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Session 37PD
Making Disability Insurance Affordable

Track: Health Disability Income

Moderator: Dennis Yu

Panelists: Scott D. Haglund
William A. Obert
Raza A. Zaidi

Summary: Affordability is a primary consideration in the design and marketing of disability products for both group and individual insurers. In this session, the panelists explore the need for affordable coverage from both the insurer's and the customer's perspectives. They discuss approaches to designing affordable offerings and present strategies for dealing with customers' concerns over the cost of the coverage. Issues to be addressed include pricing, product design, underwriting, marketing and expenses, as well as the differing needs of different types of customers.

MR. DENNIS YU: I am Dennis Yu. I am filling in for Thomas Penn-David, the scheduled moderator for this session, whose flight was delayed. We have three distinguished speakers for this session. First is Scott Haglund from Principal Financial Group. Scott has been with Principal for eight years and is involved with large-group long-term disability (LTD) and group life. Scott has 10 years of experience in pricing individual and group disability and has been involved in valuation, cash-flow testing and pricing.

We also have Bill Obert from UnumProvident. Bill is vice president in charge of pricing individual and voluntary work-type disability insurance (DI). Before being at UnumProvident, Bill was chief actuary at Berkshire Life and was at Prudential before that.

Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/037_bk.pdf.

Last but not least, we have Raza Zaidi from Aetna. Raza has 16 years of experience pricing in financial management in group and individual products. He has 11 years of experience in association DI. One of his highlights in 2000 was that he authored an article on "Association DI" in the Milliman DI Newsletter. Without further adieu, here is Scott.

MR. SCOTT D. HAGLUND: Thanks, Dennis. This session overall will be about making DI affordable. We will have three different speakers and three different perspectives. You will hear group, individual and work-site perspectives. I will give a general overview. I do not know if I will frame it differently than the other speakers who are going to follow. I think you will get three different perspectives on what some of this stuff means.

More affordable does not necessarily mean cheap, and that is one of the overriding comments about what I will look at. To make their insurance less expensive, anybody can say, "I am going to look at a 1-year benefit period and a 1-year elimination period." That will be cheap. It is probably affordable. The biggest struggle is, does it meet anybody's need? Are you providing any service to the customer whatsoever? Affordable is going to mean different things. It is not necessarily cost, and what is affordable to one person is not affordable to somebody else. I do not think you could throw one net over this whole topic and say, affordability means $5.00 a month. That is not the answer. I think in each one of these presentations, you will get a different perspective of what affordability means.

I view affordability as not just forcing it on somebody else. I think we have to look at ourselves, insurance companies, and say "This is what affordability is going to mean." We cannot just point to a consumer and say, "I will dictate to you, this is what something affordable is." We have to look at ourselves and try to decide what we can do to keep something affordable. Keeping costs affordable is the responsibility of employees, the employer, the broker, and the regulator, as well as the insurance companies. It is not just pointed to one person whose job it is to keep it affordable. It will be everybody's job to keep something affordable.

Again, it is more than plan design to say that long-term is going to be affordable. We do want to look beyond what plan design is. In stacking this thing up, I will look at employees, employers, brokers, regulators and insurance carriers each taking a part in keeping something affordable, and what I see their role in keeping things affordable would be.

For employee responsibility, honesty and integrity are key facets. This cuts across every category to say we will do things with integrity, we will do things with honesty, and take only what you need. We preach about overinsurance, how important it is to make sure that we are only covering exactly what someone needs to live on and nothing more. However, in drilling that down to the employee, if they have the option to purchase coverage, you hope they only take what they need and

not any more. It sounds simple and basic, but I think the reality is people will take as much as they can get. That is generalizing, but that drives up cost. Employees will have responsibility for making things affordable. Working at it through the employees, they should try to return to work whenever possible or as soon as possible or whenever it is reasonable or safe. That is the employee's responsibility—to make things affordable. Be accommodating and say, I could return to work but only if this thing was present, and be willing to accept that.

The employee and the broker have the responsibility to make sure there is an appropriate level of coverage. Again, that gets into not taking more than what you need. To keep things affordable, you have to make sure what the intent of the program is, view what type of product is appropriate for that situation, such as a group or individual or some combination. Make sure it is income protection versus an income guarantee. We do not want to guarantee a lifestyle, but we do want to guarantee having appropriate money to live on. The best plan might not be what is currently there, and I think that gets into our role as the experts in this type of transaction, that of a consultant rather than matching exactly what they have at the present, assuming that is the best thing for that situation.

