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Session 5 PD
Adverse Selection in Disability Insurance

Track: Health Disability Income

Moderator: Frederick J. Flores

Panelists: Frederick J. Flores
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Summary: Adverse selection is one of the greatest challenges faced by disability insurers. Due to the complexity and subjective nature of the risk, applicants often know more about their own chance of becoming disabled than do the insurers who offer the coverage. In this session, the panelists discuss the types of adverse selection faced by disability insurers and the manner in which companies deal with the risk in different markets. Specific topics include voluntary group plans, multilife individual plans and simplified underwriting programs.

MR. FREDERICK J. FLORES: By way of introduction, I'm the worksite actuary at Disability RMS. Adverse selection is one of the top concerns for disability income products, and managing it effectively is one of the keys for a disability product to be successful. We have speakers with a mix of both group and individual disability backgrounds. We will give you different perspectives on adverse selection, as well as approaches to managing it.

Scott Haglund has been with the Principal Financial Group for eight years and currently consults on large-employer group life and disability cases. He has had over 10 years of experience working with individual and group disability, prior to his work at Principal Financial Group. He has worked on valuation cash-flow testing, pricing and reserving for both stock and mutual companies, for both life and disability lines. Mr. Haglund has been an FSA since 1995 and is a member of the American Academy of Actuaries.

Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/005_bk.pdf

Douglas Taylor is the chief financial officer for the disability income business at Massachusetts Mutual Life Insurance Company. He has had more than 20 years of insurance experience in various actuarial and financial roles, primarily in disability income. He has been at various companies in both the United States and Canada. He's an FSA, a fellow of the Canadian Institute of Actuaries and a member of the American Academy of Actuaries.

MR. SCOTT D. HAGLUND: I'm going to discuss adverse selection more generally, not necessarily product specifically. I will describe different attributes that could impact the product. I am focusing internally because it's one of my beliefs that we do a lot of these things to ourselves. It's not necessarily an individual selecting against us. Often we allow them to select against us by practices that we might have or things that we say we should be doing but aren't really doing—claims areas, underwriting areas and so on. I'm trying to focus on organizational or functional types of adverse selection. I'm going to examine pricing, organization, regulation, the consumer and distribution.

The general thought is that adverse selection involves a lot more than just disability. When you think of adverse selection, you think of morbidity costs, which is true. That's how we measure it. Our claim costs are higher than we expected them to be. So we see adverse selections. Something is different from what we expect. Instead of focusing on the claims angle, there are other aspects that will impact it: the product, organization, distribution and customer all add selection. As you look at adverse selection, you need to consider how you're dealing with this variety of influences. Instead of focusing on the claims area to get claim costs down, there are other aspects that impact that.

The first aspect is distribution. I'm going to examine the broker and the sales representative. In terms of adverse selection, there are types of business that a broker will bring to you. This might focus on the group side, but it's coming into play with multilife disability as well. You're no longer dealing with a career agent on the individual side. You've got brokers becoming more involved. Certain brokers always bring you certain types of business. You may or may not realize that, but that is true in your block of business.

Brokers may always say that your company is always low on certain types of cases. If they have a bad case, they know that your company will end up giving them a good rate because of how your rate structure is developed. You have certain brokers that will bring you certain types of business. You may or may not realize it, but that is the reality. You're not perfectly priced in every aspect of your business. Distribution may know what's going on.

As far as types of information that the brokers provide, there is something about a case that might not be beneficial to you. Obviously, they'll know more than what they're saying (not that they're doing it intentionally). I do that. Somebody will ask me a question, and I'll talk for a while, not sharing everything that I could possibly

know. It's up to us to ask more pointed questions on issues that we think are impacting our business.

How accurate is the quote? You'll get an adverse selection. It's different from expected. It could be that the price isn't right for what's going on. Was it run wrong? Did the broker request something that wasn't expected? With contract features, rating adjustments and so on, underwriters can look at the risk and decide what's going on with a case. There are certain aspects that can impact it.

Regarding the relationship of rate to manual, is this case so good that it's half of what your manual rate would be? Is any case that good or so bad that it's twice a manual rate? If that is going on, I think that you have to reconsider. Is there something going on with a case so that there's some element of adverse selection that you are not measuring or capturing? How desirable is the business? What length of time will it remain in force? Everybody, either implicitly or explicitly, has an idea of how long they expect some business to stay with the company. If this case does not meet that, you have to question if it is a good fit for your company. This is where adverse selection comes in and why it's a little bit more than morbidity.

You also have "shopping" adverse selection. Some employers or brokers will move the business constantly. This is one other element, and it might be on the expensive side. How long did it take me to recapture my expenses? It could be distribution cost that you spread out over a certain time period. That's one more element of adverse selection. A company knows that this is a low rate, but they are only going to stay with you for a short time, so they don't care if you make money or not.

