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Managed Disability—The Wave of the Future?

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Moderator: THOMAS R. CORCORAN
Panelists: JOHN D. DAWSON
TED HASLAM†
JACALYN REINBERG‡

Recorder: THOMAS R. CORCORAN

Summary: "Managed Disability" may become the dominant disability product in the near future; however, managed disability is also used to describe many different approaches.

Mr. Thomas R. Corcoran: We have a panel of very distinguished speakers who will be talking about different aspects of managed disability.

I'm the moderator of the session, and I'm a consulting actuary with Tillinghast—Towers Perrin. Our first speaker will be John Dawson, who is vice president and actuary at Willis Corroon. John will speak about the brokerage market, which is the 200–2,000 life market; he will present some perspectives from brokers and their clients and what the marketplace thinks of managed disability. Our second speaker will be Ted Haslam. Ted is a vice president at Met DisAbility in Atlanta. He deals in the large case market—5,000 lives and up—and he will talk about some of the original concepts of managed disability and will present two case studies with quantitative data, especially for us actuaries. He also will speak about total lost time management. Jacalyn Reinberg, is assistant vice president at CIGNA Integrated Disability Services in Philadelphia.

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†Mr. Haslam, not a member of the Society, is Vice President at Met DisAbility in Atlanta, GA.

‡Ms. Reinberg, not a member of the Society, is Assistant Vice President at CIGNA Integrated Disability Services in Philadelphia, PA.

She will talk about an integrated 24-hour model of managed disability and will provide us with comments on challenges that the integrated market and product present to actuaries.

Mr. John D. Dawson: I'm a vice president and actuary with Willis Corroon Corporation. Willis Corroon is roughly the fifth largest insurance intermediary and risk management consulting firm in the world. I'm going to share my own perspectives, and the perspectives of some of the Willis Corroon brokers that I work with.

For the really big employers, I believe it's clear that managed disability makes a lot of sense. I have been asked to address the middle market—employers with roughly 200–2,000 lives. I believe my comments will help you see that the value of managed disability is still somewhat fuzzy for employers in the middle market.

Before joining Willis Corroon about two-and-a-half years ago, I spent 11 years working for insurance companies, and helping them bring products to the marketplace. Joining Willis Corroon represented a shift in my focus. Instead of bringing products to the marketplace, I'm now helping employers deal with those products and make decisions about products.

I will share with you what I see as the traditional product offering. Then I will outline what we like to talk about with the middle market employers. I call that a proactive disability management model. Then I'm going to present a loss-ratio problem for you to think about. Finally, I'll conclude with some personal observations.

Why do employers offer short-term and long-term disability? What are they really looking for?

- Employers buy disability benefits for many different reasons. Most important is the need to attract and retain quality employees. That's why employers offer employee benefits. Insurance companies need to recognize that when we're developing products, our clients, who are employers, will use those products to attract and retain quality employees.
- And once they have those employees, they want to make sure those employees are working proficiently for them, that those employees are able to do the job functions that they were hired to do. A good disability benefit program should play a role in corporate productivity.
- The employers want to have a product that has a sound and sensible design and that is simple to explain. They don't need something that's complicated that has

lots of bells and whistles. They want something that their employees are going to appreciate because, once again, they want to attract and retain employees.

- The product has to be competitively priced. Price becomes the more dominant decision factor as we look at smaller and smaller employers. The clients that I work with want a long-term partnership. They're not in this just for the rate; they want to have a company that's going to help them manage their disability experience over the long haul, but make no mistake, cost is important.
- Now what do employees want? Employees want personal financial security. I will say something that's kind of provocative and I hope that some people will address this during the question and answer session. From a personal perspective, if I get disabled and I truly can't work, why can't I have 100% of my income replaced?

That's what employees really want. I know there are good reasons why we don't give people 100% income replacement, but I believe that we, as an insurance industry, have somewhat failed to meet the real personal financial security need.

- Employees want professionals who will guide them through the system, make sure they're getting the right kind of medical care and make sure that they get all the benefits that they really have coming.
- Employees want to have a benefit design they can understand. I recently had lunch with a friend who was telling me about an incident where he picked up an old piano and poked a nail through his hand. He was going on and on about all the things he went through. His story was really a good one. But the best part was that his disability policy gave him money. He told me, "I'm not complaining, but I really don't know why they did that. Clearly, I was not disabled!" That benefit really had no value at the point of sale.
- Employees want an adequate benefit level that provides financial security.
- Employees want to make sure that when they go to the doctor the right thing is happening. People tend to trust their own doctors, but when they're really disabled, they want to know that somebody else is looking out for them.

Most employees who become disabled really do want to get back to work. That's a basic assumption that we really should not forget.

So what do we, as an insurance industry, do to meet these challenges? What does the employer want and what does the employee want? Here is my view of a traditional disability benefit program approach:

- We start out with a basic benefit design that is going to replace 50% or 60% or sometimes 70% of income.
- Then we have a lot of marketing bells and whistles, because the marketing people say my product might be a little bit more expensive, I must be able to go to the employer and tell him that it's different.
- When there is a claim, the focus traditionally has been on figuring out a way to either deny the benefits or terminate the claim as quickly as possible. The buying public often views the traditional claim manager's job as having to avoid paying benefits.
- We have to manage expenses very tightly in order to be profitable.
- We must aggressively price the products if we expect to sell anything, because the disability marketplace is a very competitive, price-sensitive marketplace.

That's the traditional approach. Here is what I like to see from a disability insurer.

- Partnership. I like an insurer that says, "I want to partner with the employer, and I like to work with employers that want to partner with me."

Now if we're talking about a 30-life group or even a 200-life group, that employer-insurer partnership isn't going to be all that real because the likelihood that we're actually going to have a claim is pretty low. So, in reality, the employer-insurer partnership might not be all that important in some cases.