Try to find the appropriate carrier. Lowest rate does not mean the best long-term partner. In terms of what is the most affordable, it may not be the cheapest one today. Match their intent to the insurance carrier philosophy. What are they trying to accomplish, and what is the insurance company trying to accomplish? Make sure you partner those two to keep things as affordable as possible.

Then there is a balance of risk. To keep things affordable, if someone wants to enhance a provision somewhere, we have to make sure that we decrease the risk elsewhere. Again, this is looking at long-term affordability. An interaction of provisions can make something unaffordable. Independently, each one of those decisions may make all the sense in the world to the employee, to the employer and to the broker. However, our job is to inform them that if you start combining high maximum with short elimination periods and cost-of-living adjustments, you end up with something that is not affordable. If you want to push something up somewhere, you can push down the risk elsewhere to try to keep something affordable. I view that as our role as insurance companies, to make sure that we do provide that consulting.

Regulators are needed to keep things affordable, which you think of as understanding the marketplace and market forces, because there are a lot of things going on. Regulators may not be in the best position to say what is going on in the marketplace. There are a lot of lobbying groups and insurance industry advocates that assist with that, but I think that is necessary on the regulator side. Ensure a level playing field. To make things affordable, I think we all have to make sure that we are selling similar types of rates and similar types of risk, so that one carrier does not have a regulatory advantage over another.. That can put some type of imbalance in what things cost.

Revise regulations to match what is intended. All of us can point to situations where some regulation makes all the sense in the world for health insurance, but it makes no sense for disability. The regulators might say they did not mean that, but just leave it here anyway. The match that they are doing is what they intended to do. Then, make sure appropriate risk measures are in place. Equity comes at a cost, so do the risk-based capital ratios make sense, for lack of a better word? Are they at appropriate levels? Is there some inherent measure there that makes insurance more expensive than it needs to be?

As for ratings, each company has to determine what rating level they want from Standard & Poor's. Again, that comes with some type of cost. If an A rating is fine and you do not need the AA plus or the AAA, inherently each one of those ratings will come at some type of cost measure, because of equity levels and so on. Try to decide for your company what rating you need. Then there should be some type of benchmark for risk measures, and I am not sure what those are in terms of what is appropriate for rating and what is appropriate for equity.

Again, there are certain benchmarks that exist. Whether they make sense or not is probably another question altogether, but they exist. I think you have to look at them through your own situation in determining for yourself whether it makes sense.

Then there is the insurance carrier responsibility, which I think is consulting, not just replacing. There are a number of situations that I have run across in my role where things do not make sense, such as coverage above the existing level that a company does not need. Yet there is at least one if not more than one carrier willing to replace it. I think even those companies, if they are asked whether they need this level of coverage, would probably answer no, but that is what they have now. Therefore one of our roles, although difficult, is to say you do not need this high maximum. If you want a high maximum, that is what individual is for, so again that may not be the right product for that situation. I can promote that because we have both. If you do not have individual, that is fine, and we will compete on that basis.

Have individual as much as possible. A combination is great. If you cannot do combination, that is your problem. Ensure costs are as efficient as possible. Looking internally, are claims being paid when they should be paid? Do you have efficient processes in place? What are the best practices for serving your market? To keep things affordable, we have to look internally and ask, "Are we being as efficient as we possibly can be? Are our dollars being spent wisely? To serve a certain segment, should we put an expensive distribution force in place for smaller situations?" It can be a tough message. At Principal, a large part of our business is under-10 life, in terms of number of cases. We do have interest in the small segment as well as the large segment. However, you should have the right processes in place to service that, because you do need different processes to handle both small and large. I think that is a challenge as well as a test whether we are being as efficient as we

can be to make things affordable.

In addition, the rating and underwriting guidelines should be consistent. If they are not consistent, I think that drives up cost. If ratings are expecting one thing and underwriting is doing something entirely different, that does not come without cost. To the employee and to the employer, we have added costs to that situation. Investment philosophy should match the risk. Does your investment horizon match what your liabilities are? Can you lengthen your investment horizon? Should it be shortened to make things less costly? If we can increase the investment part of your portfolio, that helps. Make sure equity levels are where they need to be. That might drive what rating your company wants. That can drive internal philosophy to say, "We want to make sure we are at a certain percentage of the actionable level," whatever that is internally.

Then there is the product and contract. Does a product offer what the consumer is trying to cover? I do think we are very good at forcing what we have on other people, but is that really what they need? Is that what they want? I think that is the challenge: Are we actually offering what they need in a traditional fashion?

