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Session 27PD
Work Site Health Products: Keys to Successful Programs

Track: Health/Long-Term Care

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Summary: Participants discuss the current issues of work site health product portfolio designs, including various supplemental health products. Attendees learn about activities and trends in current benefit programs marketed through the work site for both large and small employers.

MR. DANIEL EDWARD WINSLOW: I'm the moderator for this session, and the first of four speakers here today. I'm Daniel Winslow, a vice president and actuary with Trustmark Insurance Company, and I am going to speak about voluntary dental.

Norman Hill from Canal Insurance Company will speak about short-term disability and long-term-care insurance. Then, Mike Fish, with Colonial, will speak about accident and medical supplement. And Darrell Spell, who's a consultant with Milliman U.S.A., will be speaking about critical illness. Now for my senior colleague, Norm Hill.

MR. NORMAN E. HILL: I will start off with an overview and define my terms, telling my views of work site. I consider work site as voluntary life and health. It's not really a product line, but a line of products or a marketing line. It's voluntary life and health that is sold primarily to employees, sometimes through associations or through individual or group policies. It involves elements of mass marketing, solicitation, underwriting and billing.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

Originally, work site was sold as individual products but there's been a definite trend, a gradual significant shift toward group since 1999. Now to some extent, we combine traditional individual work site as individual products, and "voluntary group pulled from traditional group" as a sub-set of group. The two are meshed together and analyzed this way so that the combination of individual policies and voluntary group is now known as work site.

What has caused this evolution toward emphasizing group somewhat more than individual products? The key is flexibility that's inherent in group, which involves questions of rate increases, renewal, rating, underwriting, case management and such. I'll get into these issues in a little while, but they all lend themselves to, and allow more insurers, flexibility on the group side.

There is one key disadvantage with group work site as opposed to individual work site, and that's a question of portability. The business grew up with individual products, which emphasized to the employees that they had portability; meaning, if they left employment, or if the employer canceled the case for some reason, they still had individual policies. However, not too many employees have been interested in this portability.

In other words, portability hasn't been what it is cracked up to be, although it's still important in some cases, to some agents I know. There have been attempts to retain the portability in certain ways.

Now if the employee is part of a group in work site and then is no longer employed, he can't be part of that group—at least in most cases. There have been attempts to put that person in a separate group. Of course, you can always have the traditional conversion approach, through converting to an individual product at the attained age. However, the same question of flexibility remains a problem.

I refer to work site as a line of products. Usually the products that fall under work site include short-term disability, dental, hospital indemnity and limited medical of some kind (hospital indemnity with a few extra benefits added on), cancer expense and/or cancer lump sum occurrence. And there are also some new entries to work site, which include products like critical illness and long-term care.

I don't have hard numbers, but there has been a growth in work site and an interest on the part of insurers in getting into the work site market. One of the reasons is employer medical cutbacks. They have often cutbacks on traditional employer-paid group benefits to employees. This means a void has to be filled, and fairly substantial benefits can be sold on a voluntary basis under work site. Of course, it's still voluntary coverage.

Another advantage of work site leading to its growth as a line of products is that most of them are indemnity type products. They're not inflation prone, at least for

the most part. Cancer expense incurred can be considered an exception to that general rule. But with predominant indemnity products, there's the ability of the insurer and employer to control costs. One primary question is how to underwrite work site. The three bases are full underwriting, simplified underwriting and guaranteed issue.

With simplified underwriting for individual insurance, it's not a traditional application used under full underwriting; there are usually a few questions of the "yes" or "no" type on the application. Usually they're structured so if you answer "yes" to any of the questions, you are automatically rejected. These questions include, "Have you been hospitalized in the last five years?" Or, "Have you had any serious illnesses during a certain period of time?"

Guaranteed issue reverts back to the traditional group approach. To have bona fide guaranteed issue, there are some group concepts involved, like a large enough number of eligible employees participating.

Whether it's individual policies or group policies, there are still group principles at work in underwriting, such as allowing coverage only for actively at work employees. Consideration is given to the type of case at the time of issue. What type of industry is it? Is it a type of industry the company wants to issue or with which they feel comfortable? What kind of claim experience did they have with these cases in the past?

Here's another element to be considered: What kind of experience has a company had with the agent, the broker, who brings the case to them? And, are they satisfied with his loss ratios?

Still other new developments in underwriting include a mixture in-between simplified issue and guaranteed issue. Guaranteed-to-issue and contingent guaranteed issue have both arisen as buzzwords.

Guaranteed-to-issue means that some kind of a policy will be issued, but every employee won't necessarily have the same coverage as the "better class" of employees. Sometimes more limited benefits will be available, and perhaps even the length of the underwriting application falls in between those used for simplified issue and guaranteed issue. A very short form application is a possibility, with maybe only one question about a particular medical condition.

Work site products can be sold on the traditional basis, such as per-unit rates, or $10 a month disability income. Sometimes premiums are represented on a money purchase basis, in which case employee coverage is whatever can be purchased with a flat amount, such as $3 a week, $10 a month etc. premiums .
In work site, just as in group, questionable industries always come up. From my experience, there's often a tendency for some extra utilization from educational and state government groups. There are other problems related to state

government groups such as a tendency to bid cases out year after year, or at least frequently.

Other issues I've run into with government cases include the lack of ability to get dependable employee census data for billing. So, these issues are all part of the underwriting process.

Now I would like to talk about definitions used in short-term disability. They should pertain to only the first two years of disability. The more stringent definition often used for long-term disability is usually not applicable.

There are considerations about exclusions. Pregnancy can be covered like any other illness, except with complications. There's the old question of whether to restrict mental illness parity or to cover it like any other disability. Even with accident disability, some insurers have experienced problems in industries such as logging and trucking; fraud rings have been known to exist as well to plague insurers.

Short-term disability can cover ancillary benefits such as accidental death or dismemberment as well as waiver, and even hospital indemnity could be added in. In work site short-term disability and work site in general, there are some considerations on reserves. To collect experience for short-term, you probably have to rely on lag experience for the claim reserves rather than an open tabular type. Then there's the question of the additional actuarial reserves. With individual products that are guaranteed renewable, setting up those reserves is fairly straightforward.

If you have what may be called mass cancelable individual products, then it's a little trickier. And with group products, it's trickier still. To me, the general principle should be how the product is rated. Was it rated on the basis of individual issue ages even if it's technically group? Was it rated using issue age or attained age that was intended to be in force over a period of time? That is the main consideration as to whether to set up actuarial reserves or not.

