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LONG-TERM CARE: MARKET PERSPECTIVE

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MR. CHARLES C. DEWEESE: Long-term care (LTC) is an issue that is getting a lot of attention these days; it is in the newspapers quite a bit. I was at the Society of Actuaries Meeting last fall in San Diego and there was a session on LTC in retirement communities and you just couldn't get people to leave the discussion. The interest is very acute. LTC is something that many of us have a great deal of professional interest in because we work for insurance

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companies who are trying to price these products, or because we work for employers who are considering offering some kind of LTC options to their employees, or because we are trying to set valuation standards for products like this. But it is also of very personal interest to actuaries. What I noticed in San Diego was that a number of actuaries who were of a certain age were interested in it on a very personal level, because they felt this was something they were facing. But on a much broader basis, we worry about our parents and relatives. I'm sure many of you have had calls from your father or your mother saying, "What should I do about this?" At this point there really are not a lot of resources available for people to pay for LTC. There has been a lot of publicity about development of a catastrophic component to Medicare, but that is not really a complete answer to the problem. Private insurance has been very slow to develop options for LTC. We are very fortunate to have three guests to help us with understanding the market's perspective on LTC.

Our guests today are Ms. Arlene N. Weissman, who is a consultant with Tillinghast in the Philadelphia office. Arlene has a Ph.D. in experimental research, and she has specialized in market research for about the last ten years. She does market research in a number of areas but particularly in the health care area. Her most recent speciality has been the senior market. She will be talking about perceptions in the senior market and how she has measured these perceptions with regard to the need for LTC services and insurance, how people want to finance those services, and how they want them provided.

Our second speaker is Mr. Ronald Hagen, who is Director of Insurance Services for the American Association of Retired Persons (AARP). AARP has developed an LTC insurance product which it markets to its 25 million members. Tillinghast/TPF&C has worked with Mr. Hagen in the development of this product. Mr. Hagen is going to talk about products and about managed care alternatives with regard to LTC.

Our third speaker is Mr. Robert Haldeman from Continuing Care Retirement Communities Services Corporation. I've worked with Mr. Haldeman for about three years. Mr. Haldeman's company specializes in providing assistance to retirement communities in capital formation. Mr. Haldeman and I have worked together in developing demographic and financial projections for retirement communities in order to give lenders some comfort with what risks are being

accepted by retirement communities. And one of those risks is LTC because the typical continuing care retirement community (CCRC) guarantee is that if you are a member and you need long-term care, it will be provided to you. Mr. Haldeman's company has expanded its services over time and is a full-service consulting firm to retirement communities, particularly in developing retirement communities.

MS. ARLENE N. WEISSMAN: As Charlie mentioned, I'm going to give you a feel for the environment out there from a slightly different perspective, the perspective as a marketer. On one hand I hope I don't shock any of you as to what's really going on out there, but on the other hand I do hope I increase your level of awareness so you'll say, "OK, we have to develop a product. What are the needs out there of the typical consumer?"

To give you the flavor of what is really going on out there from the perspective of a marketer, I want to begin by telling you the story of Mrs. C. "Mrs. C knows what pauperization means. After nearly three years in a nursing home, she has finally spent virtually all of her resources, including the proceeds of the sale of her home, which was sold to pay her $24,000 a year nursing home bill. Now, she must turn to Medicaid to pay her bills." Mrs. C is one of the established 5.2 million persons over 65 who in 1985 were mildly to severely disabled and in need of assistance to perform normal activities of daily living. One and a half million of these persons like Mrs. C were in nursing homes. To the surprise of many of them, despite their Medicare coverage and their Medicare supplemental coverage, most had virtually no home or LTC coverage.

Analysts predict that 20% of us that reach age 75 will pass through a nursing center at some time. The American Health Care Association predicts that the aging trend of our population means that between now and the year 2000 a new 220-bed nursing home would have to be built every single day to meet the demand. By the middle of the next century, the 75 and older age group is going to increase from 10.1 million to over 42.7 million, with the over-85 segment being the most rapidly growing portion of the U.S. population. Obviously, declining mortality rates and lengthening life expectancy are producing explosive growth among the elderly population and the financial impact of this group on our health care system can no longer be ignored. More of us are going to survive long enough to need LTC services.

As you listen to some of these demographic trends, I'm sure that most of you, if not all, conclude that there is an urgent need for some sort of LTC insurance. However, we cannot sell just an LTC product. We also have to sell the need. Therefore, before we can begin to develop any product that is going to sell, we have to determine what that need is according to the consumer, and whether that need is an actual need, or a perceived need, or maybe even a potential need.

One of the most reliable ways of determining, at least perceived needs of consumers, is through market research. And what I want to do in the next few minutes is go over some of the key data that we have found at Tillinghast/TPF&C in the various market research studies that we have been conducting.

To begin with, any new product or service we are designing is made up of key features that purport to deliver certain benefits to the consumer. In any product development, it is crucial to determine the strongest core benefits that someone would want. In the survey that TPF&C conducted for one of the large hospital chains, 900 Medicare recipients were asked the following question: "If you were designing your own Medicare supplement health insurance program, what would you want the program to include?" We didn't give them any aided responses, but just left it open ended. The benefits would you really want. The benefits that were mentioned most frequently by the respondents included vision care (66%), routine dental (63%), prescription drug coverage (63%), care in a skilled nursing home (58%), routine physical exams (55%), and home health care (53%). Less frequently mentioned were inhospital private duty nursing (49%), hearing coverage (45%), a transportation service to take consumers to the doctor or the hospital (30%), and foreign hospital and medical care (24%). Again, most of these are not going to be included in any kind of catastrophic care that probably will be passed by the government.

Respondents were then told that "Some health plans provide a special service to people who live at home and have chronic conditions. These plans help the patient and his or her physician identify what local services are available to deal with problems associated with these conditions, such as: nurses or therapists who make home visits, adult day care, or meals-on-wheels. If there was a Medicare supplement plan available that offered this kind of coverage, how likely would you be to switch or purchase that plan?" Just under half of our

respondents, about 44%, reported being likely. But only 15% reported being very likely.

In another study that we conducted for an insurance carrier, 600 Medicare recipients in Maryland were interviewed to determine the types of products or services of interest to them as well as an indication of how much they would be willing to spend for these various products. Respondents were told, "Older people sometimes require long-term nursing home care or custodial care for an illness. Presently, Medicare does not cover such long-term care." And again here, we tried to increase their awareness of the fact that they are not covered. Let's ignore the fact that they think they are. We are going to tell them they are not covered to try to get a better feel for the level of need in this population. "If an insurance policy were available to you to cover LTC costs, how willing would you be to buy this insurance protection?" Just over one of three, or about 38%, reported a willingness to buy the coverage. And here we found the 65 to 74 year old respondents were significantly more willing than the 75 and older respondents (43% versus 26%). When asked how much they would be willing to spend, we find that the average amount is $69 a year for LTC. They know we want to give them the coverage, but at $5.50 a month. The older respondents were willing to pay more ($79/year for 75+ and $67/year for 65-74 age groups). Again, it puts it into perspective that not only are they not aware they might have a need for this but they have no conception of what the price is that would go along with it.