- Benefit Design. We need to have a sound benefit design that's well structured. Instead of bells and whistles, the design provides tools that enable the claims manager and disabled employee to work together. These tools need to be part of a well-thought-out disability management program.
- Claims Manager. The claims manager shouldn't be seen as the bad guy. The claims manager should be seen as the advocate for the disabled employee. I like insurers whose claims managers call up newly disabled employees and say, "I'm on your side. I understand that you're hurting, and I want to make sure you get all the benefits you have coming—not only from our insurance company, but

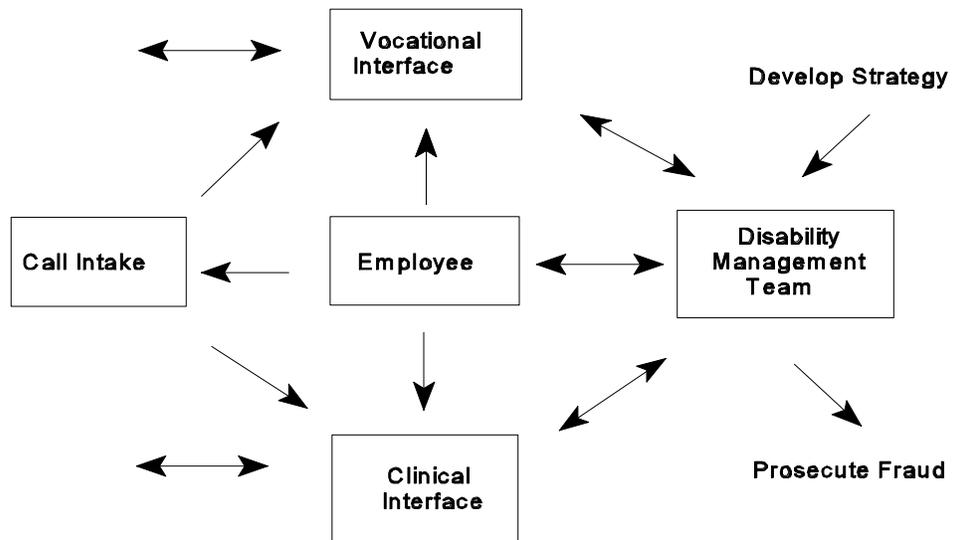
from Social Security and any other programs that you might have available to you."

The claims manager should make it clear to the employees that they will not receive benefits if they are not disabled.

- Expense Management. I believe expense management is always going to be important. There is just no substitute for solid expense management.
- Sound Pricing. Instead of aggressive pricing, I like to see sound pricing. I would rather give a client a rate that might be a little bit higher than another rate that we cannot count on. I believe it is irresponsible to set prices at a level that you cannot make money at.

I like to provide a picture to try to explain what I think proactive claims management ought to look like (Chart 1).

CHART 1
A PROACTIVE CLAIM MANAGEMENT SCHEMATIC



I've put the employee in the middle of this chart; the employee is disabled. The employee contacts "call intake." That could be an 800 number or it could be a claim form or whatever, but somehow the insurance company needs to know when a disability occurs.

Call intake then contacts the clinical professionals on the disability management team. They provide the disabled employee's name and the attending physician's name. The clinicians contact the attending physician and obtain diagnosis and treatment information.

Call intake also contacts the vocational professionals on the team. They provide the name of the disabled employee and the name of the supervisor. The vocational professionals contact the supervisor and obtain information about the disabled employee's functional job requirements.

This information is then brought together to make an initial determination as to whether the employee is disabled under the definition of the policy. If not, the claim is denied and the denial is explained to the employee. However, if the claim is approved, the clinicians begin working with the attending physician to develop an appropriate treatment program aimed at returning the worker to functional capacity. The vocational professionals begin working with the employer to develop a strategy for returning the disabled employee back to work, to the extent possible.

A picture like this is really helpful, because a lot of employers in this marketplace have never really viewed disability as anything more than a commodity. It's an insurance product—somebody gets disabled and benefits get paid. Clearly, there is a lot more to it.

Now for a little problem that you can think about. If you're working in the very large employer market, you're probably not going to have to deal with this. But if you're working in the middle market, with employers that have roughly 200–2,000 lives, there's an interesting dilemma.

Let's suppose you have a traditional disability program. The expected claims for a particular group is \$130,000, expenses will be about \$60,000 and we're expecting to make about \$10,000 in profit. (Note: These numbers may not represent actual costs of any insured group or insurance company.) The loss ratio can be calculated as follows:

$$\begin{aligned} \text{Loss Ratio} &= \frac{\text{Claims}}{\text{Claims} + \text{Expense} + \text{Profit}} \\ \text{Loss Ratio} &= \frac{\$130,000}{\$130,000 + \$60,000 + \$10,000} \\ &= 65\% \end{aligned}$$

Now you decide to implement a managed disability program. Let's also suppose you really do have a significant effect on claims by reducing them to \$100,000. But, in order to do that, you need to hire some additional vocational and clinical professions, significantly raising the expense component by \$30,000. In effect, we have not changed the overall cost, but we have shifted some of the cost from claims to administration. Let's take a look at what happens to our loss ratio calculation:

$$\begin{aligned} \text{Loss Ratio} &= \frac{\text{Claims}}{\text{Claims} + \text{Expense} + \text{Profit}} \\ \text{Loss Ratio} &= \frac{\$100,000}{\$100,000 + \$90,000 + \$10,000} \\ &= 50\% \end{aligned}$$

The loss ratio drops from 65% to 50%. An employer who may be used to seeing a 65% loss ratio may expect a premium reduction when the loss ratio decreases to 50%. However, under this set of assumptions, you clearly cannot afford to do that.

What is going to happen is that an unscrupulous broker will come in and say to the employer, "Your claims are only \$100,000. My underwriters will write this for a whole lot less than \$200,000." You lose the case to the cheaper policy and the employer's claims creep right back up to \$130,000.

So the real dilemma is, how do you make the business stick if your cost structure changes your loss-ratio calculation? You've done the right thing—you brought claims down. But somebody else is likely to misconstrue the information and take the business away from you. I will conclude with a couple of observations.

Some employers want their disabled employees back to work as soon as possible. Other employers assume from day one that a disabled employee is a lazy employee and they don't want them back on the payroll. Obviously, managed disability works better when the employer wants disabled employees back in the workplace.

Price in the middle market continues to be key. I'd like to see more managed disability. To be effective, though, it really has to lower cost. Otherwise, it's really not going to work.

I firmly believe that managed disability holds future promise for the middle market. Some carriers are currently delivering aspects of managed disability. I look to the larger employer marketplace to further develop components of managed disability

and make these things work. Those that do will trickle down into the middle market. I think it's going to take a little bit more time.

Mr. Ted Haslam: I am delighted to be here, and the topic I'll talk about concerns managed disability. There are two parts to this that I'll make reference to. First of all, I'm with Met Life, and while I enjoyed the introduction saying we're in the 5,000 and over life market, we actually go down to two lives. In talking about managed disability, we're going to look at two elements of it. One is to give you some fundamental basics, for those of you who are probably confused because everyone talks about it and not everybody does it. Second, I have two examples of actual cases with some results that have come from those, and I'll share that information with you also.

