been some success in recent years utilizing IVR technology to automate the process more and we're starting to see Internet- and Intranet-

based enrollment, which is really the future. This is most convenient for employees and obviously cost-efficient for the carriers.

Participation does vary by product. Dental is getting the best participation. As Sean mentioned, it is a very popular product, and a lot of surveys indicate that it is at the top of the list when you ask employees what types of products they're looking for. Long-term care (LTC), as an example, is a product that has struggled with participation. It's a very complex product. As Sean mentioned, simplified products work best in the voluntary market, and it only appeals to a somewhat limited segment of the employee population.

But more important than participation by product is that participation varies widely by employer. It varies based on the employer's commitment to the success of the program, their dedication, the group enrollment meetings, and the socioeconomic characteristics of the group. The company culture makes a difference, and how centralized the employees are. Can you get the employees together in these large group meetings? Group underwriters spend a lot of time in their pricing evaluation projecting participation group by group.

Now, work-site marketing, by way of comparison, is the same two-step process, but the focus is much more on the individual than on the group. Now, for the top two carriers, as Sean discussed, for AFLAC and Colonial, a captive agency distribution system has been their predominant way of selling, and it's very proactive compared to the group method where the group carriers sit back and wait for that RFP. These agents are out there selling products proactively. It's a labor-intensive, very multilayered distribution system. AFLAC is reporting approaching 10,000 producing agents. That is labor-intensive. In contrast to group the commissions are heaped, for UL, in the neighborhood of 85% first-year commissions. There is a very different cost structure for group versus individual.

As Sean went through it, I won't spend too much time on enrollment, a one-on-one approach compared to the group meetings in the group market. Laptop presentations are somewhat common. I would say the individual work-site marketers are somewhat ahead of the group carriers in automating the process. AFLAC has a system they call Smart App that enables the agent through their laptop to submit an application directly electronically, and they do that on about 60% of their business, and then about in 40% of those they can jet-issue them. The whole application enrollment process is done without any human intervention on a good portion of the business that is obviously very cost-efficient.

A question here. I'm going to go into a new distribution model that's just beginning to emerge. By a show of hands, can people tell me how many of you have heard of organizations such as Rewards Plus of America (RPA), Answer Financial Incorporated (AFI), or Consumer Financial Network (CFN)? OK (a few hands raised). This is a new distribution model that's focusing on bringing greater individual choice to consumers at the work site. They try to bring a financial supermarket to the consumers at the work site, providing a wide array of products, providers, and plans. The three major players are the organizations I just mentioned. These are all new economy-type companies, privately held, with heavy use of the Internet in their distribution, and I'll go through some of the details.

As I said, they offer a wide array of products and plan choices. Here's a short list of some of the products I've seen, and not all of the players offer all of these: P&C, auto, homeowners, life, accident, disability products, LTC, vision, dental, mortgages, on-line banking, pet insurance (which actually is a reasonably good seller), annuities, individual health, supplemental health (like cancer and CI), prepaid legal, and prescription drug plans. All of these products will be on one platform. As you can see, it goes well beyond insurance but even more into broad-based financial services. And at least CFN and AFI provide what we would classify as comparison-shopping. If someone is interested in auto insurance, they'll submit their information on-line, and they'll get back three to five insurance quotes. It's up to the consumer to choose which carrier they want to go to, rather than the employer picking the carrier. This is done on a real-time, on-line basis.

Now, to support all this consumer choice and responsibility, the AFIs and CFNs of the world, and RPA, provide on-line support tools, information-rich content to describe all the coverages, and they give the A.M. Best ratings and things of that nature to help the consumer through the process. They have electronic links, at least to some extent, to the providers to support the on-line quoting, to allow policy issue and services, all to be done electronically. They also support on-line enrollment. This is done through the Internet, and the employee can do this either at work or at home. This overcomes a primary employer objection to Internet-based enrollment. They often say, "My employees don't have access to the Internet at work," or "I don't want them spending time at work on the Internet." Well, with this type of new model the enrollment can actually be done at home, and as you all have heard, the country's becoming more and more wired. Now at least 50% of the population has on-line access.

The on-line capabilities are backed by human service capabilities. If someone doesn't have access to the Internet or gets confused, they can call up and get licensed representatives to support them through the process. They do support multiple payment options. Payroll deduction, as Sean said, is the preferred method for the carrier for persistency reasons. If the employer doesn't want to get involved with the complexities of payroll deduction, they will support automatic bank draft and other direct billing methods.