There can be geographic differences to some extent in short-term disability. Some people have noticed anti-selection in California, for example. In California and several other states the existence of state plans that compete raises the danger of over-insurance. Maximum monthly benefits including state plans are something like 60 percent of pay or X dollars a month. Sometimes the X dollars can seem quite high. I've seen companies try and hold the line at $3,000 a month, since this is voluntary work site, not cutting edge long-term disability.

In a work site mode, there is continuing interest in long-term care and there are some sales on this basis. There's always the question of cost and marketing. Long-term care premiums are expensive, more so than the average work site product by a wide margin. The product is more difficult to sell than the average work site product.

More complex is the question of how long you want and expect long-term care to be in force. With short-term disability, you don't expect it to be in force after the employee is no longer employed. It's great if an employee can continue it during his or her entire employment period, but that will end most likely at age 65 or 70.

With long-term care, the insured often expects to keep that in force for a lifetime, therefore it behooves the insurer to have a communicated plan in place. They should discuss how the billing will continue after the employee retires. Also, the insurer should make the employee conscious of the desirability of keeping that product in force after retirement.

Most work site products are sold on a mass enrollment basis on site. That's not always the case, but in the majority of cases, either the agent, broker or professional solicitation firms do the enrollment. Long-term care is a more difficult product. It doesn't lend itself to mass enrollment; it lends itself to a kitchen table sale, more like direct insurance.

In long-term care, you get into tricky questions of underwriting concessions. Most companies try to be very tight on underwriting for long-term care. There's a very long tail of deferred risk to claim cost slope. Underwriting concessions are made very carefully.

There's a question of how to underwrite employees that are 40-45, who are actively at work. Whether or not they're cognitively impaired doesn't seem to enter into the equation. Other elements have to be considered, such as approaches for guaranteed-to-issue including using a shorter application than the normal lengthy long-term version.

The normal long-term care package is nursing home and home health care. Possibly, guaranteed to issue means issuing the employee nursing home care only and/or limiting the underwriting class to something other than the best class. This means higher premiums.

To have successful work site health products, it is necessary to give thought to the commission scale. One of the traditional criticisms of work site has been that it is a device where agents would get front-end commissions for selling group insurance. If you provide front-end commissions, be careful and decide whether to grade those commissions by case size.

If you have a large case, such as several thousand employees with a high percentage of participation, does the insurer want to pay a large amount of front-end commission to the agent? Or would it be better to try and levelize it on some basis, as long as you stay within the overall pricing guidelines?

There are also important deferred acquisition cost (DAC) implications. If you pay out too much front-end commission, and then lose an entire case, the insurer is bound to have a very large DAC write-off. One expects, of course, a certain fall-off of lapsed policies in DAC calculations, but sometimes those calculations can be thrown awry when an entire case terminates at once.

There's a question of whether to give discretion to the agents in setting the commission scale within the pricing, of course. If there are several different scales, front-ended and level, let's say, you must decide whether to let market forces dictate or impose limitations up-front. The larger the case the more levelized you want to be. It is necessary to have definite guidelines in place and rules for renewal rating, cancellation and rate increases. With individual work site products, to some extent, what you can and can't do legally is already laid out. If there are rate increases on individual products, the entire form usually has to be increased in that state, (after regulatory approval). Sometimes this might include direct sales if they are included under the same policy form as work site. Usually, mass cancelable individual products can be canceled only by state, not by case. So usually the only way to bring in case flexibility for renewals and rate increases is with a group product and a group chassis.

To be successful in the work site health arena, you need to have a variety of products available. Today, both the individual and group versions have their places. I can't emphasize enough the importance of flexible systems in work site. Today, with the availability and desirability of individual and group products, work site should be treated as a combined profit center, cutting through the legalities that differentiate individual and group.

List billing has been a traditional approach to work site, just as it has been with group products. Some people argue that list billing has been over-glamorized, and that it's not what it's cracked up to be. They would prefer to have employees volunteer to sign up on a PAC basis right from the start. However, the key is a system with the power and flexibility to handle both billing methods.

Also, you need the ability to be able to track the experience of various work site sorted data, such as by work site agents and by cases. This puts a lot of demand on the system and calls for quite a flexible arrangement.

Also, you should have underwriting guidelines programmed into the system that can handle all the situations I've outlined.

A summary of what you need for work site success and profitability is this: flexibility, flexibility and still more flexibility.

MR. WINSLOW: Hello. Once again, I'm Dan Winslow, vice president and actuary with Trustmark Insurance Company. I'd like to start off by asking how many of you

work with dental insurance on a regular basis? I see that there are at least six or seven of you.

I'm the top actuary for the Voluntary Products Division of my company, and as Norm mentioned, you have to have a broad product portfolio. The voluntary line is among six or seven products that report to me.

We have a small team of actuaries who concentrate on dental insurance. When Trustmark started in the voluntary dental insurance marketplace in 1994, I was the original pricing actuary on the product.

First, I will walk through the basics of a voluntary dental product as a foundation step.

Primarily, what we're selling is good impressions and a good self-image. That's a very important thing for a voluntary dental actuary to realize. People buy dental insurance because they want to feel good about themselves. They want to feel good when they're making their next presentation by having a "million dollar smile". They may or may not have one, but that's what people are looking for. This greatly influences who buys the product and what their claim experience will be like.

The basic services are preventive. Those are considered Class A, and include routine exams and cleanings, which are the foundation of the product. The next tier of basic services, Class B, includes fillings and x-rays. The major services, which are called Classes C and D, encompass root canals, crowns and bridges. Those last classes are the areas in which dental actuaries should spend a lot of time.

Then finally, there is orthodontics, which is popular in the true group marketplace, but is actually fairly rare in the voluntary dental insurance marketplace. It's very hard to come up with a good way to structure the products so you don't get killed with the anti-selection. Basically, people who buy orthodontics coverage in the voluntary dental marketplace expect to submit a claim.

An actuary should get an overview of the plan design, the fundamentals, when looking to get into voluntary dental insurance. Pick the managed care option, and which way to come at the business. Figure out the deductibles, co-insurance and waiting period for major services and orthodontics, and spend a fair amount of time on details like the procedure codes.

For the managed care options, indemnity was the industry for many years . That was the way of the world. Managed care arrived a little later for dental insurance than it did for medical. The medical guys went first and we followed five to ten years later.