To evaluate an alternative mode of care, respondents were read the following definition of a continuing care retirement community: "These communities allow you to live independently, yet they provide for your housing, medical care, and social needs for life. You would pay a lump sum payment, plus monthly fees to live there. How interested would you be in this type of an arrangement?" One in four respondents voiced interest in this, again with the 65 to 74 year old being more to be interested than the 75 and older group (31% versus 18%). As these data show, among the respondents that we interviewed (keep in mind that most of them don't truly understand the concept, but according to their own definition of either LTC or a CCRC, there is not a very strong market appeal for this kind of a product) the key question becomes. What are the real barriers to acceptance? We sit down, we listen to the demographics. Logically there should be a need, but what are these barriers?

As Charlie mentioned, we've done a lot of research with AARP members and I want to go over some of the results that we've gotten with this population. Based on a summary of all of the surveys, we found out that there were primarily four barriers. The first one is physical barriers. Typically, consumers of this age group assume that they don't qualify for LTC for reasons of either health or age. They don't perceive themselves to be either that sickly or old enough to need this kind of insurance. Unfortunately, more often than not, both of these assumptions are incorrect.

The second barrier that we find is a financial barrier. The rich don't feel they need it, the poor can't afford it. Or at least they perceive themselves as not being able to afford it.

The third one we came up with is an informational barrier. Most consumers of this age actually lack information. They don't understand the risk that's involved. They are not aware of the costs as we have shown. And they are not aware that their current policies do not cover LTC insurance.

The fourth one is psychological. This is really a critical barrier. Consumers of this age ignore LTC with the hope that their LTC needs will go away. It is typical of most of us. If I ignore this long enough, it's going to disappear. I can just forget about it, push it aside, and I won't need it.

The other obstacle that we are facing in trying to develop these types of products is the image of institutionalization being very negative; whereas health care has a more favorable connotation, probably among all of us. To further support some of these barriers, again let me give you some hard data that we have come up with.

We asked 1,009 (typically we go for 1,000 but I guess we interviewed nine extra on the phone) AARP members the following question. "Some people, when their insurance and finances run out, go on welfare to pay their nursing home or home health care finances. Do you find the idea of someone going on welfare in this situation to be acceptable?" Almost 2/3 (62%) of AARP members reported that going on welfare is acceptable when other resources run out. Furthermore, these AARP members were asked, "How likely do you think it is that you will ever have to stay in a nursing home type facility for more than one month?"

Only one in four said that it would be likely, with the under 65 year old member having a greater tendency than the older members to say that they felt it would be likely for them to have this kind of a stay (32% versus 21%). Members were told that the "latest estimates indicate that a year's stay in a nursing home costs between $10,000 and $20,000. "If you had to stay in a nursing home for more than a month, how would you pay for this stay?" The most prevalent responses (and they were allowed to give multiple responses) were through earnings/ savings, Medicare, and then private insurance; with actually no difference between Medicare and earnings/savings. On the other hand, when we posed the exact same question for home health services, the most prevalently mentioned form of financial coverage was Medicare (78%) followed by private insurance (58%) and earnings/savings (53%). Obviously, the ramifications of such consumer ignorance are enormous.

We have those barriers that we have to get over before we can begin to start selling a product. In spite of these barriers, over three-fourths of the members felt that the American Association of Retired Persons should sponsor insurance for LTC. With the primary reasons being:

1. "There is a great need for such a plan," mentioned by about one out of four members (27%);

2. It "would help those who had no one to care for them," mentioned by about 13%; and

3. It would "help meet high costs," mentioned by about 10%.

I don't know if you can pick up the meaning of those responses. It is typical in a senior market. It's "I don't need the product myself, but I think you should still offer it because I want to protect all the other senior citizens that I know who really need that product." And again, many of these answers are verbalizing that third person type of response. Of particular interest were some of the reasons why AARP should not sponsor this kind of product: "I don't want to think about it" (9%); "It would be too expensive" (8%); and, "I already have enough insurance" (6%).

About half of the members reported being interested in learning more about insurance coverage if such a policy were available. But of particular interest to us were the reasons why they would not be interested in learning about this type of policy. This really reveals a lot about their perceptions. The key responses are: "Too expensive" (55%); "I already have adequate coverage" (32%); "I don't need this type of coverage" (29%); and "It would be too difficult to understand" (8%).

Anticipating that the development of an LTC product was still going to take place and was still necessary, we then said to respondents, "would you prefer home health care (HHC) versus a nursing home?" And overwhelmingly, HHC came across -- over 77% would prefer that over a nursing home. Nearly half (44%) preferred coverage that would pay for a fixed amount rather than one paying a percentage of their expenses. In addition they had unrealistic expectations about the price of this nursing home insurance. One in three (32%) reported that they would be willing to pay less than $30 a month for long-term nursing home coverage.

Based on the data that we had gotten from this part of the study, we decided to go into a more sophisticated market research technique. It is called conjoint analysis, and we try to find out what the features are that are most important to members, and how we then can package these features into a product that would have the greatest appeal and optimally meet their needs.

Conjoint analysis avoids the problem that we typically have in market research of simply asking respondents, "What is important to you? What do you really want covered?" The reason being that consumers, particularly senior consumers, are not aware of what their needs are. They are not aware of what motivates them to choose product A over product B. So this type of analysis presents respondents with different products, each one with varying levels of combinations of the attributes. And the analysis itself allows us to determine what the attributes are that are most important when someone is saying, "Yes, I would definitely buy this product" versus "No, I wouldn't buy this" versus "Maybe, I'd buy this." So we get a feel for what they are trading off.

Respondents were asked to evaluate 16 hypothetical LTC products. They consisted of combinations of the various features: (1) a dollar benefit, (e.g., $30

a day for skill, $20 a day for intermediate); (2) various combinations of the length of coverage, (e.g., two years versus five years); (3) starting day of coverage, (e.g., the first day you were in a nursing home this would start paying); (4) preexisting condition exclusion, (e.g., you may not be covered until 12 months after first purchasing your coverage); (5) the presence or absence of HHC; and, of course, (6) price.

What the data revealed to us as the most important factor that affected the respondents' probability of purchasing one LTC product over another was the presence or absence of the HHC benefit (27%). The least important factor was the dollar amount of the daily benefits (13%). Again, this is primarily because unless you use something you do not have a feel for what the cost is and what that dollar amount is going to actually cover. The simulation of response and preferences revealed that they would greatly prefer a package which included a 30-day skilled nursing home benefit and a home health benefit, to one that had a $75 a day nursing home benefit but not home health. The home health was a key decision factor for most of these individuals. In fact, the overwhelming majority (77) said if given the choice, they would prefer a plan that covered only home health care versus one that covered only care in a nursing home.

