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LONG-TERM CARE INSURANCE: HERE'S WHAT I THINK!

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MR. GARY L. CORLISS: This session covers long-term care and long-term care insurance. It is a subject that is frequently seen in the newspapers and periodicals as well as heard on news and special report telecasts.

Because of activity in the private sector (consumerists and lobbyists) and the public sector (National Association of Insurance Commissioners and the Pepper Commission) this topic is going to receive a great amount of legislative attention, particularly on the federal level, but not to the exclusion of the state level. Widespread discussion of a topic which involves probabilities, financing and legislation makes it appropriate for actuaries to be involved in the issue, as we certainly are. This is the third of five sessions on long-term care insurance at this particular Society meeting, which says something about the interest that we have taken in the issue.

This session will cover diverse topics relating to long-term care and long-term care insurance. The first speaker will give us an agent's perspective on long-term care insurance. The second speaker will discuss current and proposed future state regulatory activity on this subject. The program will finish up with comments relative to the investment potential in long-term care insurance.

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MR. WILLIAM C. MCMORRAN: I would like to provide you with my perspective relative to long-term care insurance as I perceive it working with both consumers and retirement community administrators who are active in the long-term care industry. It's an industry I've been involved in since 1970 when I worked with a group called the Gray Panthers in Philadelphia. In those days, we were really in the dark ages of the nursing home and retirement industry. The only way we could gain access to some of the retirement communities in Philadelphia was to wear clerical collars. If they denied us access after we'd clearly identified ourselves as religious counsel to see a specific individual, we could go to the State under a regulatory basis for denial of pastoral care. Some of these facilities just didn't want outside visitors. That's how bad it was back then. It's changed a lot, and very much for the better. We can talk about long-term care insurance as not only an evolutionary, but a significant benefit that will help many people over time. Our concern today is how we can make it better and more efficient.

I suggest the first general area to be improved is policy structure and language. Policies are confusing. It is extremely difficult to convey the benefits protection provided within an insurance contract to an individual who neither understands long-term care insurance nor, much less, ever wants to receive long-term care assistance or enter a nursing home. Nursing homes represent the end of the road -- a negative thing. The agent needs to separate emotional feelings about nursing homes from the financial aspects of planning should long-term care expenses ever occur. Many people don't want to address that. Therefore, it's very important that the policy be as clear as possible in order to remove one more barrier to the purchase of long-term care insurance. Keeping the policy simple makes it both easier to describe and to sell.

Let me give you an example of something that may be simple to insurance folks but not for prospective insureds. The hardest thing to understand is what a "year" means. One question frequently occurs: "Well, if I buy the three-year plan, what happens in 1994?" Then I have to go back to the beginning and define a year once again. The year concept is tough, and everybody has a problem with it when you present the product. So, I point that out to you so you can find another solution.

The next item I will address is product. I'm embarrassed about some of the individual products which I sold five years ago. I wish I could go back and tell them I have a better product. The person may not want to hear my news because they made a decision and they're done with it. So it would be very helpful from not only a sales but a delivery standpoint to have products that allow for upgrading of benefits as insurers change them, while still keeping the cost reasonable despite an age change. Although I'm not an actuary, it seems that when you have good persistency built up over time, you'll have some built-in underwriting which can allow for less expensive upgrading of the product than if it were a new case.

Next, there needs to be product design and claim processing requirements that are consistent. Both medical necessity and activities of daily living (ADLs) are significant definitions of an insurable event. I personally think ADLs are far more useful and objectifiable mechanisms for claim processing. However, there are even problems with ADLs. Some of these problems were first experienced in the social health maintenance organizations (SHMOs). If you're not familiar with an SHMO, it was a Medicare

demonstration program in four different locations in the U.S. Each was built similar to an HMO model, but acute care savings were used to give everybody long-term care benefits. We learned in the 1980s that you can't really run an HMO very efficiently, let alone add more benefits that are confusing and even more difficult to project in health care utilization. The social HMO had four sites: Long Beach, New York, Oregon, and Minnesota. There was an SHMO planning group for ADLs which would meet every few months to come up with a common assessment form. We found that people in different parts of the country had different definitions of the same ADLs, even though people had gone to the same schools. Some of the reasons related to different state regulatory environment, how people think and how they operate in their given areas. Therefore, even with ADLs as the benefit trigger, it's very hard to get consistent, objective values across the country. So, if the carriers can improve definitions used in claims processing, it will remove a lot of consumer pressure. Everybody says that insurers are just out to rip off old people. I don't think you are. I'm not. But we need to make sure that our claim processes work cleanly and efficiently so that claims are paid promptly and are understood.