There are also preferred provider organizations. Once again, we copied the medical world and passive PPOs. I'd ask anybody if the passive PPO is worth doing. We've

looked into it and have never come to the conclusion that it would make sense. Another major way has been the dental health maintenance organization (DMO or DHMO).

The discussion that we've had at our own place—and this data is drawn from a recent member survey—is PPO versus indemnity. These sales and in-force statistics show it fairly clearly. The PPO sells $1.7 billion, and mixes together the voluntary dental and the true groups. They did not have it split out in the survey, but it does show that PPO has become the mainstream bulk of the marketplace at this point in time.

Our experience has been that indemnity insurance mainly hangs out in rural areas. There just aren't enough dentists to make it worthwhile to build a network. And the HMOs are pulling up the rear; it looks like in the early '90s they had their run at trying to go somewhere.

The other thing that's very interesting is that with $13.1 billion of voluntary dental insurance in force, there is a large base in the marketplace. There's plenty of room to go out there, sell some business and make some money.

I'm speaking more in detail on PPOs because my company has more experience with them. If you made the decision to approach medical insurance from a PPO angle, then it is necessary to figure out which PPO plan you're going to be working with, which literally can be a make-or-break decision.

You must think about name recognition and go with a brand name that people have heard about—something that is appealing in the marketplace with the brokers and employers. It is necessary to examine the number of dentists in the network from a marketing aspect, asking if customers would actually be interested in buying this. Their typical way of looking at it is to refer to their "dentist in the network". Perhaps there are enough dentists that some people say, "Yes, my dentist is in the network."

The other thing, from an actuarial perspective, is that it is necessary to say in-versus out-of- network utilization assumptions, which means you have to have a really good idea of what the network is. For a company like mine, that market's pretty much nationwide. That means you have to look at it by marketplace and by doing a lot of detailed analysis. It's pretty typical to cite these assumptions by major cities or by zip code. It's necessary to think about national versus local aspects, picking a PPO and the pricing.

There are several nationwide networks and a fair number of dental organizations with a very local focus that are dominant in one state or one major city region. So, you have to think about the basic marketing thrust. Are you looking for employers that are in a single site, but the employees are based in one location and one network arrangement can suit them? Or, are there large employers with operations

in all 50 states, and you have to weave together something that works across their diverse employee population?

It's important to spend time thinking about the fee structure. Several different fee structures are available among the PPOs. For one, there are quite a few discounted services that operate off of a rigid schedule.

And, consider whether fee schedules are varied by dentist experience or if there are any variations inside a region. That might have a lot to do with utilization. A lot of these PPOs typically sign up the new dentists who are fresh out of school and don't have a client base.

As my dentist across the street has been practicing for about 20 years, now his attitude is to ask if he can cancel all these arrangements because he has plenty of patients coming in the door. There can also be the new young dentist who wasn't going to have a very high fee schedule, and the insurance company wasn't going to pay him or her very much money anyway, versus the high cost dentists. All those dentists were out of the network and the company is going to continue to pay them their high fees out-of-network.

"Bill versus buy," from a high-level strategic decision, is a terribly important one. There aren't many organizations large enough to afford to put together their own dental contracting arrangements across a large area such as the United States. You have to make decisions about whether you want to be one of the large players who can afford to commit to putting the resources into doing your own network.

Then, having selected a PPO, you have to make a fundamental decision regarding a plan design. With the deductibles and coinsurance, you must decide whether to look for a reward or a penalty structure in terms of marketing efforts.

It's very good for the actuary and the marketing person to be aligned on which way to handle that. It's not a good idea if a marketing person wants to sell the reward and the actuary wants to sell the penalty portion of the plan design; they tend to not go together too well.

For the dental people out there, it's pretty old hat that there's a $50 deductible for major service. In the marketplace, some people have a $75 or $200 deductible, or even as low as a $25 deductible. So, $50 pretty much covers 100 percent of preventive services and 80 percent of basic services and 50 percent for the major services. This has been pretty normal in the indemnity world.

When going with the PPO, you have to decide what to do as a reward. If you're going with the reward strategy, how much should you enrich things? One of the starting points, if you're at 100 percent for preventive services, it's hard to richen that up at all. The insurance company is already paying the entire bill.

And if going with the penalty item, decide just how much to carve out, which probably should be a function of how steep your discounts are. If you're not getting a big discount, there's not much of a reason to drive people in a network. If you're getting a very rich discount, then you have some good incentives, and this should have strong benefit differentials to drive people in-network.

The other comment, which is part of the practicalities, is that you end up with a lot of different potential plans. So, somebody has to keep track of all of them, and make sure the whole rating structure and product structure hangs together.

Regarding voluntary dental waiting periods, the key issue is the initial anti-selection. This is a product that's guaranteed issue. There is no such thing as an underwriting application for dental insurance.

As one of our consultants says, what can we do about people who have a lot of dental problems to take care of all at once? These are people who haven't been able to afford to take care of their teeth. Perhaps they just joined a new employer and suddenly have some money. People know that dental care is something that can be postponed for a long time. You can go several years without taking care of a tooth problem, and generally be just fine. It's not like having had a heart attack or cancer or something where postponing medical care is a very bad idea.

A lot of programs in the voluntary dental world have failed because of their inability to control that initial anti-selection. Having no waiting period is pretty standard in the industry, with preventive and basic care. There are quite different opinions around the industry regarding waiting periods for major services. For example, say an employee needs two root canals and a bridge the day he or she signs up for the plan. There's no way an insurer can stay in business taking in $20 a month from that person and paying out $1,000 or $2,000 in benefits on a regular basis.

The three major things that I've observed in the marketplace include that there are still a couple of major players with no waiting periods for major services. I'm very interested to see how they do over the long haul.

Quite a few players are going with the 12-month waiting periods, including six months on some services. And then there's Trustmark and a few others, who all use the same dental consultants. They have a 24-month waiting period for crowns and 12- and six-month periods for other services.

We've managed ours since we started the business in 1994. We have watched a lot of people go in and out of business while we've stayed in it, so I can say that the longer waiting periods definitely work. The part I'm unclear on, since I have not worked at the other companies, is whether shorter waiting periods work.

For procedure codes, dental is a very detailed business. There are some businesses like medical insurance where an insurance company can have a one, two, three, or

even five million-dollar claim. Being able to monitor large claims and make them work out are essential skills.

With dental, instead, there is a slew of very tiny claims. Your largest claim is typically $1,500 or $2,000. The average claim may be $100 or $200. The ability to get each of those right is important. If claims average, for example, $100 apiece, but instead a company pays out $110 on each claim because of technical errors, and the claims people are liberal when dealing with disputed claims, then you may have just wiped out your profit margin. It doesn't take that much overpaying on claims to be a significant trouble to the business.