Data also revealed that there were one in four respondents that said, "I would definitely not purchase any of your products." A key was what the demography was of some of these individuals. We found out that this group tended to be older, less affluent, and more likely to envision themselves as not needing any type of nursing home care.

Based on this data, a product was developed. I'm sure Ron is going to get into more information on the product. The product is now in a second stage of development. We just came out with a second version of the product. But after the first one was rolled out in about six states, we did a buyer/nonbuyer survey to try to get a feel of why some people were buying and others were not buying. One thing I want to highlight, one of the most interesting facts, was a key psychographic item that differentiated the two groups. What we found out was that the nonbuyers were significantly more likely (48% versus 31%) than the buyers to agree with the statement, "A nursing home stay is one of those subjects that I would rather not talk about." Whereas the buyers had a greater tendency to agree (32% versus 19%) that, "I fear I may someday become a burden

to my children." Again we are dealing with that psychological barrier and many of these individuals are saying, "I took care of my children. It is my children's responsibility to take care of me. I don't have to plan ahead, it's their responsibility."

We really get down to the question, the ultimate we all are trying to find out, Why aren't consumers buying LTC insurance? I hope I have given you a feel for the lack of understanding and the obstacles that we have to face to try to convince them of what's going on. Within a traditional marketing environment a product manager, for let's say Proctor & Gamble, would ascribe this lack of interest to the fact that consumers just don't appreciate the nature of our offer. They don't realize what a good buy we are really giving them or maybe we haven't found the right incentive to motivate them to buy our product.

However, I'd like to leave you with an example from the National Cancer Institute (NCI) which I feel really describes where we are today. For many years, the conventional wisdom for those charged with reducing cigarette consumption was either that smokers didn't believe that smoking was bad for them or they were not motivated enough to quit. I'm sure a number of us can empathize with those. But consumer surveys revealed that actually seven out of eight smokers would tell us they had in fact tried to stop. They did believe that smoking was a very bad habit. They just couldn't get themselves to stop. NCI concluded, after all this research was actually done, that what smokers needed, as a part of the marketing mix, was a set of clear cut techniques for quitting and a sense of hope that they might succeed. Because of this new consumer perspective NCI reoriented its program toward action rather than information.

Obviously, older consumers need to be educated. That's hopefully the point I've gotten across to all of you. Perhaps some of the energy that we are putting into refining products should be directed into specific action oriented programs such as techniques for learning where to go to get information or where to go to see what is available. What are your options? What can you choose from? LTC insurance has to be better positioned. We have to overcome the stigma of LTC insurance being equally associated with institutionalization. However, a key to this statement is the fact that in a true marketing sense, positioning is based on the concept that communication can only take place at the right time and under

the right circumstances. Our real challenge is to educate the older consumer that this is the right time.

MR. RONALD D. HAGEN: I'm going to be talking about some of the same initiatives that Arlene was referencing because TPF&C has done a great deal of the market survey research for us in developing the products. But I'd like to really focus on three or four major areas.

First of all, I'd like to review with you the test marketing we did with the AARP Nursing Home & Home Health Care Plan that was developed in 1985 in six states. The test marketing was subsequently expanded in 1986 to eight states.

Then I'd like to share with you some preliminary results from the buyer/nonbuyer research we've done as a result of that most recent test marketing. It is preliminary, we are still awaiting the final report, but I think it is instructive and it is important to make every effort possible, as Arlene has already mentioned, to understand the decision-making dynamics: What's going on in people's minds and what information do they bring to the decision to buy or not buy the private LTC insurance product?

Next, I'd like to talk about some of the barriers to industry market development in the area of private LTC insurance and about competitor initiatives. What's going on in the managed care environment as it relates to LTC insurance? Competitor initiatives might be somewhat of a misnomer because I'm here in part to assert to you a sense of guarded optimism relative to LTC insurance. What's out there right now in the marketplace, the large amount of activity or heightened activity among major carriers in particular, relates more to an image problem than it does to a real aggressive competitive marketplace response. Many, if not most, insurers are in this with their large toe at most, and there really hasn't been an aggressive positioning with this problem. I think there are very good reasons for that, which I'll touch upon. Most relate to the lack of any firm understanding of the adequacy of the pricing of the product, the lack of data in the pricing of these products, and maybe most importantly, to the lack of any kind of experience information which would confirm the adequacy of those products.

Finally, I'll give you some glimpse into what we are planning for the balance of this year, relative to the AARP initiative and where we are going with our product.

Let me make a few introductory comments about LTC insurance. The remarks about our product initiative through our group health insurance program will then be put in the proper perspective.

I believe AARP has a somewhat unique position right now. First and foremost, we are an educational organization. The importance of education cannot be lost. You can do all the wonderful product development work in the world and you can have second and third generation LTC products with fully managed care systems; but if you haven't got a population out there that believes they are at risk and are willing to look at the option of private LTC insurance, you are not really going to do very well in the market place. Similarly, you can do a lot of good educational work and have people understand for the first time that they may be at risk, but if you don't have products out there that are consistent with their needs, that contain more than just a nursing home benefit, and that are properly structured and offered, you are really not going to meet that need either. It's a balanced approach that's required here.

Next, LTC insurance definitely is in its infancy. We're early on in this whole project. What LTC insurance must not be used as is an excuse to reduce or somehow diminish our commitment to Medicaid and meaningful Medicaid reform. Medicaid, along with private individual out-of-pocket payments, are the only two sources in essence for paying LTC needs that we have right now.

Unfortunately, many in the industry have viewed Medicaid as a barrier to LTC product development with many beneficiaries resorting to irrevocable or revocable trusts and other quasi legal asset sheltering schemes. With that said, we must remember that right now only about a quarter of the elderly persons in this country with incomes below $5,000 per year are even covered under the Medicaid program. So, the Medicaid program is right now not reaching a great majority of those individuals already impoverished among our elderly population.

Also, I think it's important to understand that personally and individually there is a strong aversion to Medicaid as an LTC funding source. Perhaps that

aversion is second only to nursing home placement itself. I think that is consistent with the information that Arlene gave you before. When you are talking about somebody else and they run out of all options, then Medicaid is OK. If you are talking about me, there is a very strong aversion to Medicaid, public assistance and welfare as a source of payment for that care.

LTC insurance is not now readily available especially to the frail elderly and the older elderly. It is a product which is basically available to the future elderly given the way it is priced, marketed, and offered. I think that is important to recognize. What LTC insurance should be, at least what it is for our Association, is creating options and choices for people. It is not about reducing the Medicaid budget in half. It is about giving people choices and options to predictably plan and pay for any future LTC needs they may have.