A simple solution such as the one I started off with is limiting the plan design to make it less expensive. That does not necessarily address long-term costs. You may come in low, but all of a sudden realize you know things are not matching up and you have to increase it. It may not meet their protection need, because there is a certain level of coverage that is necessary for a long-term claimant to have a viable lifestyle. Does a 1-year benefit really meet that need? I would probably say at best, even though it is cheap, it does not meet the need. It also does not address the carrier inefficiency. Just because we can price for something does not mean that we should. For example, just because expenses are going up does not necessarily mean you should price for that on the expense side. A possible solution is to address the expense issue, get that resolved, and then figure out what you now need to do with your pricing.

That wraps up my comments. I think Bill will discuss some more product-specific things.

MR. WILLIAM A. OBERT: I want to echo Scott's theme about affordability and not necessarily what insurance companies provide but rather what the end consumer needs. I will talk about two very different markets that we serve with individual disability products. Disability products in general serve the professional white-collar market as well as the blue- and gray-collar markets. My area of responsibility is pricing individual products, both the individual and disability products that most of you might be more familiar with that are targeted more toward the white-collar market, and the work-site market, which is more the blue-collar market and type of market where other products are also sold. This includes critical illness, life insurance, and those types of products. I will do a little comparison and get into the drivers of the price differentials that you see. At the end, I will talk a little about

some of the difficulties in making a product affordable.

First, I want to compare disability insurance with what you might call cheap term life insurance. To put things in context, in the new disability chart book there are a lot of famous quotations that we all use in marketing our product. One of them is that the risk of having a disability lasting longer than 90 days prior to age 65 is greater than the risk of death prior to age 65. There is as much likelihood that you will use the disability product as the term life insurance product.

I did a little price comparison and looked at a disability income policy that pays a monthly benefit of $2,000 to age 65 years issued to someone aged 45 years, and the costs were $780 a year. For that same premium for a man aged 45 years, you can go to Compulife or insure.com and find a product for that $780 premium that would allow someone to purchase $500,000 of 20-year term life insurance. You go to the site and ask them how much insurance should you have if you are age 45 years, and $500,000 probably is not as much as they would tell you to buy. They would probably tell you to buy $750,000 or so. The income replacement on the disability ($2,000 per month to replace 50 percent of a $48,000 annual salary) is probably comparable to the $500,000 of life insurance that you can buy. Is disability expensive? People think of it as being an expensive product, but there are situations where it is similar to what you would call cheap term life insurance.

Let me give you a rundown of the product that I am going to talk about, which we would sell at Provident in the traditional individual disability income (IDI) market. The white-collar market is what we call Income Series, and I will get into the three different versions of Income Series. I will compare that to what we call a voluntary work-site market product, which is really a short-term disability (STD) product. In terms of sales distribution, about 64 percent of our sales last year were in the traditional IDI market and 32 percent in the work-site market. There is another 4 percent that sell individual disability products to cover business overhead expenses and that type of thing. Look at it by policy count, and in the long-term traditional individual disability product, we sell about 54 percent of the policies where there is an STD. That work-site market for STD is the growing marketplace, and Eastbridge would report that the growth in that market has been double digit over the last five years. It is a growing market. We see ourselves growing there, and I think that percentage is likely to become more pronounced going forward.

There are two products in the Income Series. Your market is the typical white-collar executive professional. We sell single life individual with full underwriting. We also sell multilife where some of that is underwritten, some of that is guaranteed issue, some of that is executive carve-out, and some of it is employee buy-up and that sort of thing.

The STD product is typically what you take into an employer, a manufacturer, for example, who is not going to offer a disability plan or an employer-provided plan. They will offer this on a voluntary basis to their employees, the employees buy

individual policies, and this becomes the company's disability offering. This is a stand-alone product. It is not sold with LTD or with other employer-provided disability benefits. It is a stand-alone and tends to be STD.

There are some differences between the two markets. The individual and the multilife markets offer long-term income protection. People tend to buy coverage to age 65 years, and "own occupation" is prevalent. Own occupation and not working is a typical definition of disability to age 65 years. You also see a 2-year own occupation followed by any occupation, and there are some variations between the two. There are other riders offered, including catastrophic, additional indemnity for catastrophic disability, for a disability related to activities of daily living. There are future insurability options, cost-of-living adjustment riders and things of that nature. There are a lot of traditional riders that have been around for a while.