An interesting thing is that about every five years the American Dental Association (ADA) redoes its book of procedure codes. Their major goal is to come up with new ways to extract money out of us, the dental insurance companies. So you have to be aware of when they're re-doing the codes and pay attention. They will re-work the definitions to the disadvantage of insurance companies.

Keep out an eye out for new or unlisted procedures. There are advances in dental technology going on. It's not the same now as it was five or 10 years ago. Five years from now, it will be different than it is today. The interesting thing is that if a dentist invents a new technology that is not yet in our procedure codes, the dentist sees it as an opportunity to earn a strong profit margin for innovative services. This is good for them and bad for us.

The other dental issues to keep an eye on include that you must process a lot of transactions in this business. This is perfect for electronic adjudication. That's been sweeping the claims paying world over the last few years. It's perfect because the claims are small, they're very rule driven, and there's very little judgment. On the system side, that requires making a significant investment. This electronic adjudication technology is not particularly cheap to put in and get up and running.

And the other item is tiered rating structures. A four-tiered structure may be this: employee, employee plus spouse, employee plus child and full family. My comment is in the rating structure. As I look out at the competitive marketplace, some of the rating structures look a little aggressive. Full family rates are just a smidgen above the employee and spouse rate, and you're saying, "Wait a second. I know those kids go to a dentist every six months."

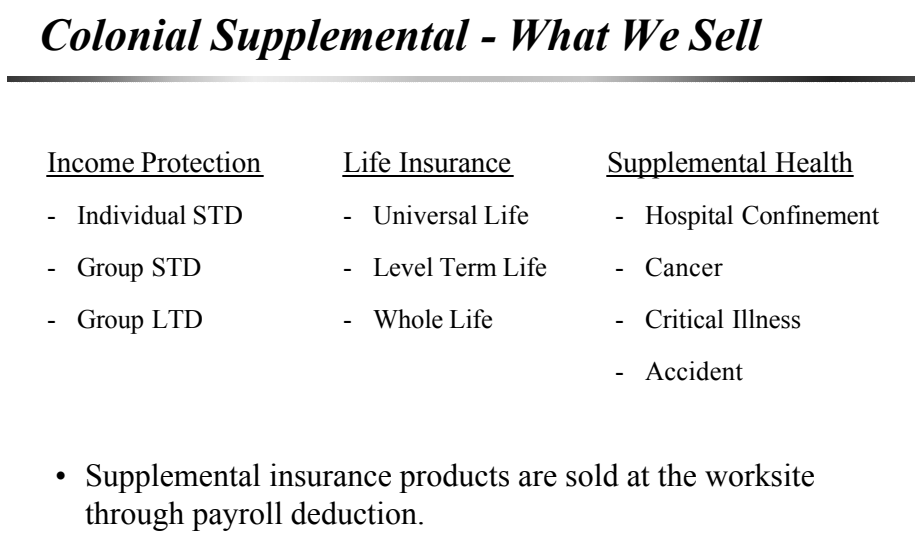
So, that's an overview of the voluntary dental insurance business. At this point, I'd like to turn it over to Mike.

MR. MICHAEL J. FISH: We exited the dental industry back in 1995. We just couldn't make it work for us as a company. There were too many issues around keeping up with re-rating on the dental plan, plus some service issues on the claims. However, every two years we rehash whether we should be in the marketplace or not, and we're currently doing that again.

My company, Colonial, is a distribution agency. We've got about 5,000 licensed agents out in the street. We do business in 50 states plus Puerto Rico and Washington, D.C., and we are an affiliate of Humana Provident. Humana was bought back in 1993, and we've remained with the Humana Provident family since the merger of Humana Provident in 1999.

Table 1 is a high-level list of some of the products that we sell. Most of these products, about 85 percent of them, are individual policy form products.

Table 1



Norm talked about the individual and group products, both of which are sold in the payroll marketplace. I agree with him that there's definitely a place for both of these products out there. From Colonial's perspective, we sell mostly individual and have traditionally done so in the years past. So, when a new product idea comes up and we start going down the path of development, we always think in terms of individual policy form.

Now, from an actual distribution standpoint, all of our products are sold at the payroll site. This is why we're always selling to employers or employees at the employer setting. We don't do any true individual sales of our products. This is what I think of as a group distribution, with some individual products.

We have three main categories. First, we have a disability income category that makes up about 30 percent of our in-force premium. Then, we sell life insurance,

and the top lines are universal life and level term. Those make up 99 percent of what we have on our block, and life makes up about 20 percent of our portfolio.

Finally, there is what we call supplemental health, and I've placed accident in that category. Accident is about 30 percent of our business and the remaining products make up about 20 percent.

I'm going to talk about the new accident policy that we developed when we hit the streets in April of 2002. Then I will talk about our new medical bridge product, which is a supplement that covers hospital admission and outpatient surgery.

We need to get at the underserved marketplace. In some of the traditional industries, a company doesn't want to sell the more risky products.

We're also on a base policy form for accident. We're not doing any individual underwriting whatsoever. So essentially if the employee is actively at work, as long as he or she is not disabled, that person can buy this product. That situation is a pretty good fit.

Minimal underwriting is more of a low-risk product where we can have some under-served markets. This is a very low-cost product as well. The average premium for the accident product runs from $150-$200 for an annual premium on a per-insured basis, so that's definitely an affordable product.

From a target market perspective, we primarily reach the blue-collar end of the spectrum. Younger employees are the average age on our accident block, at around 35 years old. A lot of those employees will sign up their families—their spouse and children as well, so that's a pretty good fit.

The accounts prefer the convenience of one rate for all employees regardless of age or occupation, so we don't have an age-based rate. We also don't have an occupation-based rate. It's one composite rate, which makes it very simple. The field likes that.

We actually designed the fit by talking to the field in terms of whether they preferred to go to more of an occupational class basis. AFLAC's product, as an example, has four occupational rates. The feedback from the field was not to go that route, and this is what they preferred.

Target industries include government, manufacturing and service. We write quite a bit in the public sector accounts and government, which is a pretty good place for us to be. Once again, people can purchase the stand-alone plan and they can also purchase the disability income (DI) rider with that as well. So that's a pretty good quest for this product.