I am going to shift gears now away from distribution and move into some of the pricing and underwriting considerations and plan design. In group-benefits pricing, again, by definition, the focus is on the characteristics of the group, and group sets the prices. A group underwriter will look at the characteristics of the group, the standard industrial classification, the size of the group (larger groups get better deals than smaller groups), the demographic composition, the turnover of the employees, and, most importantly, past claim experience, particularly for larger groups.

For larger groups, the price will often be based solely on the past claim experience of the group. A lot of attention is paid to that in the pricing. Plan design, the guaranteed issue limits, which again can vary group by group, affects the pricing. The pricing process is a negotiated one that starts with that RFP process. The companies submit their bids to the intermediaries, and the intermediaries will come back to a company like CIGNA and say, "Well, we liked everything about your proposal, but you're 10% high. Are you willing to come down?" And the underwriters evaluate it and decide, "Yes, we're willing to reduce our prices 10%." The intermediary will come back and say, "That was great, but Company X just extended their rate

guarantee from two to three years. Are you willing to do that?" It's an intermediary-controlled auction process, for lack of a better word. In work-site marketing most of the pricing is on a schedule basis. It's preset and not negotiated. Again, that's a much different process.

For group benefits, as I said earlier, the key is the word "benefit." Today the focus is on very high guaranteed issue limits. Typically you'll see guaranteed issue limits of two to three times salary, up to a half million dollars for life insurance. I've seen guaranteed issue limits as high as $1 million for group benefits. Usually it is controlled. It's only available through an open enrollment window when you can sign up to get it subject to minimum participation requirements typically in the 15-25% range, varying by carrier.

For work-site marketing, typically guaranteed issue is very limited. Some level of underwriting in work-site marketing is more common. Usually, as Sean said, there's a four- to six-question application, like a standard Table D-type underwriting. In the group benefits you see very little, if any, risk classification such as nonsmoker/smoker rates. You see more of that in the individual work-site marketing. And the plan design is set at the group level. The employer and the intermediary are setting the plan design. For example, in life insurance if there's going to a waiver of premium, everybody's going to have waiver of premium. In the individual market you'll see more of the riders being left up to the individual. There is more individual flexibility.

Portability is an interesting plan design feature that does a good job of contrasting the dynamics of group benefits versus individual work-site marketing. In the group area portability is a risk to be managed. As I said earlier, the focus is on attracting employers, and the employers' main interest is on the rates being charged to the active employees. They're more concerned about what their employees are paying than what their former employees are paying. What you see the group carriers do is in some way to segregate the "ported certs," the ones that leave the company, often with a separate set of rates. Some go as far as actually taking all ported certs from all companies and putting them in a separate risk pool and charging them rates based on the experience just of the ported certs.

You also see benefit limitations on portability in the group market, and by that I mean some carriers don't allow people to port if they're sick or injured; they'll put limitations on the duration that you can port the coverage. Or you can continue your coverage for one to three years, but after that you have to find coverage elsewhere, or they'll offer a conversion option, which isn't that attractive. They may limit the amount the person can port, like 50% of their coverage. Again, that's more of a risk-management approach to portability because there's been excess mortality reported in the order of 50% for ported certs versus active certs, at least in surveys I've seen.

In the work-site-marketing arena it's more important to retain the consumer. They pay this 85% commission, and they have to recover that through future premiums. As Sean said, maybe they haven't done a great job, but given the choice, they do want to conserve that individual consumer relationship. Given the nature of the individual coverage, if someone leaves, it's the same rate, it's the same coverage, and it never changes. It's true portability of coverage. In the group area it's much more limited. It's not true portability typically.

Moving onto the future. Obviously I spent a fair amount of time comparing and contrasting group versus individual models. I think in the future they will merge a little more, and hopefully we'll get the best of both worlds. Ideally, if we can get the group distribution efficiencies compared to the high cost of individual distribution, that would be great, along with the individual consumer focus in the work-site marketing compared to the employer focus in the group market. I think technology's going to enable some of that convergence. I think we'll see an increase in the open finance model. I talked about the aggregators and technologies enabling this. And in all aspects of financial services the power of the consumer is increasing. They want that convenience. They want control. They're taking control of their own lives. The employment relationship is changing. No longer are employees in general looking for their employer to handhold them through the benefits process. They do want access to favorable coverage at favorable prices, but they want to maintain that convenience and control over cost in their selection. I think this will grow.