We are prone to focus on the consumer. Employers and employees know things that we don't. It might be a little more prevalent in small-case markets. The actual decision-maker knows all of the employees. They know that one person has a certain condition, and that person needs coverage. If you're creative with pre-existing condition clauses, you can put things in place that help out the employees.

For self-accounting, are the lives and premium accurate? Are we getting in what we expected? On the larger cases, do the premiums make sense? Do the lives make sense, compared to what you started off with? Are they prone to shopping? Is there something about this employer that would make them switch plans often? It might be a municipal group or school group that goes out to bid every year. Is there something bad about that for the insurance company? The people need coverage; that's not in doubt. The question is, how long will they stick around?

Return-to-work attitudes can be difficult to measure. How willing is the employer to return people to work once they are disabled and to make accommodations to get them to return? That is another element of adverse selection, but it can be difficult to get a handle on it until the case has been with you. Consider financial stability

and the business strategy. How likely are they to be able to pay you? Things might happen differently than you expected.

From the claimant side, return-to-work motivation is huge. But at the time you quote a case, you probably are not talking to every claimant to find out how likely they are to return to work. Do they feel good about their employer? Did you talk to each employee to get that same type of perspective? As you write the cases, you don't know how likely someone is to return to work. Is he or she a hard worker? Does the person like what he or she does? Those attitudes have a huge influence on the risk of the case, but they are not what we look at. What about other income sources? Does the person need this job? Could he or she get by without it because there's enough income from other places—investments, a spouse, etc.? Does the person's time off from work match the expected length for that diagnosis? That is one aspect of adverse selection that's measurable.

How subjective is the condition? Short of the limits that we put in place, I think that there are other ways of managing those risks; special nurses can work with the claimants to return them to work, for instance. The 24-month limits, in my opinion, are partially there so we don't have to focus on them. We let them terminate on their own, versus dedicating costly resources to managing those claims more effectively. That's where the trade-off is. By managing the claims with the examiners, we increase cost, and so, effectively, by managing the heck out of some of this, we start to make things less affordable; those things are not cost-free.

I don't know how often we think about the vendors with whom we associate. This could be an employee-assistance program (EAP) vendor, a claim operation, an underwriting operation or a reinsurer with whom you work. How similar are your philosophies? If you have dissimilar philosophies, is the reinsurer, the EAP or the underwriting operation actually bringing you business that doesn't match what you'd like? That can be an element of adverse selection, because your rating might not anticipate that happening. If your philosophies are too dissimilar, I would say that you have introduced an element of adverse selection. Business will come in differently than you expected.

Are your vendors providing value, or are they just providing something? Are they adding cost without value? How is the relationship perceived by the market? If the market says that it's a good thing and a positive element, there's probably less of a chance for adverse selection. But if they only think that they can pull something off, then it probably is not adding value. What's the quality of their work? If you're working with a vendor, and you're not sure how well they do things, I think that you are introducing adverse selection. You are going to come back with something that you didn't expect.

Proposed regulations or changes to regulation can introduce adverse selection. If you have a certain feature in your product that you think is critical but a state makes you remove it or doesn't allow you to do that, that adds potential for

adverse selection. Some examples might be the mental/nervous or special conditions limits, gainful occupation and provisions of that nature. There are certain things that may cause your product to behave differently in that state due to regulation.

Let's talk about speed of response to product and rating changes. If it takes you four years to get something approved in a state that you think is critical, that introduces something different from what you're expecting. Examine the willingness for that state to accommodate changes or your relationship with that state. I would guess that each company has some state with which it has issues. Some of them can get personal. You hope that you don't work with a particular examiner. We have histories with people, and that introduces some problems in getting things through if you want to reprice, when a state doesn't allow that. That has adverse elements.

What risk is introduced by changes to the product that you were not expecting? Maybe you didn't reprice, even though a state told you that you have to pull a provision out. Does that fundamentally change the risks that you're selling? I would say that it does. But I also would guess that we often continue to hold the same rate manual that we filed just because it is easier to have a nationwide rate manual.

Let's talk about stock analysts in the equity market. How do analyst comments change how you do business? I think that it changes how we do business for the stock companies. Does that move make sense? This gets into the long-term/short-term perspective. Do the analysts want the short-term gains, thereby sacrificing long-term objectives? That can be a struggle. Even though it makes sense to those stock analysts, if that's not the direction that your company wanted to go, I think that you've introduced risk in your business that you weren't expecting. Do you need to free up capital to accomplish something? How does this change your product's perception? If your company wants to accomplish some type of merger or acquisition (it wants to reduce equity in a line, for example), how does that change your product objectives?