From the base plan design, there are three types of coverage. There is what we call Plan One, which is a 24-hour-a-day coverage, so it includes both on- and off-the-job accidents. Plan Two is off-job-only coverage, then Plan Three is more or less a stripped-down product. It is 24-hour-coverage, but has reduced hospital benefits and no accidental death and dismemberment, so it's a cheaper product. It's really designed for situations where we compete with another carrier and need to be able to show pretty low rates to both the employer and the employees.

Plan Three is also good to sell with disability products. If one is selling the individual disability product, we like to throw this product on top of that. It is about $12 a month for the main employee, so it's relatively inexpensive.

These are the key features of the product. Of course, we have an accidental death and dismemberment (AD&D) benefit. This is $25,000 to the main insured, and $10,000 to the spouse or child. We also have a catastrophic benefit, which was new for us this year. It pays a $100,000 lump sum benefit for a catastrophic accident, which is defined as a loss of use.

This requires the loss of use of two arms, two legs or sight in both eyes. This is a pretty healthy lump sum amount, but it's very, very low incident. So, we need to keep an eye on that because from a pricing perspective, there will certainly not be a lot of data out there to determine the utilization rates. We did our best to price that one and we hope for the best going forward.

For hospital admissions, the insurance pays $750 per accident, then the confinement is $200 a day, and double that for intensive care. Finally, there are emergency room and doctor's visit benefits as well.

Now, some riders can be thrown on top of this. We've got disability income riders for open accident only, and one for both accident and sickness. Those DI riders are available on the employee and the spouse, up to $1,500 per month. There is simplified issue underwriting on the accident and sickness rider.

The same thing is true with the hospital confinement rider, which requires simplified issue as well. For us, this involves three questions: 1) Has there been a hospitalization in the past 12 months? 2) Has the person missed 10 consecutive days of work? 3) In general, how is the person's health?
We also have a wellness benefit that pays out $50 on a calendar year basis.

Here are some general considerations on the pricing. The products are pretty easy to price because this is utilization only. There isn't any medical inflation or trend because they pay out an indemnity lump sum amount.

So, as I mentioned before, when someone goes into the hospital, he or she pays $750. There is no need to worry if costs have increased, because the patient is always going to pay only $750. The incident rate is also leveled by policy duration

and by age. With the age component, we're mostly selling these policies to those between ages 25 and 55. In that category, there is a pretty level flow. Certainly, when a customer is more than 60 years old, there will be a different flow. However, for what we're primarily selling, it is pretty flat.

I also want to hit on type of lapses in the first policy duration. Usually we see lapses of 30–40 percent, reflective of the fact that younger employees are signing up for this coverage. And when they move to a different job, they can take that coverage with them—it's fully portable, but often when the coverage shows up in the mail as a separate bill, versus the ease of having a payroll deduction, the person will cancel it.

Then finally, as I mentioned before, there is the occupation class. We could have justified a different premium by our class, but those in the field are the ones who said they prefer composite rates, so that's what we chose to do. Also, there are very low capital requirements on this product.

There are a couple of other points. Before, I talked about the size of the accident product. It's been very profitable for us, so we certainly like that. We are also looking to increase sales as a percent of our overall business through our accident line.

We've been selling a lot of disability insurance in the last two or three years. That's a good thing and it's a bad thing. As a company, putting too much emphasis on disability can be a little risky, so we prefer to sell some more accident insurance, certainly. And the major competitors include AFLAC and American Heritage. Certainly, there are a lot of players out there, but we see AFLAC is seen quite a bit on the street and in the public sector accounts.

The next topic is a product of ours that came out last year. It's a supplemental medical product called Medical Bridge, and is designed to fill in the medical insurance gaps created when employers see high insurance rates for their medical coverage, and deductibles increase up to $1,000, $2,000 or even $3,000.

This is a way for the employer to keep medical plan costs down by increasing the deductibles, then bringing in our product on a voluntary basis for the employees. In that situation, the employer isn't picking up the tab most of the time.

We needed a pretty simple plan design in underwriting. Competitive price is always important, and we're going after the small-to-mid-sized market, which is under 2,000 or so people. Once again, that coverage is available for the employees and family. As far as the plan design, it doesn't get any simpler than this—two benefits, a confinement benefit and an outpatient surgery benefit, both anywhere from $250 to $1,000.

As an example, Plan One would have a $250 deductible for both hospital confinement and out-patient surgery. If the employee chooses this plan, and any of those events occur, we'll get this for a pay-out, which is on a calendar year basis. If they go in to the hospital two or three times, he or she is going to pay $250 each time.

The benefits pay as a lump sum. There's no coordination with any other medical plan, which is good and bad. We like to keep it very simple from the field's perspective, and for the employees. The only issue is that it doesn't always match up with the out-of-pocket costs for the particular employee.

Sometimes, depending on which plan they have, they may have hospital confinement and even more than $250 because the deductible and the co-pays kick into place; but the patient will pay one lump sum. Then we have an optional rider to cover emergency room treatment and physician visits.

One of the key features includes no deductibles on those amounts. There is an individual guaranteed renewable (GR) for life product that is fully portable. Benefits are paid to the insured. As I mentioned, evidence of insurability (EOI) is not required.

As an example, let's say the employer chooses to increase his medical coverage deductible from $500 to $1,000. In that situation, our agent may present two plans to the employee, such as a $500 or $1,000 deductible. Depending on the employee's risk tolerance, he or she can choose which one is preferred.

Then, simplified issue underwriting is done on this product. GI is available for more than 20 percent participation as well as more than 100 lives. So if the account has more than 100 eligible lives and 20 percent participation GI, it will occur there. Otherwise, it's simplified issue and there are several questions to ask, but nothing medical.

On this side, there are some pricing considerations. The incidence rates that we used were based on prior hospital income products. So the only issue we really have from that perspective is that this is a different twist. It's a lump sum product. It's not a product that's going to be paid out on a per-day basis.

When one has lump sums up to $2,000 or $3,000, there may be a selection issue to worry about. So we put in the margin to continue it as the benefit amount increases to cover that. Premiums are unisex. There are age bands, which are "less than 50", "50–59" and "60-plus". Also, we have a ten-month pregnancy exclusion. When offering a lump sum product like that, we needed a pregnancy exclusion to avoid pregnancy claims.

This has been very successful. It was introduced last year. We expect to hit about $10 million in sales this year. There's been a lot of discussion out in the field, as this

is really a hot topic for our agents. The health brokers are keeping their eyes on this product because of the phenomenon of the deductible going up and up. Employers are looking for ways to help out the employees on the one hand, but they also do not want to shell out too much money to pay for their medical coverage, so it's a good fit there.