Demand and awareness is improving slowly. I think we have seen some indication of that in the research we have done with TPF&C. I think we need to have realistic expectations in the near future about the contribution that LTC insurance can make to financing these services. The best estimate that I've seen show by the year 2020, upwards of maybe 18 to 19% of total nursing home revenue will be from private insurance of one sort or another.

I think we also have to be very mindful within the broader concepts of the financial solvency issue. There are many smaller companies also in this marketplace right now writing a bulk of the individual type products. I can think of two recent examples where companies have gone out of business, sold a book of business or canceled individual's policies. We are seeing letters from some of our members in instances where they have been given 30 days to find other coverage or to make other arrangements. I think that is an issue that the regulators are very mindful of and it is one that we have to be mindful of too, as this marketplace develops: the credibility and the issue of who's writing this kind of coverage, and the kind of long-term commitment do they have to the people they are insuring.

As Arlene mentioned before, about two years ago it was decided that we would offer our six million members who are insured under the AARP Group Health Insurance Program an LTC insurance product. The reasons we did so are many and varied. One reason relates to the fact that we spent over forty billion

dollars in nursing home care (NHC) alone in this country, an increase of over 10% over the previous year. Another relates to the huge federal budget deficit and the need to continue to fund Medicaid adequately so it serves a population. The burden on families financially is insurmountable. An average of $22,000 a year is spent on NHC in this country. The growth of that population will be some 65% by the turn of the century. That is almost four times the growth of the general population. The number of people receiving HHC services is projected to increase about 43% by the turn of the century. And also importantly, over 130% increase in need for formal HHC services will be seen by the 85 and over population.

We did some work and looked at the issue of out-of-pocket catastrophic expenses. There is "magic" right now in Washington for a $2,000 figure. When we looked at those individuals that incurred $2,000 or more out-of-pocket health care expense, 81% were related to nursing home care, only 10% to hospital care, and only 6% to physician services. Over half of the total out-of-pocket expenses elderly people incurred in 1986 were nursing home related. I think that's important to keep in mind when we talk about catastrophic expenses, how we define it, and where those liabilities are occurring.

In 1985, we went to six states -- New York, New Jersey, Pennsylvania, Florida, Arizona, and Ohio. We developed an LTC product that paid a $40 day nursing home indemnity benefit. It paid regardless of the level of care required in any state licensed nursing home. It did not distinguish between intermediate skilled or custodial care. It had a 365 visit home health care benefit. It had a 20-day or visit combined deductible period. It was entry age rated anywhere from $14.95/month for the 50-59 age group to $94.95/month for the 75-80 age group. The product was medically underwritten with a short form questionnaire. The product also had a six-month preexisting condition exclusion period, and the home health benefit was only available for individuals who would otherwise need to be in a nursing home in the absence of that benefit. It was a plan of care that was required by the physician and the product was test marketed in six states. It was not available to every AARP member in those states. It was only available to some 215,000 households who received a direct mail offer.

The buyers profile from the test effort in 1985, only available to those households who received a direct mail solicitation offer through a randomly selected

group of households across all five age bands in those six states, were a group of slightly younger unmarrieds for the most part, who were slightly better educated with higher incomes, still working full-time more than not, and insured in another AARP health insurance plan. We also sense from this research a very high degree of sensitivity to private insurance, allowing a better quality of care, access and availability of nursing home care in particular. Almost a passport to placement and a better standard of care.

In 1986, we went ahead and decided to expand our efforts and we went to three additional states -- California, Texas, and North Dakota. Florida was dropped because of a new state requirement that could not be met at that time. These states represent about half of our membership countrywide. The difference here was that we made it available to any AARP member in those states. We also made some changes to the product. Initially we had a $40/day indemnity product on the nursing home side. We tested a $50/day indemnity product because in two states in particular we were becoming almost supplemental in nature. The product was always intended to have a significant cost sharing or coinsurance feature but in two states the cost of care was increasing at such a rate we felt it important to start to test a higher indemnity benefit level. The price implications for the 4-year nursing home benefit, and the $50/day indemnity benefit were approximately 11% and 22% respectively. We went again with the same HHC benefits, 365/visits. We went to a 90-day or visit combined deductible period. Again, there was no trade off here on nursing home versus HHC benefits with a maximum on both. They were independent of each other. We tested a four-year benefit period in addition to the three-year control product that we had. Also, in replacing the three-day prior hospital requirement, we decided to to develop what we would term a patient care or patient assessment case management type system. We had the individual contact us before the end of their deductible period, before they were placed in a home or starting to receive formal home care services. We were able to get some information on their activities of daily living (ADL) limitations, and what their functional disabilities were. Again, this was not used to deny care or as a gatekeeper mechanism, but was included to help the individual with other options and choices that they might have. It would give them some indication if nursing home placement was indicated, and what home or community based care options were available, and what those options might be.

We went into four states with advertisements in our publication -- California, Arizona, Pennsylvania, and Texas. Every AARP member in these states got in their News Bulletin in October of last year an ad with a toll-free number offering them trained counselors who could describe for them the product that we had to offer, how that differed from Medigap and Medicare, and what the benefits of Medigap and Medicare insurance were relative to LTC.

In the way of inquiries, we got a total of 24,535. About 6,700 of those people just asked for a brochure we were giving away called, "Making Wise Decisions On LTC," explaining a variety of different financing and types of options people might have. The bulk was evenly split between insured and uninsured members asking for an enrollment package. We issued about 8,000 ultimate certificates offered in the latest test marketing. About one-third came from the inquiry program, both from the publication as well as unsolicited inquiries -- direct letters that came in asking or inquiring about the product. Word of mouth is always a major factor in the products we offer our members. Two thirds came from the direct mail program.

In the age breakout we saw a greater clustering in the 65 to 69 age group than we found in our earlier test marketing. The interesting thing by state is that in the top five states we looked at, New York was the only state in which we did not run an ad in our publication. Yet it showed up rather well as far as total responses. The articles in our publication about Medicare and Medigap type myths, inadequacies of private coverage, and this particular product had a significant impact in those states; in particular, in those states where we ran the ad in addition to the editorial articles.

About three weeks after the test marketing in 1986, we did some market or survey research and we got some very preliminary results. We should have a report within the next two to three weeks. The difference between 1985 and 1986 was that in 1985 we had a direct mail program only, and in 1986 we had a direct mail and inquiry program. Inquirers tend to be more product aware and there is likely to be a demographic difference as well between the two groups. In 1985, we had a declination rate given the medical, short form underwriting, of about 5%. In 1986 it went up to about 7%, which is still acceptable from the Association perspective. We don't like the idea of medical underwriting but we

believe this is the kind of product where we have to have some form of screening up front.