I think there'll be consolidation across the value chain. In Sean's presentation and mine you can see it's very fragmented. There are distributors. There are service providers, enrollment firms, and carriers providing coverage. Everybody has a little piece of the action, but no one has a strong hold over that consumer relationship. That's key. And you're beginning to see carriers trying to move into the service arena. Intermediaries and distributors are trying to provide service. Everyone's battling for control of the consumer. I would say this, at least from the carrier end, if we limit ourselves to manufacturing products and being product providers, you can get caught in one of those aggregator models. You can quickly become a commodity. There are some risks of just being a product manufacturer and not engaging in more consumer distribution.

I think that you're going to see great expansion of distributors and products. We do have financial services deregulation. We can expect entrants from banks. Citigroup is quite likely to get into the work-site arena. Brokerages such as Schwab with their open finance model may enter. It doesn't take a great imagination to see them going into the work site. Mutual fund companies like Fidelity are already in the 401(k) market. They have a life insurance company, and would it be shocking to see them expand into the work-site marketing? I don't think so. We have to look at them as potential competitors.

I see a great expansion of asset accumulation products at the work site, and not just the insurance protection products that we're used to. I went through that list before, what the aggregators are offering, and that includes asset accumulation. These other competitors obviously are well positioned to bring those types of products to market. You can see a growth in the P&C lines. They're a natural because anybody who's driving a car needs auto insurance. They're the lead products of those aggregators that I mentioned before, and I mentioned Met's numbers. That's a growing market.

Increasingly, partnerships are occurring in the market. This is really a case where the future is now. It's not in the future. It's happening today. Prudential has a partnership with RPA, one of the aggregators I mentioned. Actually, Prudential has invested a good sum of money in RPA. Prudential is utilizing the RPA technology platform to support their voluntary products efforts, and RPA, which is also a licensed broker, is putting Prudential products on their platform as far as their aggregation model. My company, CIGNA, has a partnership with AFI to expand our

voluntary product offering. With the CIGNA and Prudential partnership examples, obviously you have a case where you have the old economy partnering with the new economy; these are competitors partnering. RPA and AFIC are competitors of CIGNA and Prudential, competing for the voluntary work-site-marketing arena. It's an example of "coop-etition," which is emerging in the marketplace. We will see more of that because not everybody can develop everything as quickly as they need to. These partnerships have to go on.

Within the new economy there are partnerships. CFN has partnered with Beyondwork.com, which is an organization that provides lifestyle-type benefits at the work site such as perks and things of that nature. RPA has partnered with Ceridian. Ceridian is a payroll processing company. RPA has a very small distribution force; they can't cover all the small companies. Ceridian has thousands and thousands of relationships with small companies through their payroll processing capability. Ceridian is introducing RPA to their customers and sharing in the commissions with a distribution partnership. Again, these are all going to increase in the future.

I think these partnerships do tell a story, that the consumer needs for choice, value, and convenience aren't fully being met by any one company, whether it be a group carrier, an individual work-site marketing company, or the aggregators. There are unmet consumer needs that give opportunities for new models. I think we're going to continue to see new business models in the future. It's not clear who the winners are going to be, but whoever figures this out and delivers what the consumers want is going to be a big winner. That concludes the formal part of the presentation. We can now open it up to questions.

From the Floor: A question for Warren. What currently is the employer's role and relationship with a company that can offer financial services and comparison shopping via the Internet? Couldn't they go directly to the consumer without a role for the employer? I guess I'm a little unclear on the employer's role.

Mr. Cohen: Employees still value buying products at the work site because of the convenience of it and the employer endorsement. What the employer's endorsing, rather than one particular carrier, is the aggregator and saying the aggregator brings a good package to the employees. The employees value this access. Not all employees know what they can get through the Web. Also, the carriers behind it make a difference. Usually the aggregators can negotiate better prices than are available in the retail market because the carriers have a captive audience. The consumers get better prices, and that's some of what the employers can sell their employees: that I got you a better deal than you can get on your own. The convenience of having everything in one place with the employer's endorsement and with payroll deduction adds value.

Ms. Anna M. Rappaport: I heard a comment that the programs increase morale and employee retention. I was wondering what evidence you all had about the impact on retention. I was also wondering whether you see, particularly in the smaller market where people don't have health insurance for example, this being a way to provide access to insurance for people who don't have benefits. And I was wondering what you thought about the future of things such as prepaid legal and some of the newer benefits.