Rate comparisons are important, both at the employer level and at the individual level. When you are in the white-collar market of professional executives, there will be more shopping around, and people have their own brokers whom they can talk to.

Voluntary work-site markets, as I said, are typically STD. Typical industries for us are manufacturing and hospitals, including government, municipalities, education and other industries that some competing carriers also emphasize. In a typical work site, average salaries range from $35,000 to $75,000, and you have a lot of employees who typically do not have access to insurance. They do not have their own broker who they go to. The benefits offered by the employer are somewhat limited, and they are looking for voluntary products to provide the lion’s share of the employee benefits package.

Typically we hear that the people can afford $300 or $400 a year. Some of you may have dabbled in this marketplace. I was talking to one of my associates earlier who said he remembers when $3.00 a week was the type of product that he was pricing, and we hear that too. I think $300 dollars a year would be more like $5.00 or $6.00 a week. At any rate, that is what we are talking about.

It is an employer's decision to offer the plan, and it has to be affordable. The broker who is representing the employer is going to compare different offerings and show those to the employer. The individual traditionally is not going to shop around. They will not hear from the work-site carrier’s enrollment firm, see what is available, and then shop around. Typically you do not see that happening.

You can see that these are two totally different marketplaces. In the end, you have to have a meaningful benefit/value proposition. Affordability means something different to different people. Individual products are deemed valuable by the consumer for a couple of reasons. One important reason is portability if you leave the employer, especially in the blue-collar marketplace. You can look at the statistics from the Department of Labor and different industries. Turnover rates are

published. I think you will find financial services insurance companies might have the lowest turnover rates as an industry, at about 20 percent. If you look at other industries, you see turnover rates that are 50 or 60 percent. It is not untypical to make an offering to an employer where the turnover rate is 30 percent or more per year.

Portability—the ability to take that product with them at the current rate and not to offer a conversion—is therefore valuable. The fact that the rates are guaranteed is another value proposition. The rates are not going to change every couple of years.

FROM THE FLOOR: Are your lapse rates less than your turnover rates?

MR. OBERT: Lapse rates are definitely an issue, as I get into a little bit later.

There is also ease of access, having an enrollment firm come in and talk to the employees to provide that access to insurance.

Continuing with the differences between the two products, Income Series is typically becoming more and more integrated with LTD, executive carve-out or employee buy-up. It is also for stand-alone traditional individual disability brokers. Voluntary workplace benefit (VWB) is typically sold. When stand-alone is sold with other products, they are different products such as life insurance, universal life or whole life products, critical illness, or a mini-medical product and that type of thing.

The value that the employer finds in the work-site product is that the enrollment firm not only sells the work-site product, but they are also a vehicle to communicate the core employee benefits to the employee. They can save money by outsourcing the employee benefit communication to this enrollment firm.

The data on recent issues of these three products shows the gradations. Incomes I, II and III represent different offerings. Income I is the least rich offering. It would be a 2-year own occupation not working with a 2-year residual. Income II is a little between Incomes I and III. Income III is to age 65 own occupation, full benefit, period residual, 12-month recovery and that sort of thing.

The STD product is typically a 6-month benefit period with no bells and whistles. The mix is representative of the markets. With VWB, we might sell to a lot of carpet manufacturers and light manufacturing firms. Hospitals selling to the nurses typically drive that female mix to 70 percent on the STD side. Where it is more traditional, you think of individual disability with a one-third female/two-thirds male mix, .

Income I is the least risky product. We sell that more often on an individual single life basis. The richer products II and III are sold more on the multilife basis. This work-site STD product is all multilife. It is only sold at the work site.

The average-sized case in terms of lives issued is smaller on the traditional IDI, more on the executive-type market and larger on the STD. With many STD products, you are looking at maybe 300 eligible life cases. We also have the 2,000 to 10,000 life cases. You have your fair share of small cases as well, driving down the average. Face amounts are smaller on the STD, although they are fairly small on Incomes I and II, where it is trying to provide an employee buy-up. You do not provide as much coverage as you would on a stand-alone product.

Traditional IDI typically is non-cancellable (non-can). We offer both guaranteed renewable and non-can versions of the Income Series product. In Income I, 64 percent is non-can, so there is more guaranteed renewable mix there; on the voluntary work site, it is a guaranteed renewable product. Typically individual products in that marketplace are guaranteed renewable. The average benefit period, typically to age 65 years for an individual DI, is three to six months for STD with a corresponding short elimination period.

All of these products have level rates by issue age. Broad age bands are typical in the work-site market. Our product has an age band of 17 to 49 years, which is typical.