In that realm, too, there's actually an increase in demand for employer-funded accounts. This means the employer handles 100 percent of the cost for all the employees when raising the deductibles.

That whole cost shift worries me a bit. We want to stay out of the medical business as much as we can. We're certainly not experts in that business, and we need to keep an eye on them shifting some of that risk towards us.

We know there's definitely a demand for even higher benefit amounts than we're willing to offer. And if you go down that path, certainly, you need a plan to coordinate for the medical coverage—probably a group plan. American Fidelity has a pretty good group plan that does just that. But, from our perspective, that's a higher risk than where we like to go.

And with that, I'll turn it over to Darrell.

MR. DARRELL SPELL: Thank you. I'm going to talk about critical illness insurance. How many of you are active in the critical illness market and are familiar with critical illness products? Based on the number of hands you are showing, there are more of you than I expected.

How many of you are not active in the market, but are pretty comfortable with the product and feel like you know what it is? I see that there are a few of you.
To make sure we're all on the same page regarding what a critical illness policy is, here's an overview: If a person with this type of policy has a condition such as one of the big four(cancer, heart attack, stroke and kidney failure), he or she gets a big chunk of cash. It's that straightforward.

Now, what's fascinating to me is if a person gets a lump sum of cash, such as $50,000 for a heart attack, how do you know that the treatment will cost that much? No one knows. The money can be used for anything, which is the other key thing about critical illness. The lump sum of cash is to be used for medical expenses or for anything else. That's really important for someone who has cancer, for example, because there are a lot of experimental treatments, so the money can be used for that.

My sister-in-law passed away a few months ago from ovarian cancer. Once the doctor told her that there was nothing they could do for her, they tried to comfort her. She wanted to go on vacation, so we piled eight people in the car and took a

road trip. It was not terribly expensive, but this shows that a person can do whatever he or she wants with the money.

Table 2

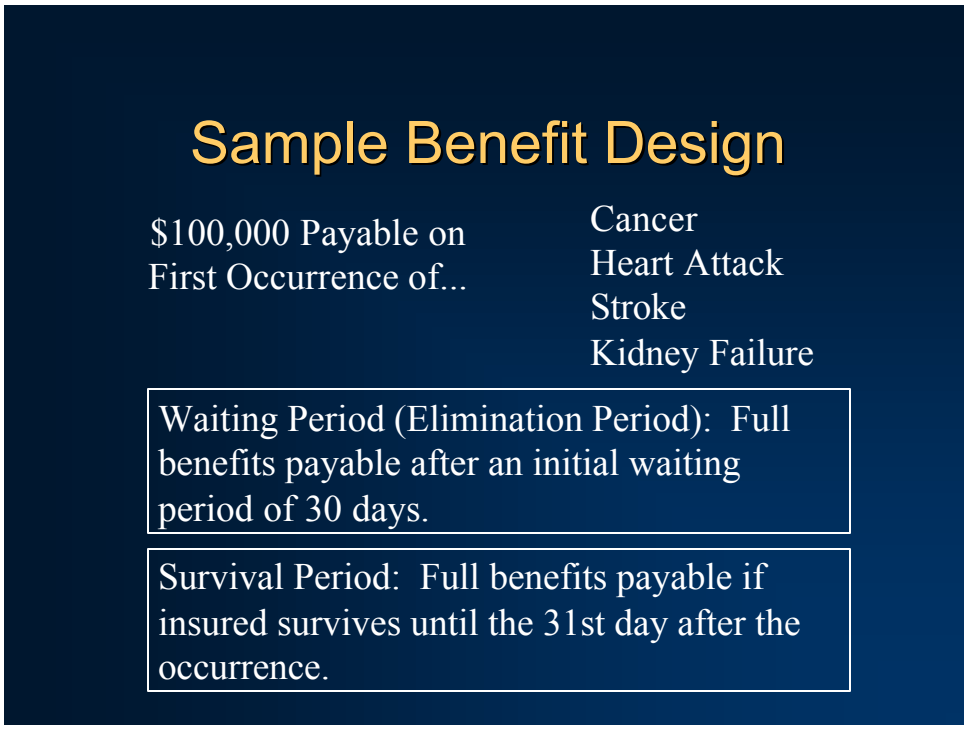


Table 2 is a sample benefit design, with $100,000 payable on the first occurrence. I picked four diseases.

There are two more things I want to talk about before we get into the specifics about work site. Typically, there is a waiting or elimination period in critical illness. It is simply the period of time from when the insured purchases coverage until the full benefits take effect. This is 30 days or some other period of time so that the person is not stopping by the insurance agent's office on the way to the hospital with chest pains.

Secondly, there is a survival period. For example, if a person has a heart attack and dies three days later in the hospital, he or she will get life insurance benefits. Do we want to pay the critical illness benefits as well?

Typically, an insurance company doesn't want to do this. So, there is usually a period of time when, if you have one of these diseases, you have that first occurrence, and then you survive to the 31st day, then benefits will be payable. That does create some awkwardness.

Lastly, I want to talk about some options with a critical illness policy. I've seen options in which if the person is under the age of 65, the company will pay double the face amount of the coverage.

I've also seen additional benefits. For example, kidney failure may not be one of the big three that the policy covers. It may not be an option, or there may be additional options such as organ transplant or severe chemical burns. The list can be very long.

Finally, I've seen policies that provide partial benefits. This means that, say, at a check-up, a doctor sees that a patient will be well on the way to having a heart attack unless an angioplasty is performed. If the person has the angioplasty, we don't want him or her to feel cheated out of insurance benefits, so the policy pays 10 percent of the bill or some other small amount for that treatment.

Now, the purpose of this session is to talk about keys for success in the work site market. There are four things that, in my opinion, will make critical illness a successful product in work site. I am very optimistic about this product, by the way. We've struggled to see it gain a foothold in the United States, but if we're going to see success anywhere, our best chance is work site.

There are four things to keep in mind. First of all, keep your product offering simple. That's true of any work site product, but it's especially true of critical illness. And we'll talk more about each of these in just a moment.

Take a portfolio view of your product design. That's especially true with critical illness. Make sure that it fits with the rest of your portfolio.

Third, address the specific needs of your multiple clients. In the work site market, there is more than one client. You've got the employer and the employees, which are a lot of people to satisfy. I remind actuaries to price it properly.

Keep your product offering simple. The first sub-point under that is don't try to include everything in your policy. When looking at contracts around the world, there are around 58 conditions in all that can be covered. That's getting pretty close to a lump sum benefit for a major medical deal.