Mr. Gilday: I can answer the retention one. There are no hard facts out there that we've seen, but what we've seen is that employees are asking for the products. In a competitive environment where the economy's basically at full employment, if an employer can offer something to the employee that another employer down the street's not offering, that's an option that the employees like. When they ask for products and the employer can offer them, that's seen as a value-added by the employee, and that builds onto your second question. In a lot of markets the employers are not offering any kind of benefits; the only benefits employees are getting are the voluntary benefits. Mini-med, dental, and onetime salary life tend to be the only products that they can get on a voluntary basis, and there are no other products being offered by the employer. In some markets it's very important for the employees to get the voluntary benefits because that's all they're getting.

As far as the other new products, prepaid legal has been out there for a few years now. There are some success stories. I know in our market in Canada there hasn't been any success with that product, but there are a few companies that are selling it. As I said, dental is a hot product; CI is really building up in the marketplace. I think UL tends to be the big product still that's being sold to the middle market, small-face amount, usually guaranteed or simplified issue, and tends to be the only life insurance employees are getting an option to buy. Agents are not after them individually.

Ms. Rappaport: What typically happens with the UL at retirement age? Do they cash the money in?

Mr. Cohen: I don't think that many get there. I don't think you have a lot of experience with what happens at retirement.

Mr. Gilday: They've only been selling it for maybe 15 or so years. It's not as complex a product as what they're selling in the upper market. I think that the sales are made. There are some cash values that can be used, and they actually give a page showing what the cash values will look like at retirement so they know that it's something that's there for them. But I think it's really sold on the fact that it's life insurance coverage that is not a huge amount of face, but it's life insurance coverage nonetheless.

Mr. Carl E. Meier: Sean, a couple things you mentioned. I think I heard you say that there has been some tendency toward perhaps a little stricter underwriting requirements in recent years than maybe what we were seeing five and ten years ago. You mentioned participation requirements, and I've never heard anybody explain to me how they actually enforce participation requirements, at least not in a way that seemed viable.

Mr. Gilday: In other words, dropping the case if you only get 10% participation?

Mr. Meier: Yes. We're not going to do that.

Mr. Gilday: I've talked to a couple of industry veterans from American General, GEFA, and American Heritage, and before they go into a case they can pretty much nail down the participation. They have a very good feel for what they're going to get in participation. That tends to be the key driver. They say, "OK, it's face-to-face; it's endorsed by the employer."

It's on company time. I think they can pretty much nail the participation levels. They haven't had to deal with that issue that much, but I know that, for example, on the underwriting usually there's an open enrollment period, say, during two or three weeks the simplified contract is used for the life product. But then after that open enrollment, if anybody else comes in and wants to sign up, it's full underwriting because it's a bit odd if somebody's just coming up four or five weeks later. That's when they tend to do the full underwriting.

As far as the guaranteed issue, Provident, as I mentioned, has a whole life that's guaranteed issue, but there are not many other companies that have that for UL, and I think that now they want to do a little more underwriting. They're comfortable with the four- or five-question contract. You kind of knock out the people who haven't been sick in the last six months or may have had cancer or that type of thing.

From the Floor: For the guaranteed issue product, you mean there's not even an AIDS question?

Mr. Gilday: We can look into it, but I'm pretty sure there are no questions, but the face amount is very small, too.

Mr. Cohen: Or a pre-ex?

Mr. Gilday: Yes, maybe a pre-ex.

Ms. Debra Haynes: Warren, I have a question about the differences between work-site and group voluntary and differences in rating structure between the two and any premium guarantee.

Mr. Cohen: As far as rating structure, at least for life insurance, I'd say generally they are pretty similar, but I'd say you see wider age brackets in the group market, at least typically five-year age brackets, and I've seen even wider. Again, there's some of that cross-subsidy and social insurance perspective that you see in the benefits market. As far as rate guarantees, in the group market they're probably more limited, typically in two to three years with a new case. That's a typical rate guarantee. Then it's re-bid. And I guess another key difference, and part of that group perspective, if it is re-bid and if another carrier gets it, all the coverage leaves, which is very different from the individual market. There's a constant re-bidding process.

Ms. Haynes: Is there a big difference in participation when you have an employer that's not really offering benefits?