Readers buying primarily for future security needs is not too surprising. Interestingly, the second major reason for buying is because it is the only coverage of its kind. That uniqueness that we were trying to convey was starting to be understood by some of the people out there. The important coverage feature of the custodial care benefit was mentioned 82% of the time. About 80% said that the number of days, the duration of the nursing home benefit versus a higher daily benefit was a very important feature. For the home health visits, 68% said that it was a significant feature. The no prior hospitalization requirement had 72% of the people saying that that was significant, which was pleasing to the Association. About 83% said the editorial articles that we had in our publications at about the same time, talking in general terms about finding some LTC, was very or somewhat important. About 78% said that the News Bulletin ad was very or somewhat important in making their decision in purchasing or not purchasing the product. As far as the likelihood of a nursing home stay, we saw some increase of awareness here from 1985; about 40% of the buyers said it was likely or somewhat likely that they would need to be in a nursing home for an extended period of time. About 43% of the nonbuyers said so but obviously they didn't choose the product as a way of meeting that potentiality.

The payment sources for a nursing home or HHC are: 37%, private insurance; about 31%, savings; and only about 15%, Medicare, which is a strong reduction there. For nonbuyers, savings about 40%; and Medicare next at about 30%.

Basically, what we come to in summary is that LTC insurance from our perspective is not the answer right now in solving our LTC financing problem. There is a danger, we believe, in overselling LTC insurance near term sense.

There is a lot of competitor activity out there as I mentioned. Travelers has just introduced a group product. Aetna has a group product that they are working to develop with the State of Alaska employees as well as the Ohio Retired Teachers Association. Metropolitan and a group called Group Cooperative of Puget Sound have developed a managed care product which is going to be

made available to the 30,000 members of that group. They anticipate about 2,000 of those 30,000 people enrolling by the end of the year.

As I mentioned before, AARP is committed to further developing its managed care type of approach with our product. We anticipate working with a number of outside experts in developing a fully case managed approach. We have a very crude assessment instrument and we are asking individuals as well as their physicians to fill it out in developing their plan of care. We are interested and committed to continuing that kind of approach as we develop and expand the marketing of our product.

The barriers that I see in the further development of LTC insurance are: there still is the lack of strong consumer demand and perceived need for the product; the Medicare and Medicaid myths still exist; and the private group and individual insurance myths about the extent of coverage still exist. People perceive that they're sufficiently covered. Until they are better informed and better understand the very nature of their own private, as well as public insurance coverage, few are going to be interested in this kind of product.

Education awareness is still very low. We believe Secretary Bowen's catastrophic proposal we believe has helped heightened the dialogue. There is the potential here of a strong risk in people sorting out the options within the context of what is catastrophic, what this expanded Medicare program will provide, and this thing called private LTC insurance. There is this whole helpless syndrome. "The problem is so unimaginable, so large, and so financial in a personal sense. I don't know how to solve the problem so I'm not doing anything to plan for it. I'm not even going to think about it. I don't even know where to go to get help to find out about it."

Compounding the confusion is the interest in promoting and defending current products, whether they be Medicare, Medigap, group or individual private insurance. And there is a perception on the elderly person's part about being fooled once with the Medigap product: "I'm not going to be fooled again. I was told that a Medigap product would fill the gaps that Medicare didn't fill. Now you're telling me that there is this other kind of product that really will meet my catastrophic health insurance needs. Now I'm not sure I'm going to look at that

in the same way that I looked at those other products I was sold before. I found out after the fact that it wasn't what I thought I bought."

There is the whole issue of regulatory and legislative lethargy which seems to be somewhat of a myopia combined with a certain degree of impulsiveness; that is, the extreme reaction at the state level from a regulatory perspective. We are seeing right now the National Association of Insurance Commissioners (NAIC) model being looked at and examined and put in effect in a number of states. It's a good beginning. It's important that we have that regulatory framework set up so people can look at these products and protect the needs of the consumer balanced against the need for increased product development innovation.

Insurers really have substantially inadequate data on which to price LTC products. The price is based on a series of assumptions. There's no insurance industry specific data. Public data is available but even that is very minimal at best. We are still debating the issue of loss ratios and whether that's a legitimate and realistic benchmark in judging the value of a policy and the return of that policy to the policyholder. We have very little, if any, loss experience or information and that has really not been shared. And perhaps the Society of Actuaries can and should share and provide an interested third party to accumulate that data and information and have it made generally available.

Finally, the Association in the beginning of the third quarter of this year will be back in the marketplace. We are right now making filings in all the additional states beyond the eight states we had mentioned before. We anticipate being available in an inquiry mode through our publication in the mid-June/early-July timeframe. We will be making our current product, probably going to a $50/day indemnity benefit, available to, in essence, all of our members at that point in time through a toll-free inquiry kind of program in our news bulletin as well as ultimately in our magazine.

We also intend to be back in the marketplace late this year. We have made a commitment of expanding the availability of our product and we do so with obviously some degree of trepidation, having no experience or claim information on the product really to speak of. It is always a danger. It is a danger within the context of products that are constantly evolving. I think we need to keep that clearly in mind and that's one of the major reasons, obviously, that most of

the major insurers that are in this area haven't gone into this as aggressively as some may have liked.

MR. DEWEESE: Both Ron and Arlene have talked about the individual market for LTC insurance. But there is another way that people have been providing for LTC.

The CCRC have made LTC guarantees to their members. The guarantees vary in nature and some of them require additional financial commitment at the time of using the LTC. Some don't, but they put the retirement communities (RCs) in the role of being insurance companies of a sort. There's a great deal of interest on the part of state insurance departments and other regulatory bodies to review the financial situation of these RCs to make sure they are going to be able to meet the guarantees that they have made. Because of that interest on the part of the state, because of the interest on the part of their lenders, and because it is just good management, people who run RCs are very concerned about LTC and are very interested in the development of LTC insurance products that would be available on a facility basis. Bob Haldeman has worked with a large number of CCRCs, particularly in the area of trying to help develop facility based LTC insurance products.

MR. ROBERT B. HALDEMAN: As Charlie said, I guess the longest institutional responsibility assumed for LTC insurance, if I can call it that, has been through the RCs that have been in existence since the turn of the century. Facilities took the responsibilities of care for the remainder of the person's life in exchange for a turnover of assets. At that time we traditionally saw institutions, that go back to the mid to late 1800s, build up enormous endowments. People turned over their assets, moved into old age homes and died relatively quickly, leaving a fair amount of resources to the nonprofit sponsors, those institutions.