Do your actual procedures match what pricing is assumed? That's one element of selection. If you say that the underwriters are going to handle a certain caseload in a certain time period, does that match what's going on? The simple things are claim procedures. Has claims introduced payment patterns that are different from what pricing had? On short-term disability (STD), are you starting to lump sum payments? That influences how STD would get priced, because your claim practices have changed. You have more of a fixed-duration product.

Turnover of experienced staff has a huge influence on your company and how risks are going to start to be perceived. If you have a high turnover, you lose the experience base, and you're going to see more selection. The motivation level of employees, with the environment that we're currently in, can be a problem, as well

as motivation. How well do your employees consider what they're doing? Are your internal employees happy with what they do? We always focus on the external marketplace. If you refocus those things internally, you get the same picture. Is your company financially stable? Does your company treat employees well? Does your company try to return people to work? If it doesn't, you can struggle internally with motivation and how well your underwriters, claim examiners and sales representatives are going to perform.

As actuaries, we can understand numbers very well, but we need to understand the people's perspectives and the processes: how claims come in, how sold cases come in, how proposals are done and how things are administered. Effectively, you must understand from when a case enters a sales representative's hand to when it actually gets issued as a contract. That whole spectrum is full of selection points that can be in your favor or against you.

What is the quality of data used for pricing? Computers are great, but I think that they just show you when things are wrong faster and that you really don't have usable information. Even though it looks slick and fancy, it's not necessarily high-quality information. How do errors impact your price? There are errors in the manual. We are looking at things incorrectly. We combine things that shouldn't be combined. There are a lot of things on which we make errors. Your contract might not be in the system right. The wrong proposal may have been issued. On experience-rated cases, you used the wrong claims. We have priced things incorrectly. What is the influence of the errors in both pricing and reserving?

How do other companies influence what we do? We are very good at chasing each other. I would say that it has a huge influence in what we do. Hopefully, whoever is in front is doing it right. How do they alter what you're doing? You think that something makes sense. Nobody else does it that way. What do you do with that? You think that something has the absolutely correct price, but if you charge that, you are not going to sell a thing. If you do sell something, you always have to wonder why you sold it.

What profit are you giving up to be like other people? Both LTD and STD are struggling in profitability. I would probably throw individual in, as well. I would say that most of you know what you should be doing, but you have to give up some things to meet both growth goals and sales goals (maybe just to sell, period). Do you have the product that you want or just a product that other people have? It may not be the ideal product; it's just what other people are selling presently.

How does your product and price stack up? Is there selection because of rating and product flaws? It's hard to say if that's fixable or not, because to say that you are going to meet what the carriers are priced at might not make sense, but that's where you may have to be. None of the questions of surveys really measure how you're doing. There is a lot of change and flux in the whole industry. I know that our rating is extremely complicated, so I don't know if the surveys truly match how

we are doing in the marketplace. For example, data for our short-term product tells us that we should be able to sell anything that moves, but I know that that's not the case. So there is some disconnect.

Are you monitoring what was priced? That's getting more into measurement. All of us have incidence rate assumptions. All of us have termination rate assumptions. All of us have industry assumptions out to about as many standard industrial classification (SIC) code digits as you can imagine. Technically, there are assumptions behind all of that. I don't know if our 7372 business is priced exactly where it needs to be for an SIC. I would wager that it's not. There's really no way of measuring down to that minute detail, but we might have a factor that's different from 7371 without any justification or rationale; it's just tradition.

Are we really monitoring what we're pricing? Have processes or procedures changed? I would say that they have, because, with us, somebody is restructuring, reorganizing or trying to do something better, at least annually. Each year, there's something that impacted what's going on. Rate manuals stay out there for 10 years. There's no way that they can really measure what's happening within the company.

What's the best way of measuring assumptions? I don't know the answer to that. There are a lot of ways that you can measure assumptions. For incidence rates, is it best to measure it on number of lives or benefit exposed? Results give two different answers. Benefit exposed probably matches your financial results more, but number of lives is a lot easier. Are there are some considerations to say what really drives it? For termination rates, is it measured, literally, where the benefits are coming off and on? Is it measured where the lives are coming off and on? There's some dialogue about the reserve-driven termination rates. How you measure it should be how you price it.

Is pricing getting what you expected? If you priced a 10 percent increase, and you're getting zero, that should indicate that something is going on that you weren't expecting. That's some type of adverse selection. What is the impact of the state-filing process on the risk and the price of the product? That gets into when you expect these prices to start turning around.