The first thing we have is the definition of managed disability. In the purest way of looking at it, it's how do you apply managed care principles and activities to all aspects of disability, and what we mean by that is very simple. In 1989–90, some of us left the managed care world and started looking at disability. We thought that there were a number of attributes that applied to disability that were being applied in the medical area. We didn't do this to make everybody's life a living hell, which is what many of you may think we have done. We actually did it to try to do two things: one was to reduce incidence and the other was to try to improve the bottom line.

There are a couple of principles that are routinely applied when you talk about managed disability. If you're saying this to the marketplace or to actuarial people, we really have to make sure that we understand what we are talking about. Early intervention in the episode is fundamental. The history in disability has been that many times we did not see a long-term-disability case until it was just about to go into long-term disability. Six months had gone by, and what we saw was that people's minds had already been made up. They were disabled at that point; for six months they had been living like they were disabled, their family thought they were disabled, and their employer thought they were disabled. They believed they were disabled, and we made them prove they were disabled in order to get benefits. At that time, we said, "Congratulations and welcome to long-term disability. We want you to voluntarily go into a rehabilitation program." So the first principle was to try to get early intervention in the episode, and take it down from six months to about eight days. The idea was to find out what was happening early on in order to shape what was going happen.

The second factor was reduction of contractual barriers. In many contracts you have to prove you're totally disabled in order to be able to get a long-term disability benefit, and you have to go through many hoops. You have to be incapable of doing any work whatsoever. What we saw was that you could refine some of those

beliefs by saying, "Disability doesn't have to be total in order for you to get some payment, you can work part of the time." Some people had chronic disabilities, such as arthritis, etc., where their ability to do things was gradually diminishing and it was going to take them a period of time to get better. So the concept of partial work was still going to be allowed. Similarly, if they had some sort of catastrophe, such as a stroke, they could return to work part time. But many old contracts were built in with restrictions that prevented them from having part-time work. We still have contracts with some employers that prevent part-time work—a person has to be 100% able to do their job before they can go back to work or else they're still considered totally disabled.

Third, one had to analyze the process of case management. Things have changed so rapidly, but six years ago was really a stamp-and-pay operation in many cases, with a referral off to rehabilitation and to Social Security at some point. But they didn't have a concept of case manager, someone who played a major role and who pulled the various things together, who talked with the doctor and talked with the nurses, talked with the employee, talked with the employer, talked with rehabilitation, and brought it together to make sure that any conflicts were resolved and the person would go back to work sooner.

The fourth thing is telephonic communication. Shockingly, in 1990, virtually no one was using the telephone to talk about disability claims. It was a paper system. You'd swear we all owned parts of Georgia Pacific. Stacks of paper were being mailed out, and you waited for responses to come back in. If you were waiting for six months for something to happen, you didn't care how long it took for you to get it back. When we started talking about eight days, you started saying, "Let's get rid of the paper, what's all this technology about, how can we start using some of that technology to put it back together again."

When I talk about comanagement, we found that people thought of short-term disability and long-term disability as if they were two totally disparate things. When you looked at it, though, anything that become a long-term disability claim had to become a short-term disability claim first, but most of us didn't even have them in the same city let alone in the same office. So when we talk about comanagement now, people who are doing managed disability do short-term disability, long-term disability, and state mandated disability for those states where it's needed in the same claim unit. There is preferably one information system. That is what managed disability was designed to be, and that's what it is with telephonic information being collected, entered into a computer system, faxes going out and as we see, we're moving towards the Internet. Return to work was the best cost-containment mechanism that we could think of. If you get someone back to work, they probably

aren't spending money on their health or on other things that are disability related. So it was a very simple set of principles that we started off with.

What other ones could be applied? These are the ones for you to look forward to as we go forward. The first is the medical network. One of the problems is that many doctors do not understand the return-to-work concept as being something that they really should be looking at when they're doing medical care. Their customer is the person who is sick, not feeling well, unable to perform, unable to function, and there's a lot of pressure on that doctor to give them some sort of justification to stay out of work. As we looked at dealing with more managed care networks, we found the most medically efficient form of medicine is when someone goes back to work because they're not spending on the medical side.

One of the things to look forward to also (since stress claims are so high, and mental and nervous claims had been the most rapidly growing) is trying to convince psychiatrists that returning people to work is the best thing for them. It's an enormous challenge that I'm sure Jackie will be talking about. Trying to change a doctor's point of view is not an easy thing to do, but it certainly is one of those things that you have to start doing. Make better use of networks in the management of disabilities and get them back to work.

The second network is the information network, and it's going to become part of this rapid communication we're all seeing.

Data transfer is becoming more critical. We do not have a similar format for submitting claims. We don't have similar definitions between contracts even within one company. I'm sure you've all seen where different divisions of one company will have different definitions for various things. Increasingly, as companies start to out-source and downsize, we are finding that there's a need for similar data and similar definitions. People are asking for better reports, more reports, and more data.

Integration with other benefits is happening, not as quickly as some might like and not as fully as some wish. Jackie will talk to that when she discusses the integration with workers compensation and medical and a shared philosophy. We find that we can price a managed disability program if we have assumptions that hold. We find that we can get a shared philosophy with the benefits people and that they will say, "Yes, we'll take them back to work. Yes, we will do the following things. Yes, we will train them. Yes, we will communicate. Yes, we will do all of those things." What we find, though, is that despite the cooperation of the benefits department you may not be in sync with the entire organization's philosophy. The line manager responsible for production doesn't want that person back to work unless they're at 100%.

In fact, one of the biggest examples is Disney. Employees are wandering around these hotels and the theme parks. They don't want to have them coming back when they can only do half their job; they want them to be able to do their whole job. So while the benefits people may say one thing, and that's what we're pricing it for, you have to make sure the line managers and the organization itself have the same philosophy and demonstrate that they're doing it. If not, you'll get caught in the problem of pricing as if you were getting all these good things to reduce the total cost of disability and not getting the reduction, and then you have bad loss-ratio problems.

With regard to the case studies, both are large clients where we did not have the data prior to them becoming a client for us. We talked conceptually about managed disability and what it was, we shared the logic and we showed them how it should work. We put all those attributes together and they said, OK, let's take a shot at it and let's see how it's going to play off on our short-term disabilities. We said it is really designed to reduce the incidence of your long-term disabilities rather than your short-term disabilities. They pointed out to us very accurately that if the principles apply to long-term disability, they should also apply to short-term disability and that the durations should in fact shorten up. We said, fine, let's do it and let's measure this as we go along. Let's discuss the first case study.