I will skip over the different benefit features of Income Series and the STD product. We are talking about an STD product that is priced with industry classes rather than occupation classes. In a manufacturing firm, we treat all those employees alike. If you go into a hospital, the doctors are not going to buy the product; the nurses and the people who do the heavy lifting will. We designed it to price based on industry. This is not as complex as you might find with a group product, where you have standard industrial classification codes. It is somewhat simplified.

The basic contract covers 24-hour sickness and off-the-job accidents, and there is an on-the-job accident rider. The benefit period goes up to as much as five years, although we rarely sell any of that. Typically you sell 3-month or 6-month benefit periods. The employer selects three or four plans to offer the employees, not a wide span of benefit and elimination periods, but enough to give them some choice. Then the employees pick among those three or four choices.

Traditionally we have not covered mental or nervous conditions. Occasionally we got requests for covering that. We have a rider now that can be added, but it is only selected at the employer level.

Now we get to Paul's question on lapse rates. Lapse rates are very high in the work-site market. It is amazing how high the lapse rates are. Your traditional individual disability products sold single life have the lowest lapse rate. Multilife has an extra lapse rate for when employees leave the group and their product was paid for through payroll deduction. Now they get a bill and you see some lapse coming in at that time. You see higher lapse rates, but much higher on the blue-collar work-site product and driven by the high turnover and payroll reduction. When the

magic of payroll deduction goes away, the lapse rates kick up.

On interest rates, I want to point out the key pricing assumption. It is more critical on the longer term product, where the average life of a policy is six to seven years. The average life of the short-term product is more like three to four years. When you measure the change in interest rate and what that does to your profitability and what you have to do to get your cost to get back, even a 100 basis-point change in the interest rate drives cost by 5 percent on the IDI product and 2 percent on the work-site STD product.

Slide 18 is a graph of the illustrative claim cost, to give you a sense of where the differences are in the work-site product paying higher costs. This shows two industry classes, and the VWB AA class represents really good industries that are closer to white collar; the A class is more the manufacturing and hospitals. The C1 and D1 are the two lower occupational classes for traditional IDI, so that D1 would be more the blue collar.

Part of the difference is driven by experience. The VWB product has higher female content. These are unisex claim costs, and VWB has a higher female content. The two products handle maternity claims differently. There is a waiting period on the individual disability product that is not there on the work-site product. Then you have the accident coverage. The traditional IDIs have 24-hour coverage, including accident and sickness, and the work-site product typically excludes accidents at the workplace.

Required capital is a factor. Every company has their own internal required capital formulas that they include in pricing. The longer benefit periods mean you are building up more reserves. We use higher factors for non-can than we do for guaranteed renewable and higher C2 risk factors for longer benefits than the shorter benefits. We get hit on the longer term product from the non-can feature. The longer benefit period and the reserve build-up mean you have more C1 risk. As much as two to three times the capital required on the longer term product than on the shorter term product. Your internal rates of return are affected by the capital you put up and the cost of the product is affected that way.

Some of these drivers are definition of disability and higher cost with the longer own occupation period. With benefit periods, whatever occupation class you are in and whatever industry you are talking about, your experience in those classes and industries drives the cost. The multilife experience on individual disability versus the single life experiences make a big difference, and that will affect the cost.

The lapse rates that I mentioned and the high early lapse rates hurt you on the deferred acquisition cost, but the high later lapse rates actually help you. The claim cost curve is increasing, and having those lapses actually helps lower the cost. With the blue-collar product, those lapse rates generally hurt you, but it comes from the early lapses.

You put it all together and try to come up with some pricing comparisons on the different products to give you a sense of the price differential for the three levels of Income Series, if they were all comparable to benefit periods for age 65 years with 90-day elimination periods. You compare Income I for a 2-year benefit period with the work-site product for a 2-year benefit period. The work-site product is a little bit more expensive. It depends on a lot of different assumptions you make as to what type of multilife product and what level of discount you provide and that sort of thing.

Affordability is challenging the high distribution costs, and we are trying to provide voluntary products at the work site. The cost of enrollment through the enrollment firm or broker or whoever is doing the enrollment is paid for through a first-year commission. You end up with a high/low commission structure so that the distribution cost is a challenge. We want to have the one-on-one, face-to-face enrollment. We find we get better participation, and greater participation improves the risk result. Improving the risk results plays into your experience and levers the price that way. Participation is a key, and the employees' belief in the need or their limited funds is another challenge to the affordability.