In terms of solutions, I don't think that what I say is going to solve everything. There's always something that we can't measure or something that we don't know. But I truly think that measurement and knowledge are important. Even if results are not what you want to hear, that doesn't mean that it's not true. Maybe the product is not priced right, and you are giving up certain amounts of profit. I think that if you know that you're giving up that profit, at least you can understand what's happening. You can start to say that what is now expected is something lower. There are a lot of moving pieces in how we rate. Maybe we all could decide that there are only six ways of modifying a rate and have everybody go with that. It's wishful thinking, because I know that we probably have 50 ways. That's why it's

difficult to measure these things. It's not going to be perfect, but I don't think that means that you shouldn't do it. You may have to make assumptions to obtain it, but it's a way of measuring.

You have to provide what's needed to manage, because people are making decisions on this. You have to measure what was assumed. You have to review the organization to understand its flaws and problems. It's just an understanding of what's happening. One of the simple measures would be loss ratios: actual and expected patterns by broker, group representative and underwriter. You could look at incidence patterns by claim examiner, because they might be higher than what's going on. Look at the close ratios of your group representatives; if they're too high, that should make you wonder. There might be a very good reason for it, but it's something to look at. Persistency can be the measure. If a product is doing extremely well, you might have to question that. Fundamentally, you would expect some people to leave. If they are all staying with us, you have to wonder if it is priced incorrectly so that there's no reason for them to find a different rate elsewhere.

What's the influence of pre-existing condition clauses on incidence patterns? What does your pre-existing condition clause actually cause in your rate with takeover groups? A lot of companies still would give discounts for certain types of pre-existing conditions. Does it really matter? Patterns of newly written business can be an indication of selection by broker, by representative or by underwriter. A lot of claims coming on in a new case should indicate that something is going on. After a change occurs—like rate changes, changes in life or changes in the economy—how does a case behave after those changes have hit?

MR. FLORES: I'll talk about some ways to manage adverse selection. As I talk about this, I'll start at a fairly high level and describe some of the ideal characteristics for risk controls that you might use to manage adverse selection for a particular product. I will list some of the commonly used approaches to manage adverse selection. I'm going to focus on using minimum participation and simplified medical underwriting as primary risk controls and describe what I see as some of the strengths and weaknesses of these two approaches in order to draw a contrast between the two.

It might be helpful to describe some of the products that I typically work with at Disability RMS, in order to give you some idea of my perspective on adverse selection. I work with voluntary LTD and STD products. These products are primarily distributed through worksite distribution channels, although some of them are distributed through traditional group channels, as well. These products are all sold to employer groups on a group basis, but since they're voluntary, they're ultimately purchased at the individual level. These products have both group and individual risk characteristics, so the risk controls that we need for these products must have some level of group and individual characteristics.

I thought that I'd start off by illustrating how some adverse selection can show up in your product experience. The chart in Flores, page 2, slide 1, is an example of actual-to-expected incidence by year from issue for sample voluntary short-term disability (VSTD) business. One of the things to note is that I've included not just normal claims in this chart, but also claims that come from pre-existing conditions. This chart does a reasonable job of representing all of the claims that could be filed on a VSTD product. The incidence is quite a bit higher in the first few years of coverage. This is indicative of the potential for adverse selection, because the employees that are most likely to file a claim are more likely to purchase coverage; they file their claims within the first few years that they're covered. Clearly, for a disability income product to be successful, you define an effective way to manage this type of risk.

The chart in Flores, page 2, slide 2, shows maternity incidence for the same block of VSTD business, by year from issue. When I think of maternity, I think of it as one of the most selectable causes of disability (at least for a VSTD product, I think that it is). True to form, you can see a steep pattern of incidence on this chart. Since it's fairly selectable, it lends itself to a fairly steep pattern of incidence. Due to the nature of maternity, you may think that you see excess claims in the first year of coverage, but that in years afterward, you may not see some excess claims from selection. However, at least from looking at this chart, it appears that the excess claims that you might be able to get will last longer than a year. It illustrates that the dynamics of adverse selection can be a little more complicated in some situations than you intuitively might think.

As I start to talk about risk controls in particular, I will describe some of the ideal characteristics of risk controls for a particular product. First, risk controls for a product need to do a good job of balancing a number of competing interests. Obviously, the balance is going to vary from product to product and by the type of market and the type of company that you're in. I don't think that there is any one set of risk controls that is going to work best in all situations or for all products. But the risk controls for a product need to provide risks that are priced appropriately. They need to allow you to identify a fair price for the risk that you're insuring, and the price that you come up with doesn't need to be unreasonably high.

The controls that you use need to be objective and well understood by everyone responsible for managing your product. Certainly, if the risk controls that you're using aren't well understood by people who are managing your product, you can set yourself up for some problems down the road. Controls need to be robust enough to fit most of the situations that are likely to occur for your product. Although this is at odds with the other things that I just described, they should not be exceedingly onerous for the type of situation that you're in. This is going to vary quite a bit by market and by product, since what may be too onerous for one product or market may not be in another. You need to find the best balance between these items to be successful.