Mr. Gilday: Yes, huge. I can give you some examples, say a small restaurant chain or even a large restaurant chain where the employees are being offered these products. There are no products being offered to them, and the participation rate's going to be 50-70% for even something like an LTD, life, and CI combination product; it's incredible, and it makes a huge difference. I know in Texas they've seen some companies that don't offer any benefits, and people are buying them up, almost every employee.

Just one point I was thinking when I saw Warren give his presentation talking about the aggregator model. That aggregator model is different from the one I was describing. I was describing the integrator model. Insurance companies have a couple options when they're looking in the voluntary benefits market. They can be either an integrator where they're bringing in some solutions such as maybe billing or application processing or some way to consolidate the information that's captured at the enrollment site and delivering it to the carriers, or they can be a manufacturer where they're creating products and trying to give it to distribution to sell.

One of the advantages of being an integrator is that you can actually attract distribution, which may not come to some of the other carriers that are just manufacturers. If you can add some value somehow to distribution in terms of technology or support or using a call center capability as I described in the integrator model, distribution might be more likely to come to you. As Warren said, one of the fears, if you're just a manufacturer, is your product may end up becoming a commodity. You'll be competing against other manufacturers, and you might not have as much control over distribution.

Mr. Cohen: Aggregators are distributors. That's what they are bringing to the table. They get paid through commissions. They are licensed brokers.

Mr. Gilday: And one of the reasons that the aggregator model has been working is that employers are trying to download the responsibility for managing the core benefit enrollment. So these companies are coming on and taking over the management of the core benefits, and then the products that can be offered through the aggregator model can complement or add value to that relationship with the employee.

From the Floor: Do you think the ones that offer the competitive bidding versus the single product are going to be more successful in the long run or will it not particularly make a difference?

Mr. Gilday: Right now you can see that if employees are offered one UL, and it's the only life insurance they've ever been offered, they're probably going to take it. However, as they become more sophisticated and understanding that there are other options and that other companies can offer competitive products, then I think they want to see more breadth in the offering.

From the Floor: It gets the employer off the hook from needing to be able to say, "I got you a really good deal product." I mean the employer has less need to do a lot of due diligence.

Mr. Gilday: Yes, I think that also ties into brand. I know that in some cases the brand of the carrier is very important. In other cases it's not. For example, Transamerica has a great brand. When they're in the market selling employees like, oh, Transamerica it has to be a good product. They're not so concerned with seeing other competitors. That tends to be an advantage. The smaller carrier with not as much brand recognition might run into a bit of trouble.

Mr. Cohen: The employers still have to do due diligence for the carriers that are in the aggregator model.

Mr. Gilday: But I don't think the consumer is at the point now where they're looking at the rating of the insurance company before they buy. I think they're pretty much looking to get some sort of deal or at least they're getting ease of convenience and a payroll deduction.

From the Floor: Are there differences in the regional demand for voluntary products?

Mr. Gilday: The Southeast and South tend to be very popular, like Texas, Florida, the Carolinas, Georgia, and now California. But there's a pretty strong market here, too, in the Midwest area.

From the Floor: Do you have any feel for what the pricing difference would be for, say, offering employer-sponsored dental and term life versus the corresponding voluntary coverage?

Mr. Cohen: Actually I could speak more on the life insurance. I don't know as much about dental, to be honest, since we don't have the product on a voluntary basis. Group voluntary rates actually tend to be slightly higher despite the distribution cost. It depends on the guaranteed issue limit. Guaranteed issue is very expensive, but employers like it. Again, it's the benefit mentality. Employees tend to like it. Sometimes they're not investigating the cost. They like the easy access to the coverage. They don't have to go through any trouble, and they can get large sums of insurance without any questions asked. It's not the premium cost. It's tied into the guaranteed issue/price trade-off.

From the Floor: In the dental offering occasionally there are larger benefits. In some of the life products that I've seen on television there are limitations on benefits. Is that being used for work site as a way to get around the need for guaranteed issue? Are life benefits immediately available in the full amount right after enrollment?

Mr. Cohen: In the group market they're immediately available. There's no limitation.

From the Floor: How about individual?

Mr. Gilday: Yes, I think it's the same on individual work site. I think that it's very competitive. The brokers want to be able to go to the employer, and employers are going to ask those kinds of questions. They want to make sure they have a fairly bullet-proof contract that's easy to sell to the employee and doesn't have those kind of issues attached to it.