MR. RAZA A. ZAIDI: I am Raza Zaidi from Aetna's association and affinity markets, and my approach in this presentation is slightly different. I do not want to jump into the product discussion, because I think we need to bring people up to date on the association market, a channel that was popular at one time, but has slipped out of popularity for many reasons. Aetna has changed quite a bit, so I want to show you what Aetna looks like today. This should give you an idea what the association and affinity marketplace is like and what the dynamics are. I will explain to you who the customer is and then why Aetna wanted to get into this business. Aetna is attempting to find affordability, and the disability product portfolio that we have developed for this marketplace addresses the affordability issue.

Many of you know that Aetna is an established employee benefits carrier. In the past nine years, it has transitioned itself from the traditional multiline insurer to a leading health care provider. As the transition was reaching its completion, it became necessary to look at other sources of revenue. Also, they wanted to make sure that the revenue came from sources where they could leverage their existing infrastructure and expertise and the fact that we have a very broad portfolio of employee benefit products.

The other thing that we realized was that employers are reducing participation in employee benefit programs, and people are looking to alternative channels, for example, the Internet for term life sales. It occurred to the management that perhaps they should take a look at an old marketplace.

The association market is estimated to total, in very conservative numbers, $1.6 to

$1.8 billion. I have been told that the potential is much bigger. The problem was that this marketplace was suffering from slow growth, due to lack of product innovation and lack of product availability that fit people's needs. The carriers in this marketplace going back 10 or 15 years still had a very limited offering. They did not have a total insurance solution for this marketplace. Associations wanted to find a medical solution, and then they would look at life and disability and the other products.

Another thing is, how do you sell in this marketplace? On the surface, it looks like a two-part sale. The association buys them and the carrier sponsors them, and then the carrier will market the product to the association members, and the members buy the product. However, there are another couple of prongs to this. This business is traditionally done through TPAs, because the association wants to make sure that the individual records are not the property of the carrier, but that they can take them wherever they go. The TPA needs to buy into the carrier, and the fact that they can work with you and all of that becomes very important. Sometimes the TPA is also the broker. They facilitate the sale. You have to sell to them and say, we can give you what you are looking for for your clients. You make that sale first, and then it goes on from there. The carrier still retains the underwriting and claim management, for very good reasons.

Who is the customer? The customer is a professional, a member of a professional association. These customers are looking for affordable solutions, and they like to define those solutions. We will look at a definition a little later.

Sometimes they like to spread the insurance coverage across individual, group, and association group products. The individual product gives them affordability, and the group product is an easy way of getting some protection and it comes from the employer. They look to the association group products to fill the gap, because they look at the association group product as a hybrid of group and individual. They want streamlined medical underwriting. They want to be able to get some level of coverage with three to five questions asked, what they call simplified issue. They are probably not going to find the individual case that is willing to do so on the association side, because of the size of the groups and the fact that you have a block of business that is coming to you. You can go ahead and create products like that. Some examples of professional groups include accountants, architects, business consultants, doctors and dentists, engineers, pharmacists, lawyers, scientists and teachers and, of course, actuaries.

Aetna completed their transformation and became a leading health care provider, and they started looking for sources of income or revenue that were substantial in size. As we have seen, the affinity and association marketplace offered a tremendous revenue potential. However, the challenge is that you need to fully address the customer needs and be seen as a viable place to shop, otherwise, it will dwindle.

In 2002, Aetna decided to pursue the association and affinity channel. They started out offering life and disability coverage for professional associations, community groups and multiple-employer associations. Earlier this year, Aetna decided to broaden the strategic approach, and they will begin to offer medical, dental, long-term care and pharmacy products, as well as the life and disability. They are bringing all of these products into a discussion of disability products because, in this marketplace, you suffer from two different kinds of lapses. One is the lapse of the member. The member gives up coverage and goes elsewhere. The other one is the whole membership or the whole association leaves. That is a shock lapse, and you want to minimize that. The way to do that is to develop a packaging strategy and get them tied into as many kinds of coverage as you can so that it is harder for them to leave.

What is affordability? What does it mean to you? Something that happened to me a year or two ago came to my mind. My wife and I were in the market for a minivan. She wanted a minivan with certain specifications, and I was more on the economical side, looking more at the price. She said, "That is not going to happen. The family is going to be traveling in there, and these are our needs. It has to be safe and have specific features." We bought the minivan that fit her specifications. It was not the cheapest. As a matter of fact, it was one of the more expensive ones. We stretched our budget to make it fit, because it was necessary. This was how we had to define our needs.