To help evaluate what might be the best balance for a particular product, there are some considerations. What level of guarantee does your product have? If you have a guaranteed renewable or a noncancelable product, your ability to correct problems as they arise is going to be limited. You may need to be a bit more cautious. A second consideration would be the claim severity that you're going to expect. If you compare LTD to STD, your LTD products are going to anticipate fewer claims, but they're going to be a lot more severe. With LTD, it's going to take a lot fewer claims to have a significant impact on your experience. You need to be more cautious on risk controls.

You need to analyze the market segment and the demographics that you're expecting to have with your product. This should give you some feel for what particular type of claims you may need to be most concerned with. Are there any special risks or occupations that you need to worry about? You need to consider the distribution channel. This will give you some idea as to what may or may not be too onerous to use and what capabilities your distribution has to support risk controls.

There are commonly used risk controls. You could split these between group and individual, but it's not uncommon to see mixes of both group and individual risk controls on the same product. At the top of my list for group is required minimum participation. This manages selection by achieving a spread of risk over a minimum percentage of a group and avoids an unreasonably high concentration of healthy lives in the population that you're insuring. This, typically, relies on a number of other group-style risk controls. Typically, you'd see a fairly strong pre-existing condition clause with this. While you're providing coverage on a guaranteed-issue basis, usually, there's a limit as to how much coverage you're willing to provide on guaranteed issue. You typically see conservative plan design features and some level of group underwriting.

There are a few individual risk controls. Full medical and financial underwriting would be the most thorough approaches. A step down from that would be simplified underwriting approaches, for which you'd rely on a limited number of health-related questions that would be asked on an evidence-of-insurability or enrollment form. Claim design certainly is important on an individual basis, as well.

As I start to talk in more detail about using minimum participation as your primary risk control, I will describe a few of its strengths. The biggest strength is that, since you're providing coverage on a guaranteed-issue basis, it seems to be a fairly simple process (if you hit your participation target). Since it's so simple, it's fairly common, at least with group products. If you think back to what I described as the ideal characteristics of the controls that you want to use, I think that this one should get good marks for not being too onerous. Whenever enrollment conditions are good on a particular case, I have had reasonably favorable results from a participation standpoint. If your enrollment conditions are good, this is a reasonably robust approach. Unfortunately, enrollment conditions aren't always good on all cases. If you're going to use this approach, you need to try to understand when the

enrollment conditions will be good, and then you'll be able to hit your participation targets.

Of course, this approach has a number of weaknesses. The biggest weakness is that there are no great fallback options if it doesn't work and your participation comes in too low. There are number of options, but I don't think that any of them are great; you're going to be faced with a fair amount of dissatisfaction if you need to fall back on any of these. You could try to decline the case, underwrite the entire group on an individual basis or change the plan design of the rates. None of these are going to be received terribly well. If there's a reasonable chance that you might not hit your participation target, and the enrollment conditions aren't particularly good, this approach turns out not to be very robust.

A second weakness is that this relies on some level of pre-existing condition protection to work well. While the pre-existing condition clauses are a strong risk control, they have a number of shortcomings. They expire. You only have a limited period of time during which they give you protection, and there are a number of other important risk characteristics that aren't screened directly by using a pre-existing condition clause. The one that immediately comes to my mind is obesity risk, which is becoming an important risk characteristic in the United States for disability products. Since there are a number of shortcomings with this, it's important to understand what's going to lend itself to a good enrollment and hitting your participation targets, because you need to minimize the chances that your participation is going to come in too low.

What are some of the key factors to having a good enrollment and hitting your targets? The first one is the actual method used to do the enrollment. In general, methods that provide for greater direct contact with employees are going to lend themselves to being more successful, since you're going to be able to do a better job of explaining the product. These are a few commonly used approaches. The one with which I'm most familiar would be a one-on-one approach. An enroller sits down with most of the employees and tries to explain the product. It has a strong level of direct contact, but it is fairly costly to implement. You can contrast this against a group-meeting approach, in which you sit down with groups of employees at the same time. This is a bit more efficient from a cost standpoint, but has the drawback of having less direct contact.

The actual track record of the enroller that you're using is important. There are going to be some enrollers who are going to be better than others. Understand which enrollers are good and rely on those as much as possible. The commitment that the employer has for the product is important. For an enrollment to work well, you're relying on adequate access to employees to make sure that you do a good job of explaining the product and conducting your enrollment. The employer needs to be supportive enough to grant you the access that you need to do this well. In most situations, this is the case. Unfortunately, there are some situations in which

this doesn't turn out to be the case. Be able to identify when this is going to happen.