Finally, a long-term care policy should be designed to provide for continuum. The buzz word of the 1980s in long-term care treatment was the continuum of care. The idea is to provide whatever is necessary to the individual so that you give the precise level of utilization necessary (and not any greater). If you give too much service, you'll lose money. If you don't give them what they need precisely, you undercut your product design and set yourself up for greater claims down the road because they didn't get the proper care earlier that they needed. Products that would offer an effective continuum of care may be more cost effective in the long run because you can spread your benefits and use precise utilization rather than simply dumping older persons in the nursing home at the more expensive benefit.

The second general improvement area I will cover is marketing the product toward appropriate personal applicability. Someone at breakfast asked me how I pick a company to represent. I look for companies that don't use scare tactics in their presentation materials and offer a good, solid product rather than a list of why people should buy long-term care insurance. Do you want to go broke? Do you want to live destitute in a nursing home? Those emotional things are used as a wedge. This takes the focus away from the product itself in the long run, and I think is a discredit. This is a discredit to our industry which really needs to grow and thrive to overcome the objections of a lot of people out there who don't want it to succeed. It often seems that they're the ones who are most vocal. So, we need to use less scare tactics in presentation of our product and really focus on how it fits into a broader range of long-term personal financial planning so that people can maintain their independence for as long as possible. Older people want to maintain their independence and their personal integrity. This product allows them to do that. If you present it in that way, people are more likely to respond. The market we want to respond, will respond. Scare tactics bring in the wrong market. Half of those affected by scare tactics may be on or close to Medicaid already.

To properly market this product, the agent needs to expend an extensive and intensive amount of time for most sales. This is not like selling a single premium, $2 million, key-man policy to executives in a major corporation where the company says, "we're buying

it, everybody sign here." Long-term care insurance can be the sale of a very high premium product to an individual who doesn't understand the concept and who has a high degree of suspicion towards you because you're an insurance agent. Therefore, you have to spend a lot of time carefully explaining everything. Often you have to go back and explain everything more than once. It's a time-intensive effort. The agent who doesn't take the time to prepare his or her client does a disservice both to the company and to the individual.

This requires stricter agent review and oversight by the writing company. I know a lot of insurance people. I like a lot of insurance salespeople, but a lot of insurance salespeople are still insurance salespeople who've been selling other products for 20 years. Their understanding of this unique product does not allow them to walk in, pull a magic application out of their bag and say "sign here." Long-term care insurance is something that people need to understand. They need to have it presented clearly. Therefore the company needs to make sure that the agent understands the product so that as products change, the agent can keep up with the changes or the nuances of what companies are providing and advise his clients appropriately.

When a newer product comes out, agents don't bother to notify their clients. They don't understand what the product actually is, they don't see how valuable and important the coverage is, and therefore, they don't go back to their clients.

Let me give you one example I've discovered in a group product situation where I have reviewed existing in-force products. I'm embarrassed sometimes to be an agent when I see the lack of service by a prior agent. In gerontology, we have what's called "aging in place." That typically happens in a newly opened retirement community where everybody about the same age moves in, and then they remain. Eventually they all begin to look alike. All the people are the same age. They grow old together. The same thing happens to their long-term care policies. Then, one day down the road one of these people tries to use the product. They find out it isn't very effective. For example, maybe the policy has a three-day prior hospitalization requirement but they only need to go into a nursing home. You get a local focus where everybody's down on long-term care insurance. All of them hit the same problem at the same time and are too old to change their programs. The insurance industry receives bad press. It's important to find ways to keep the policy current in order to maintain the continuity of the product over time.