This is a large retail company with people working at 1,400 different locations. Prior to us putting in this program, their average duration was 53 days. After we had gone through this for two years, we asked what in fact was the duration before we started doing this. That's when they told us 53 days. The average durations after the first year was 41 days, the second year was 40 days. There were 18,000 employees. Their annual savings was estimated at being \$3.5 million.

What we did was get rid of all paper. Everything was telephonically coming into an 800 number. We used an external vendor who took that in and who would fax over the information to us, and we would have our case managers call the people and start that process after the eighth day. Many of them were very quick and we were paying their short-term disability claims very quickly. Stamp-and-pay and get those things out with the other ones. We were even able to manage the pregnancies appropriately. It was interesting because they had a concept of pregnancy leave. They called it maternity leave, which was like an entitlement program, and we asked if they wanted this to be an entitlement program or a benefit? They said, it was actually a benefit, not an entitlement program. We said, OK, let them have as much time off as they want for the entitlement that they think that they have coming, but the benefit is how long, given their job, they should in fact be off work. So if they can come back to work and actually perform in two weeks but you want to give them six, that's fine, but it's not a cost of your disability for that. They

basically left it up to their employees, and that's part of the savings that they got here.

The second case study is a large communications company. What we did in this one was interesting, because they didn't even know what their number was beforehand. They got a group of actuarial folks outside of our company to start sifting through their data in order to figure out exactly what their durations had been. They did not have the best data (even some of the big companies don't have very good data), but they did manage to come up with what they were looking for. In their case, it was 55 days that they had beforehand, and they had 35,000 employees. It's a much bigger case, but not as difficult to implement because we didn't have 1,400 different locations that we had to set up for and educate. In this one, there were only nine different locations that we were looking at. They went down to 37 days and saved \$2.8 million per year.

The actuarial folks that I work with have told me that there are a whole bunch of caveats to put around this, but I'm not going to bother with the caveats. What we're finding with managed disability is that the time when you do it evolves. In 1990, the North American Free Trade Agreement didn't even exist. Right now you have to take each company and assess where they are and what is happening with them before you try to figure out what the savings are going to be. I predict, as we go further down the road, that the savings you're going to see coming from the managed disability part of the total integrated disability is, in fact, going to start shrinking just like in managed health care. In applying managed care, if somebody was already partially managed, the savings were less. I think we're going to see the same things happening here that have to do with managed disability over time, but the principles continue to apply, and there's a vast number of people who don't have it. It has been in the large cases rather than in the smaller case market so far. In the smaller cases, you apply the principles to your block and hope your reserves are going to go down rather than by an individual company.

Ms. Jacalyn Reinberg: I'm going to talk to you about integrated disability services. I believe your role, as actuaries, like the world, is changing very rapidly, particularly in terms of what's happening in disability. I'll spend some time talking conceptually about integrated disability and what we're doing at CIGNA, and also what opportunities and challenges the emergence of 24-hour provides for you.

Let's talk about what 24-hour coverage is, because you hear a variety of different descriptions. There are multiple definitions of 24-hour coverage. Some of the more popular definitions are a single policy, applying disability management to workers' compensation, applying managed care to workers' compensation or coordinating administrative processes. CIGNA's definition of 24-hour coverage is the integration

of health care delivery for both occupational and nonoccupational disability management for both occupational and nonoccupational injuries and illnesses, information and data analysis, and wellness and safety. Most people would say that those are probably the right components. They might use a different word or two, but basically most folks in the marketplace and our customers agree that those are the right components of 24-hour coverage.

Why is health care integration difficult, and why am I talking about integrated disability instead of 24-hour coverage? I'd like to spend a moment talking about that, because I think it's really important. First, health care delivery is localized. It's tough enough to find a health plan that crosses Orlando, let alone the same one that will serve you in Miami. It just doesn't happen; it tends to be a very localized network.

Second, employees have personal preferences. If I take my spouse's plan at his company, it is very difficult to manage me if I have a disability claim because I'm not in the health plan. People want choice, autonomy, and control.

Third, delivery mechanisms vary. There are more acronyms than Carter has liver pills, i.e., individual practice associations (IPAs), preferred provider organization (PPOs), health maintenance organization (HMOs), etc. The way in which we deliver care is very complicated. The way doctors are compensated is very different in each mechanism, and that drives the actual outcome. Outcomes are dependent upon delivery systems, how an employee gets reimbursed or pays for health care, the level of care, and how frequently and aggressively people are treated.

Fourth, for the current availability of cost-containment mechanism, there really isn't one entity that owns the entire health care piece. Everybody does his part, but nobody's looking at the entire picture. One of the best examples of this is that years ago insurers had organizations that handled mental health and separate organizations that handled physical health; however, the world doesn't see the body and mind as two distinct parts anymore. We have to start treating people holistically. This is a distinctly different approach which helps explain the need for integration.

There are also statutory variances in workers' compensation with respect to channeling and directing patients. It also can apply to the health care market as well. There are some different opportunities in terms of the setup of the design. So if anybody is telling you 24-hour coverage actually exists effectively today, I think they're full of hooey because it doesn't. We're out there, we see it, we talk about it. There are models that prescribe to it, but when you really start to peel the onion and open it, what you find is it's somebody's own interpretation.

What I'm here to talk about is integrated disability. We opened our integrated disability service center in Irving, Texas in 1996. It's a service delivery model that combines short-term disability, long-term disability and workers' compensation into a single service delivery model. Why did we do it? One was to satisfy market demand. We've heard for a while that this is what customers want and need. Many people talk about 24-hour coverage and for a while, CIGNA had looked at trying to set up 24-hour coverage. We found out that optimally you have four engines—the four components that I talked about. You know a lot of planes run well on three engines and were designed that way for efficiency. Based on that, we took integrated disability out of the hangar with the three components because this was something we could deliver to our customers today. The second reason we started to fly was we wanted to quantify savings and benefits accrued from integration. Third, we wanted to establish best practices, processes, and measurements to learn and leverage from workers' compensation, group disability, and medical management. Fourth, we wanted to become even easier to do business with and create a customer feedback tool that would measure our progress. Fifth, determine the resources, technology, and infrastructure we need to continue to develop and roll out integrated disability services from three states, Texas, Illinois, and Pennsylvania, to a national scale.