It is important to know if there are other products being enrolled at the same time. You need to be aware that during an enrollment, there's only a limited amount of time available to explain your product and its benefit to employees, and employees only have a limited number of dollars to spend. For example, if you're trying to enroll a critical illness, a life and a disability product all at the same time, you may need to be prepared.

Consider the case size. With larger cases, the enrollment process tends to be more complicated since you need to see more people. There may be multiple sites that need to be visited, and it can be distributed fairly well.

To manage this approach, you need strong enrollment conditions. Similar to other types of risk management, you need to do a good job of tracking your results to make sure that you hit your participation targets. You need to emphasize exactly how important it is that you track what your participation is. You need to do a good job of making sure that the quality of the data that you're capturing is good, that you clearly define all of the data elements that you're going to need and that it's reasonably accurate. Once you capture it, you want to check each case that comes in to make sure that it meets the minimum requirement. Track it by segment so that you can understand in what areas you are going to do well. What areas are going to give you problems? That can give you a better understanding of how things are going.

Finally, it's not only important to monitor it at the time of sale, but also monitor what your participation level looks like over time. There are going to be some employees that are going to lapse their coverage, and that's going to erode your participation level. If you monitor it over time, you can identify when your participation levels start to drop too low and know that it's time to do some re-enrollment.

I'd like to contrast this against a simplified-medical-underwriting approach. With this approach, you're using a limited number of questions on an enrollment or an evidence-of-insurability form. Questions are typically health questions. There can be follow-up questions for additional health information if any of the questions are answered affirmatively. Primarily, you're focusing on making a judgment as to whether or not to issue coverage based on the answers to a limited number of questions. This has a number of strengths. There's a lot less that can go wrong in this approach. You're not relying on spread of risk. You're not hoping for participation to come in at a certain level. If you want to compare this to the minimum-participation approach, it's more robust. Since you're asking some health questions, you may be able to produce a better risk that may be more priceable. You're not relying on a pre-existing condition clause, since most of the pre-existing conditions would be screened by your health questions. You're able to address

some of the other health risk factors that aren't covered by a pre-existing condition clause—most notably, obesity.

Of course, this approach has some weaknesses compared to the minimum-participation approach. It's a lot more onerous. Things that are more onerous tend to run the risk of being less accepted. It's less common, at least with group products. It requires a lot more effort to do up front, since you need to collect your applications, have somebody review them all and then decide what you want to do with each employee. If you have a lot of follow-up questions in your process, asking for more information tends to lengthen the amount of time that it takes for you to issue coverage. If this process starts to take too much time, you may run the risk of frustrating the employees or the employer or even the broker. It's not as thorough as a full-medical-underwriting approach would be.

If you're going to use this approach, there are a few questions that you want to ask yourself. What will be the most effective questions to ask, and how many do you want to ask? You need to identify what types of claims you should be most concerned with and make sure to include questions that are going to do the best job of screening those. Since you're asking a limited number of questions, you need to focus on the most important ones. As I mentioned, height and weight are becoming more important. You want to consider how complex you want the enrollment process to be. In general, if you can streamline it, that helps. You want to consider how you are going to handle situations in which somebody answers in the affirmative to one of the questions. Do you want to emphasize simple questions, or do you want to have a lot of follow-up with requests for more information? You can do a better job of evaluating the risk with requests for more information, but it makes the overall process more complex.

To give you a feel for what kind of an impact you might be able to have with a simplified-medical-underwriting approach, I looked at some of the enrollment data that my company received when we've used this approach. We found that the decline rates were on the order of 25 percent. I'm not sure that the 25 percent itself is a solid benchmark to use, since this is going to vary by the type of product you have, the questions that you're asking and the market that you're in. The one thing that it does tell you is that you can screen a number of less healthy risks by using this approach. The chart in Flores, page 6, slide 1, shows the distribution of the reasons why coverage was declined. You can see that the top two are weight-related reasons. It shows the importance of including a height/weight question. You need to remember that that's a risk that isn't screened by a pre-existing condition clause. It gives you an extra amount of protection that you otherwise wouldn't have.

Before I finish, I want to mention a couple of things that tend to come up in practice that are special cases. First are the takeover cases. Typically, you may be required to grandfather prior coverage. On those cases it's a big advantage, since you know what the prior participation and the prior experience was on the case. As

you look at those, you should keep in mind that if your new plan design is a lot different or if the new rates are going to be a lot higher than the previous ones, you may not get the same participation on takeover, and so the experience may not be the same. You should be aware of that. Similarly, on renewals, if you're increasing rates on cases that are performing poorly, you can open up another round of adverse selection, and your experience can deteriorate. You need to factor that into your strategies and programs. If you can emphasize things that aren't purely rate-driven, that can be beneficial. Finally, you should be aware of any special requirements that states have that would limit any of the controls that you're seeking to use.