This is complicated. In a work site arena, there are only seven or eight minutes in a typical enrollment. You couldn't even read the list of conditions you're going to provide benefits for in that amount of time. So you really need to keep this contract simple and make the insured understand three or four coverages.

A second thing I encourage actuaries to do is to not present a lot of payment options to the customer. By that, I mean ways in which the insured can get money from the insurer. Either pay a lump sum or a monthly benefit amount, but don't give a lot of options. Instead, provide just one or two choices and be done with it.

Finally, don't give a lot of options for the benefit amount; offer a one-time salary, or a two-time salary, for example. Keep it very simple and straightforward. Make this something that can be talked about quickly during that seven- or eight-minute enrollment process.

The second sub-point under that is avoid defining features that only a genius can understand. Typically when I get in front of a group of insurance people, less than a third of them really have any understanding of critical illness.

Also, imagine how extremely small that number is in the general public. Be very clear in what a company is offering. For example, there are products available with multiple severity levels. They are really slick products. I even saw one with eight levels of payment.

For example, if a person is diagnosed with cancer, he or she may be paid 10 percent of the face amount. As that cancer progresses and becomes more and more advanced, maybe the person gets 30 percent of the face amount, so they pay out another 20 percent, and that continues to go on.

Now, the reason carriers do this is because at some point the cancer may go into remission, and maybe they've only paid out 70 percent of the face amount so they don't have to pay out the other 30 percent. They would only pay the full 100 percent if it reaches the highest severity level.

So, this is a nice feature. It's a nice way to save money and it's a nice way for the benefit amounts to be reasonably paired with the severity of the condition. In work site, that would be a huge mistake because it's just an unnecessary complexity. We need to keep it simple.

Two other things are the complex triggers and the illogical definition. The benefit payments need to make sense. For example, if, two months after enrolling a group of people, Larry has a heart attack, the insurance company pays the claim and he gets a check for $50,000. He comes back to work a few months later, slimmer, looking good, and is dressed nice. He's talking about the $50,000 check he got from the insurance company and he is ecstatic. He is proud of that insurance. He's changed his lifestyle. He is a happy man. He's alive—that's probably the main reason he's happy, but he's bragging about the insurance company.

A few months later, Joe has a heart attack. Joe is lucky because his heart attack isn't as severe as Larry's heart attack. When the claim comes in, the examiner writes back to Joe and says, "Congratulations. Your heart attack wasn't bad enough so we're not going to pay this benefit."

That just won't cut it in the work site market, because Joe comes back and says, "You paid for Larry's, but you won't pay for mine."

Now, there are a lot of good reasons for all the definitions in critical illness contracts. In the work site arena, it's better to have a product that's a little more expensive, yet one that's going to meet the customers' expectations and will pay them when they think they're supposed to be paid.

The next thing is to take a portfolio of product design. Specifically, be certain that product design does not clash with other product features.

Now, I'm going to tell a personal story because I learned this the hard way. My very first job was with a payroll company. I loved it. I started out as a young actuary and moved up in the company, and finally reached the point where I was responsible for coordinating product development. Our pricing actuaries were in another city, but I coordinated between the pricing actuaries and the product guys.

We decided to come out with a whole new portfolio of products. They told me to develop certain products, so I worked with the marketing people, and sent the specs to my co-workers in Dallas. We worked through it, and they made product design decisions, which I drove. We would do one product, then ship it off to marketing. Then we'd do the next product and move it out.

We made decisions that made sense for every product, but I never took the time to really look at them together. But, we got all the products out, and were really proud. Then the marketing department started putting all the brochures together and were getting ready to take these products to the field.

About that time, the vice president of marketing left the company. They needed somebody who could really jump in there, and who understood these products. They asked if I would do this, and I said that would be great. I knew nothing about marketing, but I never let lack of knowledge keep me from doing things before, so I jumped right in and became the head of the marketing department.

The developers started rolling out these products. I would stand in front of agents and train them on this new product portfolio. One particular example that I can think of is talking about Product A, for which the issue ages were 18–64. The issue ages for Product B were 16–65. Now, we had very good reasons for those differences, but the agents felt that didn't make sense—and they were right.

A year and a half later, I became responsible for a sales unit and had to recruit agents, so I got the full perspective. I wouldn't change that for anything in the world. The main thing I took away from that experience was the value of looking at the whole portfolio to make sure that it all fits together.

Now, with that said, there are a couple of other things. There's cancer insurance, and critical illness goes very well with it, if it's designed right. I think these two products fit well together, but when coming out with a critical illness product, make

sure that it's not going to cannibalize cancer sales. Don't be so good in marketing the critical illness product that everyone is convinced that it covers cancer, and that they don't need their cancer policy anymore. It's necessary to think about how those two products will go together and how they will complement each other.

Visibility is another thing. If somebody's going to get a big chunk of cash, the person may think all he or she is worried about is a heart attack or stroke, not about breaking a leg. worker's comp will cover that and provide the cash, so there's no need for disability insurance.

Be careful. You don't want tot cannibalize the disability sale. In fact, critical illness fits really well with disability. There's a neat opportunity, which I don't know if anybody has done yet, to have a disability policy with a critical illness rider. This is double benefits for someone who is disabled due to a critical condition. I think that would be a nice feature. But remember, some things don't go well together.

The third point is to address specific needs of multiple clients. First of all, figure out who your clients are. They are all different. There is the business owner. There are the white-collar workers. There are the blue-collar workers. Each of those groups has different needs, and you have to make sure that this product addresses the needs of all those groups.

Figure out what they need. For example, the employer needs employees to be happy, to feel satisfied, and to feel good about that employment relationship.

The employees, on the other hand, need something else. Some people think they need a big chunk of cash. Others think they need to feel like they're taking care of their family, and maybe preparing for the college education.

I'm going to say that it's a little simpler than that. What they really need is the security of knowing they're going to be paid and that they're going to have an income. Most employees think that as long as they're working and they're getting the paycheck, they can take care of it, and everything will be fine.

In the work site market, you may sell this product so that someone gets $20,000, $30,000 or $40,000 when faced with one of these conditions. Instead, I suggest that a company should sell it so the person gets a paycheck as long as he or she is disabled due to these conditions. A contract can be structured in such a way that it's much less expensive and it really meets the employee's need for safety, security and comfort, versus merely some big chunk of cash.