Let's talk a little about best practices models. We've learned a few things since we've opened our doors. One of the key lessons we've had is that an effective implementation and communications strategy is critical. I'm not talking about your company's internal one; you need that too, but the important communications strategy is at the customer level. One of the hardest things to accomplish is to continue to try and gain consensus from both the risk and benefit people within an employer organization that are often very disparate and don't talk to each other. When they come for a walk-through in my office, oftentimes it's the first time that risk and benefit folks have even met each other, and there's usually some yelling and screaming at the table. So we try to work through that, since neither side has an appreciation of what the other does. One of the things we've learned that's useful we must help them develop a communication strategy to deliver to all their different constituencies, supervisors and managers, the HR community, and the employees. We utilize a variety of vehicles—letters, refrigerator magnets, or wallet cards—to really help them understand what's in it for them.

When an employee has an impairment or injury that may result in lost time or require treatment for a work-related injury, they call one number to report the incident. In workers' compensation this is often done by the supervisor. We ask the employee to take control and own the process from the initial report. The claim comes in telephonically, and the disability is reported through an 800 number no matter where or when the person is ill or injured. We walk them through a guided

interview. We don't ask them to declare, so they know they will get what they need whether it is compensation or a disability claim. What this does is level-set some expectations across the disability continuum. One, it tells employees that we care about you, and we want to help you return to work. Two, it helps supervisors have one point of contact. Three, it provides providers with one point of contact—what a novel idea. In today's environment, you can have four or five different entities asking you questions about the same employee.

Let's discuss preincident management. In disability today, what happens if I were going to deliver a baby, or if I were going to have carpal tunnel surgery? If you call in about it in advance and, say, "In two weeks, I'm going to have this procedure," the disability carrier will say, "Thank you for calling. Call me when it actually occurs in two weeks." Most people during that time don't make calling their insurance carrier their first priority.

In our environment, we take that information and we call that employee's physician who's doing the carpal tunnel surgery and say, "You know what, Ted is having surgery with you in two weeks. He has a sedentary job. Based on our duration guidelines, he should be able to return to work in four days on a part-time basis and full-time within eight days, and we'd like to work with you to help him return to work." So we level-set expectations upfront with the doctor. We level-set expectations with the employee, and we level-set expectations with the supervisor so they know when they're going to get the employee back. Obviously, we're trying to manage the incident upfront, and this current best practice, often used in worker's compensation, is now applied to nonoccupational disabilities, which changes our ability to actually proactively manage disabilities on a loss-cost basis. Anybody who manages disability claims will tell you that not too many people return to work on Wednesday; everybody returns to work on the first of the month or on Monday.

By managing the duration you're trying to get the optimal return-to-work date because for every day an employee is out, that's dollars out the door for the employer.

We have a cross-pollination of skill-sets in our staff. What that means is that I have one disability claim specialist in my organization who manages all aspects and lines of coverage on that claim from start to finish. They are cross-licensed and cross-trained in both workers' compensation and disability.

Let's say there's an employee who has a workers' compensation claim. Many employers today have very rich benefits, so they'll pay you up to 100% of your earnings by accessing benefits under your short-term disability plan. In today's world, you could have several people, as I had indicated, manage that plan. In our

world, you have one individual who will coordinate those benefits and make sure that everything works together. The employee understands what's happening with his stream of income. The traditional practice creates many issues because in compensation you usually get the claim anywhere from day one to day five. They deny it because they don't believe it arose out of the workplace. So then they send it over to short-term disability (STD) and the STD people say the doctor says it's work related. Well, guess what? We play ping pong, and while we're playing ping pong with the claimant, they go to a lawyer and then you have litigation to contend with. I'm very pleased to say, in the nine months that I've been open, I have not had one worker's compensation litigation case, and that may not be particularly relevant to many disability people. Although its growth rate is fairly low in compensation that's very important in terms of what it drive, because in today's world the litigated cases in compensation drives 90% of the cost.

We set expectations early in our intake process. We define roles and responsibilities for all three constituencies upfront. We have clinical intervention for duration management and return-to-work strategy. We also have a clinical specialist on our team who handles all the medical aspects of the claim, so that provider is being touched once no matter what the benefit stream is. We believe this is very important in terms of facilitating and expediting the process of return-to-work and capturing the information we need at the closest point possible. We have specialty services for loss cost management in addition to what John talked about in terms of Social Security advocacy. Ted talked about rehabilitation. We also have loss prevention and we have special investigative units. We have fraud, an American Dental Association help line and a variety of things to leverage all the loss costs to help them get to the optimal outcomes. So it isn't just the premium that employers save. The real piece, as Ted said, is the lost cost piece—the dollars they actually save on the back-end. We haven't even discussed the indirect costs of disability, like lost productivity, recruitment and training, job morale, etc.

Integrated reporting consulting. We have not created new systems except for an intake system, so we use our mainstream systems for workers' compensation, short- and long-term disability and clinical case management. We have them all fed into one reporting vehicle. We can actually get integrated reporting by an International Classification of Diseases-9th (ICD-9) Revision code. So in today's world, as I bet a lot of you know, we use a variety of different ways to code diagnostics, and most of them are not ICD-9, they are made up codes and even within our own organization, we don't use the same ones for the compensation side as the disability side. We're all going to an ICD-9 base, so it's very important for an employer to find out what's happening with a broken leg. I'm seeing the duration begin to look the same on that broken leg. In compensation, they're back in a week while if it was a nonoccupational disability, they're out four weeks.

We have an intake specialist who acknowledges the claim. They don't make a decision about whether it's compensation or disability. We have three different scripts that have a guided interview process: one for injury, one for illness, and one for pregnancy. We felt that for things like pregnancy, we shouldn't ask them where and when did it happen. We decided that we needed a special guided interview. Our intake system has the ability to do all 50 states workers' compensation to capture the first notice of injury and complete the first report of injury, so we're able to capture that information and send it to either the electronic data interchange (or fax to the appropriate individual. In the states where we are open (Texas, Illinois, and Pennsylvania), it's also required that the physician and the employee in two of those states get those reports of injury as well. To date we have not had any penalties from compensation for lack of compliance. How frequently and how quickly you have to report these things is very stringent. From the intake individual, it's electronically transmitted to our team leader, who looks at it based on case loads and where things are happening and sends it to the appropriate disability claim specialist who gets the claim rolling. The clinical specialist concurrently contacts the provider using her protocols to facilitate a return to work. We use ICMS, which is INTRACORP's proprietary system for duration management. It was built for workers' compensation, which covered about 55% of the diagnostic landscape and we've enhanced it to add about another 25% of nonoccupational diagnostics in five critical areas that we see in disability that are outside of the muscular, skeletal and injury categories. They are cancer, cardiac, respiratory, OB-GYN, and mental and nervous. When the clinician and the disability claim specialist get the information, they actually sit in round-ended cubicles so they can rotate around the edge and actually staff the case and create a strategy and get it going to help that person get back to work.