It's important to manage risk well for a product to be successful. While there are a lot of controls that you can use and different choices you have to make as to which are the best ones, it helps to understand the strengths and the weaknesses of each and what's required for the ones that you're going to use.

MR. DOUGLAS W. TAYLOR: I'm going to talk about the fully underwritten business. I'll concentrate more on the individual disability insurance (DI) issue. I'm going to give a high-level idea of what the impact of adverse selection can mean to a company, products and rates, the underwriting process, how you should monitor things, what you should do when things go bad and some other considerations that have factored into fully underwritten business or risk selection, in general, over the past couple of years.

The 1990s had a lot of bad times and a lot of improving times, but the DI industry has seen improved incidence and fairly stable termination rate experience. However, we are dealing with more severe claims as a result of lower incidence. The SOA's Individual Disability Experience Committee Report confirms the troubled segments that the industry has known about and been dealing with over the past several years and provides new information on what's going on in the industry.

According to the Life Insurance Marketing and Research Association's market share survey, the industry has shrunk quite a bit. In 1992, there were 300 different individual disability income writers. Now there are 26, and the top seven control 75 percent of the market share. There has been a lot of consolidation and a lot of exiting. The industry itself is shrinking on a sales basis. It's a tough business to be in.

It doesn't take much to mess things up. When we look at the Society report, our incidence rates on average for our Class 1 (which would be the 5A, 4A, 3A) would be roughly four claims per thousand people per year. That is a very low incidence with high impact. If the incidence climbs just by one per thousand (a 25 percent increase), that does a lot to your financials. The average length of claim is two to three years. Disability reserve for a new claim could be $100,000, easily. That can climb up to the millions of dollars if you get high-indemnity incidences. It doesn't

take much to mess up your results. Risk selection is very important in this type of business.

It all starts with products and rates. Your rates have to be priced to reflect the risk that you're taking on. You need to pay enough compensation to attract people to sell DI. You need to make sure that you are spending enough to cover your risk management expenses. You can't shortchange those areas. On the other hand, you have to be aware that you have to deal with minimum loss ratio requirements. Pricing needs a balance to make sure that you've got enough to cover everything.

There has been tightening in contracts over the past several years, but the tide might be turning a little. I'm seeing some liberalization in the industry, slipping back to old times. It's not just in contracts; things like issue and participation limits are starting to creep back.

In terms of the underwriting process, you need to be aware of several considerations. Actuaries often are accused of driving a car by looking in the rear view mirror. Underwriters are somewhat guilty of that, as well. Underwriters like to look back at individual history. They need to analyze not just how much you are making today, but how stable your income history has been. How stable has your occupational history been? Are you jumping around from job to job? Are you in work? Out of work? If you think of the noncancelable product, it was designed for the 1950s when people got out of college, worked in the same job for 50 years and retired from the same place. That was a very stable career. How many of you have led that career today?

Consider occupational history. What are you doing today? What are the duties within your job? Are you doing a lot of sitting and working at your desk, or is there a lot of physical activity? What has the history of your occupation been?

You need to look at the medical side of things. Examine not just your medical history, but your family medical history or the things that have happened that may impact you in the future. Underwriters need to think about what can happen to you going forward.

Motivation is very hard to try to gauge. Ultimately, that is the underwriter's judgment call. How motivated are you to work? How motivated are you to stay disabled? They have to get that information from what they see in your financial, occupational and medical history. They have to make a judgment call in terms of what your motivation will be.

You have to consider the producer. The producer plays a big part not only in field underwriting—it's not just their face-to-face reaction with individual clients—but in how they generally deal with clients and how trustworthy they are to the home office people.

Completed applications are very important for a couple of reasons. Underwriters need to get as much information as they can, and they rely on producers to get that for them. The more information underwriters have, the better decisions they can make. If applications are not fully completed, they have to go back and ask for more information. That delays things. That frustrates producers and frustrates consumers and can cause them to leave for another product.

Face-to-face interaction is very important. It's tough to tell what somebody's medical condition might be like over the phone or on a piece of paper. What are the person's living conditions? There are a lot of visual signals that we rely on the producer to pick up for us. DI is a tough business to underwrite, particularly compared to other choices, like life or annuities. There's always a balance between making it easier for the producer to do business with us and maintaining our risk management. We need to make sure that we're getting everything that we need to underwrite the business properly.

You could bring the underwriting process inside to the home office. The office can conduct phone interviews if there are details that producers didn't get on applications or if underwriters need a little more information. There is rather high wastage. There are a lot of declines for various reasons. There's a lot of substandard business. When all is said and done, half of the stuff that may come in the door may go out the door differently—whether it gets declined, the consumer and/or producer gets frustrated waiting for things to happen or the case gets rated substandard. It's always a tough sell for the producers, knowing that they have a one-in-two chance that they will have to go back to the client and give different news than what was applied for. But having a disability product is a privilege; it's not a right. We don't give it to everybody, or there would be even fewer than 26 companies left.