People in the field game the product. Let me give you an example. Because it is time intensive, I like to spend half an hour with someone and lay out the parameters of the coverage and tell him he doesn't have to make an immediate decision. But I ask him his birthdate. Because everybody age-rates their product now, you can sign up someone the day before his birthday and save his insuring age. If you sign him up the day after his birthday, it costs him maybe $10 or $15 or $20 more a month. Signing the day before makes sense. The idea is that if you get him that day before, you can save him money. What I often do is use that birthdate as the way to help him make an effective decision, maybe six months away. I got a call just yesterday from someone I met with three times: nine months, seven months and five months ago. He called and said, "that policy we've been talking about, I want to get it, and we need to do it next week." Well, his

birthday's two weeks away, and he wants to give himself some breathing space. However, the insurer may get caught because it may skew premium ratings. I don't know if you go back and look at your cases, but you may find that purchases occur very close to people's next birthdays because that is the best time to buy the product.

Third, we need product benefits that are meaningful and understandable. People need to understand how the product could apply to their lives. What's an adult day-care benefit worth if it's not available in your state? You need to be able to explain the different levels of nursing care and types of nursing facilities. The agent needs to be able to explain it. And because you're working in so many states, you have to allow for differences in how you define your benefits from state to state.

Finally, I'd like to touch on the role of financial planning. I think it's important, if we're to succeed with this product, in integrating it into a broader lifetime planning. It is part of a financial planning picture. It's not buying insurance to protect one thing. It's for asset protection of everything. It's for security. It is to make sure that insureds can maintain their independence. Regardless of what happens, they won't become poverty victims. They won't come under Medicaid. They control their own destinies. There is no need to worry about their kids taking care of them. And I think that we need to focus on long-term care insurance as part of a broader financial package, something that's integrated into annuities, that's integrated into insurance, planning for the future.

One person said "I don't worry about long-term care insurance, I'll just sell my house if I need to go into a nursing home." He was single, but when there's a spouse involved, you have to worry about how that person will be handled also. How we do that is something that you may want to consider because, if the market is to succeed, then we need to focus on how we integrate it into much more of a mainstream focus. Within a broader context, the ways to do that are to look at different product development models. Wouldn't it be great if there was a cash-back mechanism that would be fair and would work in all the states? Perhaps I dream.

The way of targeting group product sales I think is more significant than individual sales. The potential of reaching groups as a vehicle is enormous and untapped. Retirement communities are one option. Associations are another. The American Association of Retired Persons (AARP) is a good association. But what binds the members together except the fact that they're willing to pay $5 a year for a nice magazine? We need to hone in more effectively on groups, employees, retirees, as well as retirement communities where we can specifically define the group, its unique needs, and create good products.

I will close with a summation and a "new" idea based on an old failure. There needs to be simpler product design, continuum-of-care benefits for claim cost control, consistent claim handling, thorough education and oversight of agents, and properly integrated financial planning for long-term care insurance to succeed. To put it all together, maybe we can take a note out of the HMO industry and go back to my original point about keeping policy structure simple. As you know, HMOs had what was perceived as a golden opportunity in 1981-1982 under the TEFRA risk program. The feds would capitate 95% of the expected per-capita cost. HMOs would then define benefits which

would either give monetary savings back to the government or they could throw in more benefits. HMOs got excited about how they could be different from their competitors and design unique benefits that would give them an enrollment edge. Within the succeeding five years, it became obvious that people who needed high pharmacy benefits went to the HMO that gave them the greatest pharmacy package. Other people went to the HMO that gave them free transportation if they couldn't drive. Other people went to another HMO for one reason or another. Finally in about 1987-1988 all the HMOs that thought they were so clever realized they were getting burned badly because they had targeted their policy features precisely to adverse selection. The result was that a homogenization of product developed in the HMO Medicare risk contracting field because no one wanted to stand out. Instead of coming up with more and more radical concepts of long-term care products on a company-by-company basis, we may want to look to some common standards that will provide a clear base so that then the companies and the product can be understood by all, compared more equitably, antiselection can be avoided and profitability attained.

MR. LARRY M. GORSKI: Before I begin the main portion of my comments, I'd like to give you some personal views on why I think private insurance in the long-term care area really is the way we need to go. I just don't believe that public financing or social insurance of long-term care services is feasible. I think long-term care insurance demands prefunding, and I just don't think that's possible through a social insurance program. So, I believe that private insurance is really the only effective mechanism for providing funds for long-term care services to the people of our country.