To review the integration of investigative techniques and to measure our effectiveness, we have one quality review tool and one set of quality and performance standards. When you have three different technical specialties integrating a process, you need to combine the best of each of their specialty tools. We believe this will drive the outcomes that our customers expect to see.

In today's world you can have multiple correspondence from different entities. In our world you'll get a letter that says, "Dear Tom, We are pleased to make you aware of the fact that your short-term disability benefits have been approved. They've been approved as of this date. We're also letting you know your workers' compensation claim has been denied, and this is the way in which you appeal it." Frankly, most employees just want to be paid. The ping pong effect goes away by giving them one set of correspondence that sends a clear consistent message that makes a significant difference. I will not tell you I've gotten to one check, because it hasn't happened yet. We have return-to-work protocols that we use. We have

both rehabilitation people on our team and a Social Security advocate. We have physician advisors attached to our team as well as all the additional external resources that we use from our core businesses that we believe are very important in managing disability.

One key functionality of our intake process is that we preload eligibility and census data. This has made a big difference, because our intake usually takes between nine and twelve minutes and that's a very short period of time in terms of getting somebody through the disability process. Folks who have experienced our process, and some customers who have experienced a different process with a previous disability, are overwhelmingly positive in their feedback. More than 75% had said the service was superior or excellent, and nobody said the service was anything less than average. That sends a pretty strong message in terms of service delivery. The intake system is ICD-9 driven. We have a provider directory preloaded, so if we can channel or influence provider selection for workers compensation, we do that. We do the state reporting and we have the ability to do integrated management reporting.

The anticipated clinical case management results I alluded to will be from shortening of duration. I think ultimately the savings people will see will shrink a bit in an overall tightly managed program from initial implementation. We believe that we will derive some savings operationally. We just haven't yet been able to quantify these through time and motion studies as our volume is insufficient. We expect shorter event duration which we've already seen. We've seen claims that have not gone into long-term disability because of our management. We've seen some claims that haven't even hit STD by sending out ergonomists and actually working with people on site. We've reduced the potential litigation expenses. It's in the total lost time cost we expect the change, and we're beginning to see that. I've talked about these. We know employers still will want their reporting by line—workers' compensation STD, LTD—but the idea to actually have integrated information is critical for them to start planning their future because it really gets at productivity. It gets to their benefit design. It helps them understand what they need to do to level the playing field in terms of managing benefits or entitlement.

So what does 24-hour coverage mean to you as actuaries? There are a number of challenges and since we are in the land of Vitamin C, I'll talk about the four Cs. I don't think it's very different from the product development cycle for 24-hour. The four Cs are: cost, care, compliance, and customer. Our customers are changing very rapidly. The way they buy today is they put health and disabilities together. Even though compensation is in a whole different line of business, it's in the property and casualty segment and customers see it as another disability coverage, and that's how they buy it today. Customers aggregate their life, annuities and

retirement and pension in another bucket. So our customers are changing, or the way that they want to buy benefits or services is very different. One of the challenges is to stretch yourself in terms of how an actuary does actually learn how to price workers' compensation, disability and health care all in the same model.

Let's talk about pricing for a moment. Workers' compensation is priced by covered payroll; health care and disability is priced by lives. There's a big disconnect there, so your ability to bridge that gap in terms of what our customers want is going to be a challenge in terms of being able to create one price to be able to understand what that means.

Regarding care, How do we price for the variety of networks and layer on occupational specialty networks and contract with doctors to ensure that the quality of care models are adhered to? How do we create metrics to help us quantify this? Many of you may spend a lot of time doing reporting of statutory and generally accepted accounting principles. In compensation, they have a whole different set of reports. It's driven by each of the individual 50 states, and there are 50 different ways of reporting them. So our current reporting systems fall through the cracks. How do you effectively analyze the data to decide how you're going to move this forward. There's a big challenge on how to overcome those barriers. So the diversity in your ability to cross some of these specialty lines will become even larger. I talked about care. I talked about customers. I talked about cost. The cost of doing business today becomes more difficult in this environment. People want more for less, as you all know, and our ability to absolutely capture the margins and believe that we can provide to people a value that is greater than today is one of the bigger challenges we have in the future.

Mr. Corcoran: Before we go on, I'd like to ask Ted and John what they see as the role for actuaries or the possible role of actuaries?

Mr. Haslam: I think that it is going to be very difficult to deal in data you feel very comfortable with, and I say that because there are so many things that are changing, and there are so many different sources from which the data are coming. There are also so many hypotheses on which you are going to be asked to base pricing. For instance, Jackie brought up the issue of disability and health being put together and trying to price the impact. People are going to expect an impact as a result of the packaging, and you're going to have to look at the health data and disability data and try to define what the savings will be and put that upfront. You're not going to have good data that reflects what the impact of it is.

Many of the companies we are dealing with will exclude entire classes of employees from certain parts of this disability coverage. So while you may have workers'

compensation coverage for 100% of the employees, they may have a voluntary disability plan or a noncontributory plan or a contributory plan depending upon the work group, the union agreement, and the geographic preferences and the state requirements. The set of data that you are dealing with becomes very dynamic, and I think an enormous challenge is going to be to try to price that going forward. We also have some customers who want to get out of the benefits business while still having people work for them. They say that their job is to make computers or to make copiers. That's what they focus on. While they have employees working for them, they will pay them and have benefits for them. But after they have been out for a period of say 24 months when they go from the employed to the nonemployed status, they don't want to have a contract. They want you to have created some sort of a 401(k) that is funded so that they do not have any kind of fiduciary implied responsibility in the future.

I think the challenge to the actuarial community with this vagary is going to be that there will be marketing people such as myself saying that the market is asking for the following things. We have to put it out; it has to have a price. Some of your colleagues will be aggressive and some of your colleagues will be conservative, but all of them are going to be doing it without as much information as you probably would feel comfortable having in the future. I think that's going to be a major challenge.