The last thing I'm going to talk about is pricing the product properly. I won't talk about everything in pricing, just two things. First, there is underwriting. As actuaries know, with critical illness, a lot of things need to be looked at to underwrite properly. Look at some lifestyle things such as family and medical history.

There are a lot of ways to get that information. Ask questions on an application. Do attending physician's statements (APSs). All those things can't be done in a work site market. You really have to be able to rely on that application. Nonetheless, ask questions relating to some of these aspects, and be able to do it in three questions. It is necessary to be creative and think about how to get this information in an effective, simple way so that you can consider it in setting rates.

The last thing I will talk about here is data, specifically the morbidity issue. There's a lot of really good stuff that you can get to. You could spend a lot of hours digging on the Internet for information. I know that because my staff has done it. It means wading through mountains of data.

This is great, but make sure that you understand where that data is coming from, what it represents and that you're using it properly. A lot of people can help. There are a lot of specialty studies. Go to internal company data, go to consultants or go to re-insurers. There are a lot of great sources, but make sure to modify that data to reflect the experience as it should be considered.

The last thing I suggest is that this market is definitely in its infancy. It's a neat product. It can be very successful in the work site arena, and I would just suggest to you be different. Try some stuff and see what works, and see where to find your niche.

With that, we'll open it up for questions.

MS. LORETTA JACOBS: When you're doing individual type forms and there is employee turnover, how successful are you at keeping those people on the books on a direct pay basis?

PANELIST: I'll jump in. That's a good question, and it's interesting. In years past, one of the reasons we have always sold individual products is that at the time of sale you can sell to the employee the fact that it's really portable, and they can take the coverage with them.

But, in fact, what actually happens is less than 10 percent of that business sticks. As I mentioned before, part of it is the ease of the payroll deduct slot. When that comes off the paycheck, people don't notice it. Then a bill shows up in the mail, which people do notice, then we find that the number drops off significantly.

PANELIST: I have to agree with that from our own experience, too. Maybe there are better ways to do it to try and conserve more of the employees, but we haven't hit on it yet in our own situation.

MR. WINSLOW: We have had a similar experience. I attribute it to payroll deduction, where you don't have to think about it. Writing a check in today's world is getting to be old-fashioned and I think most people just don't bother.

MR. DAVID BAHN: The Florida Department of Insurance has taken a very firm position against any form of individual underwriting of group insurance. Have you found ways to deal with that? Presumably, that means if you're in Florida you have to have strictly individual forms.

MR. WINSLOW: First off, I'd like to emphasize that we comply with all laws. We have a huge law department.

We spend a lot of time with Florida actuaries, such as insurance department actuaries, legal types and consultants. We work hard to comply with every single law that we've run into. In Florida, all our practices are open and disclosed, and we comply with all the laws. That is my short answer.

PANELIST: I'll give a short answer, too. I don't interpret the situation as precluding the group form, but there is a question about whether there's an attempt to wipe out a good part of the difference between individual and group flexibility in that one state.

MR. FISH: As I mentioned in the presentation, we sell mostly individual insurance. The business to which we do sell group is going to be all GI so we're really not doing any EOIs on our GI group.

MR. SPELL: Our offices are in Florida so we get this question quite a bit. David, I think you're right. Most of our clients are going with straight up individual coverage to avoid problems with the department.

MR. PAUL HANSEN: This is for Mike Fish. Your accident product indicated high lapse rates in supplement product. Are you assuming the same high lapse rates on that product?

MR. FISH: That's a good question. It's probably not quite as high. I'd say it's certainly somewhere less than our accident product, which has one of the highest lapse rates of any products in our portfolio. We certainly hope it's going to be running better than that. We price it out similar to our hospital insurance (HI) lapse experience, which has first-year lapse rates that are certainly not as high as 35–40 percent. However, they're still going to be pretty high. Once again, it goes back to the question before with people leaving employment and losing that payroll deduction. We have always got the issue of how to conserve that business.

PANELIST: Certainly that gets at how much commissions and fees you're willing to pay in that first year to make sure you hit your profit target.

PANELIST: I believe this is pretty flat commission. It's just a bigger product.

MR. EARL HOFFMAN: : Regarding the supplemental medical product, which is the GAP filler product, a lot of employers implement the high-deductible, high-cost sharing plan to get a change in the utilization, and a change in the mindset of the employees. It seems that by implementing it we're adding a supplemental plan and they won't get that benefit. Can you comment on that?

PANELIST: That's a very good question, and certainly there are situations where the broker will not place his product if the employer is going that strongly. One of the things that's going to help out in the situation with our product is we're only paying on the hospital admission and on the out-patient surgeries. In terms of utilization for things like doctor visits, emergency room visits, diagnostic work like having an MRI, those are not going to be covered in our plan.

I think there is a situation where you can impact utilization rates. In terms of someone going into the hospital or having out-patient surgery, it's very difficult to have an impact on utilization, changing the benefit plan. Personally, if I had to go to the hospital, I would go, regardless of my deductible. However, you raised a good point.

MR. BAHN: This is for Mike Fish. On your Medicare medical supplement product, I know many of you say they're designed to fit in on situations where the employer is raising the deductible, et cetera. How does that product fit in with some of the alternative funding schemes around—FSAs, medical savings account (MSAs), et cetera? And do you see that as a conflict for future medical supplement? Which one is going to win?

MR. FISH: I am not very familiar with the whole medical marketplace, but right now we're not seeing much of a conflict. As far as which one's going to win, I couldn't say. I do know that at the current moment—and our product has only been out about a year—certainly there is a lot of talk in the marketplace, and there is a lot of interest from the brokers on the medical side. The particular issue around bumping into FSAs and so forth has not come up, at least as yet as a major issue.

MR. WINSLOW: I'll speak to it from the perspective of my company, which does a lot of medical business. Each one of those you named is really targeted at quite different markets or segments of the employee population. The medical gap or limited medical plans, however, are mostly targeted at very low-income employees. I'd say for the people in this room, if any of you had to write a $50,000 check, you wouldn't be totally happy about it, but you could also pull out your checkbook and write the check at that moment.

We're really dealing with very low-income people, with a $20,000 or $30,000 a year salary, minimum wage. This is more targeted to people like that who need to pre-budget this because they have absolutely no savings and no ability to write a $500 check or $1,000 check, and that's very difficult. It's a very different market, yet, again, like spending accounts, which are targeted more at upper income people

who are working tax advantages and tax plays, and in the lower income market taxes are just not a consideration in what they're doing.

Thank you very much for your attendance. We appreciate it.