As life has changed, death rates have dropped dramatically for the older age groups, the economics of that situation began to change, licensing began to come in, facilities were more expensive, people lived longer, and the exchange of assets for LTC became a very risky situation. Back in the 1960s, there were some insurance company vendors which got involved with trying to price the payment of an entry fee on an annuity basis which would take care of a person for the remainder of his life; i.e., instead of taking whatever their assets are,

try to price the amount of assets needed to take care of them for the rest of their lives. Many of those facilities were not financially viable over the long term. What began then to develop was a model with the addition of a monthly fee added to the initial payment. Initially the concept was a fixed monthly fee. That didn't work so well. Then they were put in with consumer price index (CPI) type adjustments. That really didn't work too well because the health care component exceeded the average CPI. Now what's current in the market for the most part is an adjustable monthly fee which can be adjusted sometimes every 30 days, sometimes annually.

What began to develop was the process to try to price an upfront payment or entry fee together with an adjustable monthly fee, which provides for a long-term viability of a very small insurance portfolio of somewhere from around 3 to 500 people. From an insurance company perspective, that's a very small population, and it is an enormously high risk from a predictability point of view. Nevertheless, there are a whole group of facilities commonly referred to as life care facilities (LCFs) which undertook this kind of liability in exchange for the kind of fee structure that I've described. Many of them are alive and well.

I was telling Charlie about a letter I got from an executive of one of those facilities who has been very active nationally in coordinating the development of new nonprofit LCFs. He had seen a brochure that Charlie and I had done on a seminar and wrote me a very pleasant letter saying "I was very pleased to see that you are still active and that you are doing creative things. Please do not contemplate marketing this product or any LTC insurance product to nonprofit RCs because they don't need it." He and I have an ongoing discussion about that. I think that even for marketing terms we are going to see that there is a need for that. But his experience comes from the fact that he has been administering two such communities for about 20 years. They have built up substantial reserves. They have been able to feel very comfortable with the nonvolatile nature of the LTC as opposed to acute care.

Let me give you an idea of the market as compared to the individual market. There are probably 900 CCRCs consisting of independent living unit facilities where assisted living and LTC comprehensive nursing care are on site. Of those, about half of them would be facilities that are offering a residence and care agreement which covers the prepayment and insurance element, resulting in

the fact that the resident does not pay substantially more when they move into assisted living or skilled care than they are paying in their independent living unit. The economics of it very simply are, a part of the benefit from the up-front entrance fee is economically spread over the life of the resident. And a part of the monthly fee paid in the independent living unit goes to offset the cost of those people who have required skill care. So it is a very simple kind of insurance product, if you can price it.

Probably all of those that I have referred to are essentially nonprofit. Up until 1984-85, 98% of the life care or LCFs were nonprofit sponsors. There are probably 3,500 to 4,000 other nonprofit facilities that are not yet RCs, but most of them believe they need to grow in that direction. So they may have apartment living and want to add nursing care, or they may have nursing care and want to add independent living units. But there is a pressure for them to diversify and get into the full spectrum of care.

Beyond that, there has now been an enormous growth in interest in the proprietary sector in getting into the CCRC format and it is coming from all directions. It is coming from both the large and small nursing home operators, who are feeling the need to diversify into independent living units and vice versa. One of the advantages is, as the concern about private pay (the need to attract private pay patients) in nursing care grows, one of the ways in which you partially fund that is by creating an RC which includes independent living, as opposed to drawing your people from the general market. You are then beginning to prefund that which fits with some of the concepts earlier.

One of the interesting things that I was mulling over in my mind, as I was listening earlier, was that it appeared that the market of 65 to 75 year olds, or a little younger, was the most interested in the LTC product. In CCRCs with entry fees and prepaid medical, it tends to be on the higher side. And I'm not quite sure why that is. My initial thinking is that perhaps it relates to the total concept of community life which is attracting the elderly person. And a CCRC typically will combine an attractive, independent living unit with common areas, and with the provision of personal care and assisted care on campus, but not with a central focus on the independent living community; all connected, the kind of place for husband and wife teams. That's the only kind of environment,

generally speaking, where one of the two partners can go with a need for skilled care and still be within the same community.

Typically, the fee structure for entry fees would range between 50,000 and $100,000 for a single person, and $20,000 to $40,000 for a second person. And the numbers I've just given you in general terms relate to an entry fee which vests in the community at 2% a month. So if a person leaves at the end of one month, they would get 98% of their entry fees back. If they leave at the end of 50 months, they don't get anything back. That's to give you an idea of pricing. If you move that to an entry fee policy with a larger portion committed to go back to the resident or the residence's estate at any point, say a minimum of 50 or 90%, then the sizing of that fee has to go up, because the economic benefits of the community go down. You might expect that the entry fee size is going to go up by 20 to 40%, depending on the particular refund policy. So today you can see entry fees in a community with a 90% refund which will range between $75,000 and $275,000. What the resident is getting typically is a residence and care agreement which covers the full continuum of care.

We did a survey of the 900 CCRCs, the nonprofits, several years ago. And the most consistent thing that we found about the structure of the contracts was that there was no consistency. The market is very volatile. We have noted the market has not sorted out what appropriate services are. Typically though, a CCRC will include the independent living and ambulatory care units within the community center, which can provide HHC to the independent living unit on a fairly efficient basis. It will often contain assisted living or personal care in which people get assistance with activities of daily living and then it will contain comprehensive nursing care. In some of the RCs, the life care facilities have actually provided acute care coverage as a supplemental coverage. Obviously there is an extraordinary danger associated with that if the current acute care supplements and Medicare are withdrawn from the market or reduced. Trying to cover the acute care exposure on a population of 300 would seem to be, at least, risky.

One of the evolving products in the market is a takeoff from the life care community called "Life Care at Home" for lack of a better name. And in that circumstance the resident would pay an entry fee; would maintain themselves in their own home; would obtain the benefit of centralized services including home

health care and central dining, if they wish; would have recreational services, and would get assisted living and nursing care when they need it. Often those types of programs as designed are anticipated to include emergency call services in the persons' homes so they can get accessed to the central facility when they need it. They may also include home maintenance and various types of nonmedical and nonhealth related services. The products that are currently being marketed in that framework include both an entry fee and a monthly fee priced very much like insurance.

With the entry into the market of the proprietary sector, the taxable entities are looking for LTC insurance products to back up their obligations under the residence and care agreement. They are not comfortable assuming that liability without the participation of an insurance company. What I want to spend a few minutes on now are at least four types of products which are desirous from the operator's point of view.

One approach would be to take an individual indemnity benefit, such as described by Ron, and have an assignment of benefits to the operator.

A second would be a facility based group policy treating the facility based operator as the equivalent of an employer and the resident as an employee. That obviously gets into all kinds of questions about discretionary groups and so on, but that would be one model.

Third would be a facility based contractual liability policy with the insurance company entering into a contractual liability with the sponsor of the project. That raises certain questions since it's likely to come out of the casualty security side and you are going to have an asset-liability matching question for the sponsor. If the insurer needs to opt out on a limited days' notice and the sponsor has undertaken an LTC contract, they don't quite yet have an asset-liability match.