Mr. Dawson: That's a good answer, and it's quite a challenge for our profession, but I believe that we're up for it. We need to look at the whole disability thing as a financial security system, and we've always looked at it in fragments because that's where it came from. We looked at short-term disability one way and long-term disability another, and workers' compensation another way, etc. It really is one system for an employer or an employee to deal with. Actuaries need to think of it that way and start helping all of the people who are having an influence on how things work. Actuaries can help them understand what will work and what won't work so that we can start structuring things that we can price, and so that we can start gathering the data that we need for reasonable pricing. Then we can come to terms with the fact that we're just going to have to make some assumptions without having the right kind of data; I do think we're up for the challenge.

Mr. Corcoran: I agree. One thing I would add is that we may see noninsurance companies in the marketplace. There has been a huge change in the medical care market where HMOs and noninsurance companies have come to dominate the marketplace, and actuaries in those organizations have different roles than they do in insurance companies. That's something I think the disability actuaries will soon be faced with as well.

Mr. Thomas X. Lonergan: As someone who's a member of the Society of Actuaries and the Casualty Actuarial Society, I will vouch for the fact that there's a needlessly artificial dichotomy between a property/casualty actuary and a life actuary. Something like worker's compensation disability is more like medical disability than disability is like life insurance. The same is true for health insurance and the health insurance part of indemnity. My question is how do you divide up the money? Traditionally, life insurance companies and health insurance companies provided the disability coverage, and the medical disability and property and casualty insurance companies provided the workers' compensation coverage. In dealing with insurance departments on so-called nontraditional products, I've realized that this is a real bugaboo. I was wondering how you get around that bugaboo. Where does the premium go? Does it go to a life insurance or a health insurance company or to a property and casualty insurance company? In terms of how the claims are being divided up, is that a real big issue?

Ms. Reinberg: What they do is continue to let it flow to their own profit and loss. The employer has multiple contracts today. They have one for workers' compensation, either a contract or a service agreement, depending how they're funded. The same thing applies for disability. The premium streams are very clear. Ultimately, an allocation would actually be done by creating one process which is going to be a major challenge given the amount of compliance reporting that we have. For those of you who think this is really going to happen in the distant future note that 45% of our requests for proposals on large cases today come in asking, "What are your capabilities in the integrated arena?" The translation is, it's already here.

Mr. Haslam: Yes. Our experience has depended upon the size in the under-2,000-life market; we don't get many questions about this because the brokers really are looking for the lowest price, and they're driving it down. It's a whole different world. In the larger cases, 35–40% of them are asking "Do you have plans to be able to integrate with workers' compensation?" We are not seeing the medical and disability ones as much as we are seeing the workers' compensation and disability ones, and that could be because we don't have medical at this point. We are seeing virtually 100% of the large cases that are coming through saying that putting STD and LTD and state-mandated disability benefits together. It appears to be the building block. If they don't have those in, trying to add workers' compensation is suicidal. Most of the ones we're seeing have that base, and they want to go to the next step and build on it. I've hypothesized that in a period of five years, you're going to see many more cases who are doing it. Getting around the legal problems are challenges in the various states, but you definitely can see it coming.

Mr. Benjamin George Peters: I'd like to know if anyone on the panel has heard of an idea that came up about how managed care might be care management, where

you would identify claimants who have asthma, or chronic asthma, or chronic heart problems?

Ms. Reinberg: There are four Ds of care management that help treat a person across their life cycle. The first is detection—trying to help the individual or provider detect what's wrong. Early detection can be critical for effective treatment and a return to work. Two, you help your employees make good decisions so that hopefully they don't have a disease process. Three is disease management, which is to help manage the disease while staying at work. The fourth component is disability management, and hopefully you're able to manage that individual back to work. There is a whole environment that talks about care management, protocols that take the long view of health care versus transactional bites. The one thing I didn't speak to is the whole idea of wellness and prevention being the key to care management. So you are right; there's a lot out there in care management.

Mr. Haslam: One of the things people ask about is a discount on their disability rates as a result of having put in a wellness program. To be honest, I think that's a bit of a red herring because we all know what types of people are committed to exercise. I am not one of them. The ones who are your disability risk are those people who sit on the sidelines and watch everybody else sweat. So we are more concerned about what's being done with the people who are not going to wellness programs than we are about whether or not there is in fact a wellness program. We have also found that culturally, inside companies, as senior management changes, the commitment to the wellness program sometimes evaporates. With the retirement of the single marathoner, a wellness program has been seen to go from being an absolute necessity to being an overhead that was quickly erased from the expense line. We are much more concerned with what is being done in the prevention area, and there are some intriguing things being done with some of the pharmaceutical companies in that area that I think has more promise for us.

Ms. Reinberg: Health risk appraisals may be one of those things that hold promise. I'm in a different mind-set, working for an organization that has a high level of participation under wellness. I believe we should give a discount, because it gives the right message, but that's a personal philosophy.

Mr. Haslam: The bigger problem in the larger companies is the elimination of an employee's position while they're out on what they thought was a short-term disability. That is becoming more of a factor; not only does the job get eliminated and all the assumptions you had about return-to-work get thrown out the window, but now people don't have a job anymore. They're working on teams and their assignments are changed so they need skillsets that you're supposed to evaluate. The total dollars aren't going to change all that much, but how you go about

assessing those and analyzing them with the precision that you have had in the past is becoming more and more difficult. I think there's an enormous need for data that we don't have in our systems. I'm not talking about Met Life specifically, but I think in the industry, those of us who deal with large cases have better information systems than anyone else. Increasingly, however, those information systems will require significant investments to provide us with the data that will be required from an actuarial perspective for those people taking risk to feel comfortable.

Mr. Jay A. Barriss: We've talked about employer attitudes, buy-in, and partnerships. What do you do to assess the employer's desire to buy into the concept of managed disability, and is it something you do hopefully pre-claim and pre-sale. How do you determine whether this is someone you want to play ball with?

Mr. Dawson: In working our clients, the first thing we talk about is global strategic issues. We want to know how this employer thinks; how do they treat their employees, how do they perceive their employees. We look at five different components of this employer before we ever talk about benefits. Every employer needs to be a strategic planner. They need to know what they're in business for and what their core competencies are. Then we talk about operations management—how are you going to carry out that strategy? We also talk about human resource management—how are you going to attract and retain people so that you can carry out that mission? We talk about risk management; you're in business, and you take risk. How do you make those kinds of decisions?

Finally, we talk about asset management. If you are successful, you'll make money and what will you do with that money? Before we talk about benefits, we talked about all of these things so we have a good feeling for how the employer really thinks. In going through that discussion, we can very easily figure it out who are those employers who are going to act like a partner and those employers who are looking for a low price and who aren't going to stick with this program in the long term. That's our job in the marketplace before we ever get to the insurance companies. The insurance companies that we deal with recognize that when we come to them and tell them what the employer is doing, they can believe us. That's not always the way things happen, though.