A couple of months later, my younger brother had a midlife crisis a little early, and he wanted to get a red sports car. I sat down with him, and he wanted a V8 engine and 350 horsepower and this and that. As I listened to the guy, I did not hear the word "price" anywhere. Once he finished specifying what he wanted, he went out and got the car. I guess there was a pricing decision in there somewhere, but it really did not come up. It was more how established the car was or the superb handling that he was looking for and how cool he was going to look.

Basically, then, I realize that affordability fits the need and fits the budget. We wanted to apply that concept to our disability product portfolio. The product design goal was to design a product that fits the budget and fits the need. We needed flexibility, and needed to leverage the existing infrastructure and the product expertise that were present in Aetna. Therefore, we went with the group LTD chassis. It reduced the learning curve for claim administration and in general allows you to turn on the program. However, the difference will be that our LTD is based on salary, and we are more of an indemnity-based program.

The other thing is, if you want to develop a block of association business, you have to go out there and take over some existing groups. When you take over existing groups, you also have to work the sales in them. If you do not, then over time the loss ratios are going to go up. The case is going to deteriorate, because the pricing of these groups assumes that there will be fresh blood coming in. If you cannot do that, you will have a lot of problems. Therefore, you need medical and financial

underwriting. I cannot stress that enough. You need both. You need financial underwriting when you actually take over a group. You have to look at it and see what you need to do and what features you need to change, because the group was in trouble somewhere and you do not want to bring those troubles over. You need the medical underwriting because you want to get these sales going. You have to balance the fact that people are still looking for the streamlined medical underwriting.

You also need a set of manual rates. When you take over the business, sometimes you take over their rates, but for the new sales and sales for those associations with start-up programs, they require a manual rate. We have decided to build our manual rate structure on the 1985 Commissioners Individual Disability Table A, and I wanted to modify it to reflect the Individual Disability Experience Committee survey findings.

The basic features of the disability product portfolio do not include anything new. However, it is the flexibility that I look for. If you go into an LTD manual, you will see a lot of flexibility in it. The difference is that I will be selling an indemnity-based coverage; however, I need all the flexibility. Let me go back to my sports car analogy. Take a product with a monthly indemnity of $10,000 and a benefit period to age 65 years. There is a 60-day elimination period, and definition of disability that is specialty own occupation for five years and then own occupation thereafter. That is a hot-rod sports car. Somebody wants it and has to pay for it.

The safe minivan could be a $6,000 a month indemnity with a benefit period of five years. The elimination period could be 60 days with a definition of disability that could just be own occupation. That could be a safe bet for a professional. In other words, it fits the budget and fits the need. If they want something really dirt cheap, they should be able to do that too. They should be able to provide a $1500 monthly indemnity and a 180-day elimination period with that and a 2-year own occupation thereafter.

What is a discussion of disability products without discussing cost efficiencies? There are some features that allow the underwriters and the association group administrators to tailor programs such that the programs can fit the need and fit the budget.

You can go into those examples I gave earlier and try throwing in a limitation on substance abuse and mental nervous conditions. Now you have a pretty flashy DI product, but you have to try to get this within your budget.

A coming attraction of the association and affinity marketplace is not a product, but an approach. We developed the holistic approach where the medical and the disability claim management are integrated to create a win-win situation. This approach is very successful in our employer market. We believe it is value added. We want to bring this to the association marketplace. As the experience emerges, I

am very hopeful and convinced that there will be room for some pricing discounts, because this approach is able to hit the disability claim management right when the person is beginning to make use of the health plan. The pricing discount tried to fit the need. Now, because it only works in cases where medical and disability coverage are sold as a package deal, and the customers are insured with Aetna, it goes back to the fact that the member wanted medical, and they want life and disability. This puts things together in a nice package, and it fits the need, too.

There are standard provisions that you see in a disability contract. But these are just provisions, and there is a lot more out there. When you are trying to fit the need, you know what the customer wants, you know what they are looking for, and you should be able to offer that. You can charge what you want as long as you charge a fair price for it, and the customer has to make the decisions on where to stretch the budget, like my brother with the sports car who did not get the disability coverage.

There are bells and whistles that are optional at the group level or at the individual level. This is a decision with the underwriters. We have to take a look at each case and decide if it is what we want to do. Maybe the business overhead benefit rider is optional at the individual level. However, the survivor benefit is optional at the group level. If the group wants it, yes; if not, then nobody gets it.