Then a fourth type would be an aggregate stop loss for communities which intend to self-insure their own liability but need reinsurance, pushing the coverage limits out fairly far. There might be a grace period in the community of, perhaps the first 365 days of coverage. Thereafter, there would be a sharing on each individual stay. There might be a sharing in the aggregate in

excess of a budgeted number of utilization days. The typical problem in this situation is that the further out you go, the more liability the community assumes, the lower the premium expectation on the back end, and the higher the volatility from the insurer's point of view with regard to the tail. I think one insurance company's comment was that they were prepared to offer it, but it looked to them as though they needed to do it on the basis that they would charge four times what it looked like their liability exposure was, because of the high volatility out there. That is one of the ways to approach it. From my standpoint, which is more of a business standpoint, there could be an enormous potential for getting 25 or 50 existing communities to set up a facility based aggregate stop loss in a pool which was reinsured by an insurer, giving the insurer the benefit of perhaps an average of ten years experience in each of the insured communities. There are lots of problems with how do you take on existing lists and that sort of thing. We deal with a number of sponsors who may own 25 to 30 RCs offering residence and care units of the type described. Those units offer an opportunity for structuring that kind of arrangement.

Let me describe those particular problems that I see in each of the policy areas. On the individual indemnity, it is obvious that the pricing for the age group which fit the RC is very high relative to the principle for others. On the other hand, having looked at the premiums run for the group insurance, using a group employer concept, that premium is low. So there may be a place here where the fit of an RC group with a group type of policy would work very nicely.

The elimination of the prior hospitalization requirement, as in the AARP policy, is necessary for the CCRC based policy because they anticipate keeping people out of acute care to the extent that the CCRC operator picks up a portion of the liability on the front end. This should be a disincentive for them from over-utilizing the nursing care. And I tend to negotiate, as a starting point, that the temporary care days ought to be assumed by the community because that's a management decision. They can easily decide whether they are going to provide HHC in many situations as opposed to moving them into the skilled nursing center. If the insurance company is sitting there, picking up the tab, we can have a good idea where they are going to put them. There are some economics operating there. If that person is in a single unit, and they are moved to the nursing care center, releasing that unit, and they get a new entry fee, there

are some economic forces to get them out. So there are a lot of items in a group based policy which need to be looked at.

In a facility based group policy using the employer/employee kind of approach, the desired policy, from a sponsor's point of view, would have guaranteed renewability upon continued payment of premium. They'd like a premium cap for any one year over a long-term period. And what they'd like to do is have the insurance company feel comfortable enough that they can predict, within a certain framework, the claim exposure. They're not seeing the necessity of limiting to a fixed premium, but they will limit to a fixed benefit. If they could understand that the volatility of that premium was going to be limited to 15% in any one year, over an extended period of time, that would give them what they need to match their asset-liability under the residence and care agreement. Obviously they want a level premium calculation approach funded on a group basis rather than on a term calculation approach. What they are trying to do is build up sufficient reserves to care for that population on a long term. If they can avoid it, they don't want to have an enormous premium increase that can't be handled in the marketplace on monthly fees, as the insurance company would not either. They will typically look for a benefit for any qualified facility.

One of the problems is that when you size the facility type, you may have to size the number of nursing beds in such a way, as you may outgrow that at some point. When you go back in for a certificate of need there are governmental limitations on how quickly you can have your skilled care beds. There might be a point in time at which they place some of their people in other facilities. The benefit needs to follow the individual in that extent.

There are some technical kinds of things in building a group policy which I thought I would mention to give you more of a feel for how these animals are put together. Typically, it will take three years to put an RC like this together. You've got to go through all your public approval processes. Then because of the high entry fees that are charged and the discretionary decision on the part of the retired person, you need to presell most of your units before you start constructing. Typically a presale requirement will be at the 60 to 70% level. People will have paid 10 or 20% of their ultimate entry fee to the facility to be held until the facility is constructed. In that circumstance it takes a long time for people to make up their minds to do that. Typically, unlike another kind of

commodity product, an automobile or a condominium, you will find the elderly person spending six to seven visits with marketing staff before they'll make a decision to put that kind of deposit down. It's a life change decision. It involves all those helplessness kinds of issues and the psychological issues which we talked about before. It takes a long time.

Then as a developer it is going to take you a long time to open the doors. And if you are basing your contract, with the resident, on the idea that you are going to have an insurance backup, you need a commitment for the insurance perhaps two to three years in front of the time when you are going to start paying premiums. That has all kinds of interesting ramifications for insurance people. It is not impossible to structure because it is anticipated, for example, that a major portion of the premium, let's say a $10,000 prepaid premium, can be paid at the point of opening the facility. So there is a reserve fund there to work against and the utilization statistics for the first few years ought to be relatively low, if there is case management on admissions.

I guess we are going to see insurance companies coming into this type of product on a management basis as opposed to an insurance basis. They are going to want to manage the liability for the sponsors as opposed to assuming the insurance risk initially. Ultimately, what the sponsor is looking for is more than that.

On the aggregate stop loss, I think the major problem is that you have to get a large enough group as a bulk to generate a premium dollar which will make it attractive for an insurance company to do the work that is necessary to put the product on the market. One facility with the insurance company covering a small tail out on the back end is not going to generate premium sufficient to attract them into the market.

A theoretical issue in risk evaluation is what the determination of permanency is by definition. If you include temporary care days, how do you handle the decision of permanency and when does coverage begin? How do you estimate the mix between assisted living and skilled living in this type of community for purposes of estimating your premiums in your risk premium analysis? One of the issues is that there is a general concept of step forward, for lack of a better term. When somebody moves into personal care, do you treat them from a

mortality point of view as being the same age or do you treat them as being older. If you treat them as being older, how much older do you treat them as when they move from independent living into skilled care? And actually the case mix between assisted living and skilled care is affected by those two assumptions because if you assume that there is a much more aggressive, a much higher mortality rate on people who move into skilled care, there may be more of them in skilled care but they are going to be there for a shorter time. Your people in personal care assume to have a longer life expectancy and therefore, they are going to be there longer. Over time your case mix will shift. We don't have a lot of data on the details of these kinds of things.

Second, the original concept regarding the application of mortality statistics to these kinds of communities, was that people were putting down large lump sums which they were giving up. If they died, they lost it. And therefore you applied the annuity tables to them. What happens with a 90% refundable contract? I don't know. Do you take 80% of it, or 90% of it? Those are the problems and refundable contracts really only date back to about 1975-76. And the real growth hasn't occurred until 1983. There is very little data so we don't know what happens. We can see some individual community changes. It is an exciting area. The need for that kind of facility based product is going to grow. I don't pay much attention to the numbers anymore, for LTC alone between now and the year 2000 will be $200 billion in capital development. If you add the independent living unit facilities that are associated with that, you probably triple that. We are talking about a trillion dollars or so worth of capital development in this particular sector and that represents a whole bunch of group insurance plans for somebody to work on.