I've covered products for individuals. There are business products that come with their own sets of rules, whether it's business overhead expenses or buy/sell products. There's also coverage for retirement protection and other things that affect underwriting. These products cover not just when you buy the policy, but as you progress in your career and, hopefully, your income is going up, that leads to needing to upgrade your coverage, adding benefits to it, making changes to the contract and adding monthly indemnity and other features to your contract to align with your changing income needs.

Once the stuff is underwritten, we have to keep an eye on it to make sure that it's doing what we thought it was going to do. In terms of lead indicators, we have underwriters audit what other underwriters do, to make sure that they're getting all of the proper information and they're making the right decisions. If things aren't going the way the chief underwriters like, training needs to take place to try to make sure that people stay in line with the underwriting guidelines. Another lead indicator we look at is contestable claims. Anything that happens in the first two years is fair game to examine whether this policy should have been issued in the

first place. There are always audits of all the contestable claims, just to make sure that they are all legitimate and nothing more could have been done at the time of underwriting. This can lead to specific actions on specific claims or more general guidelines that need to be changed.

You can examine lag indicators and experience analysis. Look at loss ratios, claim incidence and claim termination. There are different measures that you can use to check how your experience is doing relative to the industry. Profit studies are another way of looking at how the business is performing, by throwing in assumptions for morbidity and other things. After the fact, how did we do compared to pricing?

After you've done the monitoring, it's time to take corrective actions if necessary. If you're in the noncancelable business, or, to a lesser extent, in guaranteed renewable, you have to get it right up front. You can't change anything once the product is issued. If you price things incorrectly or misjudge how your underwriting is going to work relative to pricing, it's going to catch up to you sooner or later. For guaranteed renewable, you can change the rates going forward, but that's not an easy task to do because of regulatory issues.

There are actions that you can do for the in-force block, but you are limited. You always can tighten up the claims department, but I don't know how far that can go, and you have to pay fair claims. Maybe there are things that you can do to get claimants back to work or on the right course of treatment more quickly. If you're in a mutual company, you can make dividend adjustments, but those may only go so far, and regulators can step in to make sure that between claims and dividends, you're giving fair value to the claimants. You can modify issue and participation limits for coverages going forward so that certain occupations may not be able to get as much coverage as they might otherwise have been able to get earlier. We've learned from our mistakes. We'll have to correct them on new business going forward, whether it's repricing or product changes or other underwriting changes. Again, that affects new business going forward. You're stuck with the business that you've already issued.

Other issues have come up over the past few years that have factored into the whole risk selection process. Sarbanes-Oxley is one of my favorite topics. When we went through our assessment, we included the underwriting process. While you can't say that underwriting this policy leads to "x" amount of financial impact tomorrow, we know that if things deviate from underwriting practices, it's going to catch up sooner or later. It's going to hit your reserve assumptions, whether it's through reserve strengthening or cash-flow testing, etc. We made sure that we included the underwriting process within our Sarbanes-Oxley assessment because it affects us sooner or later.

Enterprise risk management is something that has become more prevalent in our company. Diversify risk; don't put all of your eggs in one basket. One mistake that

the industry has made in the past 10 to 20 years is overdoing it in certain occupations. When those occupations go bad, it drags down the entire block of business. In some cases, it forced entire companies to pull out of the business. As I mentioned earlier, we went from 300 writers down to 26 writers. Within our company, we look at both geographical and occupational risk to make sure that we've diversified enough. The geographical risk is more in line with total company risk. For example, if this building falls down, what does that do to us from a life insurance, disability, annuity and occupational perspective?

You must always keep an eye on regulation. The most recent changes are in California, where there's some questionable interpretation of language in the contracts that will make it tougher for companies to do business there if things go through. There's always something that comes up with regulation that companies need to be aware of and factor into their risk selection process.

In closing, it's a full-time business, as many have discovered the hard way and have exited it. There is not a lot of room for error. One extra claim per thousand can blow up your results. There are large consequences to a small number of events.

FROM THE FLOOR: On the individual disability side, when looking at your issue and participation limits and considering the level at which those should be, what are some of the factors to be considered, specifically in terms of adverse selection, when trying to be competitive and making sure that you're not putting yourself in a riskier spot than you want to be?

MR. TAYLOR: You mentioned that the competitive aspect is important. We'll look at the replacement ratios. What percentage of income do we think is going to be replaced? This is a judgment call in terms of how much we can replace but still leave sufficient gap between what they're making and what they could be getting from disability. Is there something to motivate people to return to work?