I believe that if you make a commitment to a proactive product management, which involves financial management and product development, and if you develop benefits that respond to the need of the marketplace and continue fitting the need of the customer, a channel such as the association and affinity market can be very viable. I am counting on it, because I switched my job to go there. Thank you.

MR. YU: To recap, it sounds like affordability, especially in disability, means different things in the different markets. It seems to be good in a different perspective. In the employer group market, it seems to come down to economic decisions. The employer is making choices in the framework of receiving a double-digit increase on their health benefits, a lot of times. They are coming from that perspective. With the professional association, basically the decision or the perspective is choosing between the Mercedes car payment or the disability payment. With a voluntary work-site product, they just want to know, can you buy beer this week? I should not simplify it too much, but distribution needs to address those different perspectives. Having said that, are there any questions for the panelists?

MR. PAUL MARGOES: There is a little cliché that we always bandied about, which is true, that affordability comes down across all lines of business. It comes down to an enlightened self-interest. If we do not find a sound way to be affordable, then the kind of business that we will sell will probably not be high quality. It will be so expensive that only the bad risks will want it. Therefore, I think an affordable price is really something that will be more financially sound in the long run. The problem

is how to get there.

MR. YU: Are there any other questions?

FROM THE FLOOR: On the group side, I hear day in and day out these days, both on life and disability, is that affordability is in the context of medical insurance, which just went up by 10 or 20 percent. Now I cannot afford the disability or the life product anymore. I also hear people talk, and Raza in particular may be familiar with this, about companies that are able to bundle the medical and the life and disability and perhaps offer discounts either notionally or really in the package sale. Can you comment?

MR. ZAIDI: That is true. At Aetna, because we are a leading health care carrier, we have been trying to package the products together, like integrated health and disability, which is a claim management approach. That creates cost efficiencies, which are beneficial to the customer. The other thing that comes to my mind is, for instance, this benefits overhead expense rider on a disability product. The benefits overhead expense product is also sold separately, but if you combine the two, there is only one underwriting cost. If you submitted two applications, you will hit underwriting twice. This way, you just check it off. We are looking for those kind of situations, especially because the medical rate increases are 10 and 20 and 30 percent, and people start to take a second look at their life and disability. We really are focused on trying to find the room in the pricing, because we want people to have both or all three of those types of coverage.

MR. OBERT: I would like to add that the cost that the employer is finding on the medical has fueled the growth in the voluntary work-site marketplace. You find the cost shifting to the employees to buy their own coverage.

MR HAGLUND: I want to chime in quickly on this whole combination thing. I think the only area of concern when you start looking at combining coverage is, given how like expense structures within your company work, if you actually see expense savings when you combine coverage, I think we all would say it would make sense, that it is less expensive. With the way your company actually sends expenses to a product line, do you actually see any real savings over time? Do you or the company see savings? Then the question is, would your actual product reflect that, or will your company just look better? Then keep an eye on morbidity charges, because we have seen that with medical combined with some of the disability coverages, there is some improvement. There is probably more on the short-term than on the long-term side. We have also seen, and most carriers will see this as well, that combined, the LTD runs worse. We have seen the STD also run worse when combined with LTDs, so it is a double whammy. To some extent, this is also true on the group life side, and probably more on the waiver side, that you can see deterioration as well when you combine coverage. In terms of long-term affordability, we need coverage that works better together. There is a lot of speculation why that happens. It could be the ease of claim filing is why you start

seeing coverage deteriorate, but certain things are going on. It does not necessarily improve the situation from the morbidity side when we start combining these things. I guess one of the watchdogs as well is that some of the expense savings might be removed by claim cost increases.

FROM THE FLOOR: As a Canadian, I watch daytime American television, and I sometimes see commercials where companies will offer to convert annuity payments into a lump sum. Are these offerings applicable to disability insurance and if so, how might that affect claim costs ultimately?

MR HAGLUND: It might be a clarifying question, but would that be converting, let's say, the disability payout into an annuity?

FROM THE FLOOR: That is what I am wondering. Is this a normal annuity, or would they offer it on a disability as well?

MR HAGLUND: Do you mean a settlement?

FROM THE FLOOR: It sounds like it, yes.

MR HAGLUND: But it is not the insurers doing it? It is some other entity?

MR. YU: It is a third party. I do not think I have seen that on the disability side. That seems to be more related to life settlements or some type of lawsuit litigation. It would take some type of long-term payout and convert it immediately. I have not seen this, and I would not say it is a primary market. I would not be looking for it. That is also daytime television.

Are there any other questions? If not, thank you for your participation.