MR. JOSHUA JACOBS: With regard to income, the panelists have mentioned Medicaid only taking care of the poor person. You have to be quite poor to be eligible. There are also a lot of people who have some assets and who go into nursing homes and spend them down until they get to be eligible for Medicaid. In selling this, isn't one of the chief promotional ideas the protection of an estate from this spending? And if so is the market more or less limited to people who have a certain amount of affluence? Have you any idea of the size of the estate that needs protection? I'm thinking of a broker going out to sell this. Is this going to be one of the major promotional ideas that he is going to make?

MR. HAGEN: Yes, I think you are absolutely right. One of the problems of home equity conversion, reversing annuity mortgages and all those things is precisely the reason that people are interested. One of the reasons that they are interested in buying LTC insurance is to protect their home which is their primary asset. The extent to which an individual's motivation is specifically based upon that, I think, has to go a little deeper than that. I think the extent to which we have done some work indicates that people have a desire to avoid Medicaid, they have a desire to stay out of nursing homes first and foremost obviously, and they have a desire to leave or at least have some independence and control over their lives. Their home is a very real and tangible symbol of that independence and the control that they have over their lives. As to the extent anybody has marketed or will market specifically to the idea of asset protection, it is already happening to some extent. It will have to happen more frequently in the future, because it is a factor at this point.

MS. WEISSMAN: It's sort of a "Catch 22" situation. I don't think people overtly say to themselves, I'm going to rely on Medicaid. I think the difficulty and the critical problem we are dealing with is that consumers believe they have coverage. They are entering this situation under the belief that they have the coverage; then they suddenly realize that they don't have the coverage and they see their finances quickly disappearing. They have the choice of one or two situations. The typical case study, that is in the literature right now, is the story of the couple married for fifty years, and suddenly the wife legally divorces the spouse because she's not going to have any finances to live on if she continues draining their resources to keep him in a nursing home. Therefore, he then goes on Medicaid to cover those costs and this allows her to have a certain amount to live on. I think the first issue that we have to deal with is to make the public aware that they do not have the coverage. Then, how are we going to market the policy? You are absolutely right and one of the real points of marketing is that it is a financial protector to your finances.

MR. HAGEN: Some 50 to 60% of people in nursing homes on Medicaid have entered as private paying patients, so that is a very significant issue. Another thing is that right now in Congress, there is a very strong effort that will probably be successful in dealing with the whole issue of spousal impoverishment. What happens to the spouse when the primary source of income is the institutionalized husband? What happens to that spouse when that income to

maintain that home, that independence, and that life style outside in the community is compromised by the draining costs that are really taking away all family resources and assets? There is an effort to allow a noninstitutionalized spouse to maintain a certain asset, as well as income level, protection.

MS. WEISSMAN: One other interesting thing that I just saw in the very preliminary results of the most recent buyer/nonbuyer study for LTC, is that significantly more males are buying LTC for their spouse as a means of protecting the spouse. They assume they will be the one to go first and wish the wife to have some sort of LTC protection to cover her needs.

MR. PAUL N. FALCONE* Ron, you mentioned that you removed the three day hospital requirement in your 1986 survey program. Would that be how you would determine whether you would be working with these people?

MR. HAGEN: There is a patient's assessment, as well as a physician's form that have to be filled out that really will quantify for us the ADL limitations that exist. The individual patient will be required to submit that before the end of the deductible period. That information, including the physician's name, will in turn be used to confirm or raise questions about the limitations on activities of daily living and the disabilities that that individual has. We are looking to go way beyond that though and have trained individuals who will be able to consult with persons who call and contact us about relative care options: what their care options are, and what won't be used to deny benefits at this point in time.

MR. FALCONE: You said that LTC insurance is not the answer now. Then is it education?

MR. HAGEN: Education is very important. I think, again as Arlene already mentioned, there is a very large group of people out there who perceive themselves to be already sufficiently covered. I emphasize, it is not just Medigap insurance and Medicare, it is also employer based group coverage. People are under the very distinct impression that they are not at risk, that

* Mr. Falcone, not a member of the Society, is Account Vice President with CIGNA Re Corporation in Wilmington, Delaware.

they are covered and are taken care of. I think we have to clear some of the Medicare and Medigap myths as well as the general private insurance myths that exist. That has to be a multi-faceted, broadly based communication strategy involving state and federal government, the private insurance industry, and other private secular interest. And it has to happen now.

MR. STARR E. BABBITT: Ron, your Medicare supplement policy is very, very good. It is one of the best kept secrets in the industry. I average probably one telephone call a day from a citizen of Tennessee saying, "I want to know about Medicare supplement policies. Is the one that some senior statesman of the television industry, or the one that Tennessee Ernie Ford or whoever talks about any good?" I ask, "What company is it with?" They reply "I don't know." I then ask, "Are you by any chance a member of AARP?" They will say, "Yes." And I'll say, "Have you looked into their Medicare supplement?" And they'll say, "Do they have Medicare supplements?"

MR. HAGEN: Well, there are about 3.5 million of our members who do know. I did not mean to belittle what you are saying. You're right and I think there are real problems that that kind of advertising presents from an image perception and educational point of view.

MR. BABBITT: People watch television more than they read modern material.

MR. HAGEN: I think ultimately, though, one of the things that has been talked about a lot as potentially being the answer, or one of the pieces to the puzzle, is the idea of a super Medigap policy which will combine the Medigap acute piece with an LTC piece in a fully case managed environment. I think we are a long way away from that happening yet but that clearly has a lot of very significant advantages from the ultimate consumer's point of view. We are quite a ways away from that. We are having problems right now with all the things happening at the federal level, with Medicare maintaining the Medigap products and maintaining the prices of those products. But I think ultimately, that is one of the ways to go and I think we should be looking at that.

MR. BABBITT: One of the other things on your list was that you listed regulatory and legislative lethargy. You did mention an NAIC model, which I

confess, I didn't even know existed. All we have received so far, when it comes to LTC, are three submissions. Two have been approved and one is pending for some minor change. Maybe they left the form number off or something like that. So, I don't think that we are the ones that are lethargic. I think that it is the industry out there.

MR. HAGEN: Every situation is not necessarily the same. The model law was approved by the NAIC on December 9 of last year. It is the basis for putting together a regulatory system to regulate these kinds of products differently from Medigap and other kinds of individual limited health type policies. There is a regulation that will be worked on by an NAIC advisory committee, chaired by Bill Gunner of Florida, that will implement that. The loss ratio provision and other provisions are in the regulation, not in the model law. Our association is supporting the model law and its implementation. There are about half a dozen states right now where it is close to passage. I know Virginia has already passed it. There are slight variations obviously from state to state on these things, but it is a good beginning. It's a good start and it has disclosure and strong informational type provisions in there.