Mr. Corcoran: I agree with your comments. The intriguing thing is if you get someone who promises to do the right things, what are you going to do in terms of the price? Tell me the discount you're going to give as a result of someone saying, "We do strategic planning. We think human resources is extremely important, we train everybody, and we're going to take everybody back to work whenever we can." It's very difficult to take those things and translate them. We ask the questions, but getting those things translated into hard dollars is very difficult, and

it's becoming even more difficult. In the disability industry, in the 1980s, the after-tax margins in the disability business was in double digits. In 1995 it was at 1.1%, and that was an increase from the year before when it was negative. So we aren't talking about something that is just nice to do. We are talking about whether or not people stay in the business. You have a lot of pressure to try to get your price down as a result of these things, but the industry as a whole right now is not making money. Thirteen of the 23 companies who reported last year on the John Hewitt survey did not make any money; that cannot go on for a long period of time. While we can say that all these things do something, they have to start showing a bottom line return or else people are going to get out of LTD. The bottom line is that the margins that need to be there in the industry are not there.

Ms. Reinberg: I'd like to add that from a consultative approach you should look back at that question. We do sit down with our customers and do a needs assessment—what is it they need and want, because the reality is that there are a lot of customers who haven't taken that quantum leap into wanting to manage disability. The reality for some is that they still see it as an entitlement benefit. They still see their relationship with their employees as child-adult instead of adult-adult and, until that changes, your interaction with them is driven by their appetite for change. Do we walk away from business like that? It depends on the risk. There are still many core businesses that want only long-term disability coverage, and that's all they want. They do not understand that they can't properly manage LTD claims until they manage STD.

Mr. Corcoran: We're selling disability insurance, not employment insurance. If we know the employees' functional inabilities and what the clinical data say, and what their main job functions are, then once those people are able to perform their job, we should be able to discontinue their benefits. We can't predict whether there will be a job waiting for them or whether the employer will be working with us or not. We do know when that person is no longer disabled, he or she should have no more benefits. If this person never became disabled and his job was eliminated, he'd have to go find a different job. People will say I don't want to take on a group that has a lot of 45-year-old males in management positions, because if they become disabled the company will have to replace those people and once they are rehabilitated, they are not going to be able to find a job. I don't think that's the point.

Ms. Reinberg: If it was that easy, everybody would do it. The reality is that in disability insurance, we do have a commensurate test. The individual might have an impairment. They are no longer totally disabled functionally. We see this in an aging population, particularly in those people over age 55 who had a position. It was physically intense, and they did it for more than 25 years. They now have a

heart condition. They have been rehabilitated physically and probably could do sedentary work. They might have had heart surgery and developed complications. There are no more jobs for them at their employer, and they are not trained for anything else. Perhaps they're in a rural area. I can't deny the claim that easily. It's not that I wouldn't try to vocationally rehabilitate them, but our ability as a disability carrier to close down a claim on an individual where there isn't a job within a 50-mile radius of the standard metropolitan area won't stick. They need to be capable of earning at least 60% of their prior earnings; that percentage may be different depending on the contract and carrier. It doesn't make sense to rehabilitate someone to a job that doesn't exist or one for which they can't earn the income to impact your claim. You also can't force people to move. If I believe somebody should have back surgery and that it would help them return to work, that doesn't mean I can force them to have the back surgery.

Mr. Haslam: It's scary sending this kind of question to a marketing person. What we're finding is that, in many cases, our customers aren't signing contracts that will let us do exactly what it is that they are saying they would like to have done. For a variety of historical reasons inside their organizations, they need to be competitive in their industry when other people are offering nonoccupational definitions to age 65. It's a very difficult challenge, and certainly there's no hesitation on the part of any carrier to enforce the contracts they have in place, but you just don't always have the right contract in place. The bigger problem we have is that at any point in time, 10% of the working population could be on disability. I could conduct a survey here of how many people have a bad back. Your jobs probably involve a lot of sitting, which causes your back to twinge every once in a while, and you need to get up and walk around. If you hear a layoff is coming, that bad back can become something that causes you to not even be able to get out of bed. I think we can price for the contractual provision that says you can't put them back to work even if they are fully functional. It's the ones that you are not pricing for that have had the bigger impact on us. Those are the ones that, in the uncertain times that many corporations are facing now, come out. Stress is one and backs are another. Those two together make up a major portion of the claims that we see and I'm sure that other insurers are seeing that as well.

Mr. Corcoran: To add to that, it's fairly well shown that disability is not just a medical condition. It's a psychological condition and, as Ted said, it's affected by your job, whether there's a job there, or whether you feel that you're valued at all. It's a cultural issue in the company, and I personally think that what some companies are doing now makes their employees sick.

Mr. Dawson: It sounds like we're selling an awful lot more than just disability insurance then. If you're in a metropolitan area where there are lots of jobs, there is

disability insurance, but if you're in a rural area, it's disability insurance plus employment insurance.

Mr. Haslam: I'm not sure that's exactly the way you can look at it. I think that more often you're selling something other than disability insurance. As our customers are increasingly outsourcing many of the benefit functions, we're selling lost time management, and that means getting people back to work. It means FMLA administration. It means a whole bunch of other things in addition to the risk bearing part that you may have with long-term disability. So you're right. There are things beyond disability, and we have to train our claims people constantly to know that what they are dealing with is not just a disability; it is also about getting a person back to work. It's returning them to work that we are more focused on rather than what they can't do with the disability. We focus on what you can do, not what you can't do.

The next thing that we're going to see coming is bridge insurance rather than the traditional disability insurance. Right now if you have someone who wants to buy life insurance, and you ask him or her how much he or she wants to buy, you can sell them that amount. The tradition in disability is that you provide it until age 65 or when Social Security takes over; I think we are going to start seeing things that are limited in duration. Maybe we'll see a five-year policy or a ten-year policy sold with complete disclosure upfront. We'll give you \$2,000 a month and at the end of that five years, you better be back to work.

It will be priced appropriately for that number of benefit years, and that to me is more like bridge insurance than traditional insurance. I think that with the carriers coming into the industry now, no longer the traditional specialty carriers or multi-line carriers or medical carriers, we are seeing some intriguing things that are going to make your life miserable. But it's going to make the product offerings very different and very interesting over the next couple of years.