My presentation will really be in four areas. These four areas are nonforfeiture values, inflation protection, experience reporting and valuation. I've been involved with all of these topics at the NAIC level for about two years. I'd like to share my views, and I have to emphasize these are my views. I know that oftentimes one regulator's view is thought of as the view of all regulators, but it's really only one person's viewpoint. I previously spoke on state-mandated health benefits. I probably came across as a person who did not believe in state-mandated health benefits. I mentioned that Illinois and other states are looking to eliminate or pare back in that area. It might seem kind of ironic that earlier I took that view, and now I am a proponent of required nonforfeiture values in long-term care insurance. The basic reason is that I believe nonforfeiture values in long-term care insurance is a matter of actuarial equity, not a mandated benefit. The very nature of the prefunding of long-term care, in my view, demands some type of nonforfeiture value. I'm not necessarily committed to a cash value, reduced paid-up insurance or an extended term type, but I think it's absolutely essential that some form of nonforfeiture value eventually be incorporated into a long-term care insurance policy.

I have to say eventually because, if any of you have read my paper that I presented last year at the NAIC, you will note that I recognize all the practical problems with nonforfeiture values. I don't see the issue being resolved necessarily at the June meeting, at the December meeting, or even at next June's meeting. It's an issue that's going to take time; all the questions need to be asked and answered. All the problems are going to have to come out and responses to those problems developed. I see it being an evolving issue. However, in the long run I do believe that nonforfeiture values will be a required

feature of long-term care insurance. Along with the equity issue, I have a very great concern that products are being developed that, on one hand, are being viewed as a level-premium-type product, but in reality the company is viewing it as a step rate product (Chart 1).

I tried to identify in a schematic form a claim cost curve identified as Line 1. Line 2 would be a level premium to finance those increasing claims costs. Line 3 would be a step premium approach. From my perspective, if a consumer believes he or she is buying a level premium long-term care policy and in reality is buying a step premium policy, I think there's a great amount of misrepresentation in that case, and I think that is going to evolve to a tremendous number of complaints and consumer problems. Of all areas of regulation, I think that regulators are taking a somewhat different view when it comes to long-term care insurance. In most cases, when a regulator is presented with a new product, he or she immediately reacts in a very negative way. In long-term care insurance I believe regulators are looking at the big picture. They see the problems of the aging population. They see the difficulties of financing through a social insurance program. And I think they perceive private insurance as being a viable, reasonable and maybe the only way of financing those costs. So, I think, on one hand, they're supportive of private, long-term care insurance, but once you become supportive of a product, you're linked to any problems that might develop, and if any types of problems do develop, I think the finger will be pointed towards regulators because of their support of the product. Because of that, I think we're even more concerned and need to address some of the perceived problems that might occur in this area. To recapitulate, I think that nonforfeiture values eventually will be mandated. I don't think it's going to happen in the near future because of all the practical problems.

The other area I'd like to talk about is the experience reporting form that I have been trying to develop. Charts 2 & 3 are the result of initial development activity. (Charts 2 & 3) From my perspective the experience reporting form is to serve two purposes. First it's definitely to be used for loss ratio monitoring from a consumer standpoint and second it's going to be used for financial monitoring. I feel that in the long-term care area there's a tremendous amount of uncertainty. I think all the speakers are going to echo that. We're all working in an area where there is not good data to work with. I feel that the experience reporting form is going to be useful in seeing the development of experience relative to company pricing expectations. Will actual experience be reasonably comparable to what was expected? That's important from two standpoints, one from compliance with loss ratio standards but just as important for financial solvency purposes. I've been with the Department for several years, and one of my main responsibilities is financial monitoring. I'm sure some of the companies that you represent are on our company claim reserve monitoring system. Our claim reserve monitoring system is a system wherein we receive claim data on a paid and incurred basis on accident and health business from about 50 companies at any one time. We try to monitor the accuracy of claim reserves on an ongoing basis. We don't wait for Schedule H in the next year's annual statement. We try to detect solvency problems by midyear for short-term health insurance, either group or individual. We put an awful lot of emphasis on financial monitoring. I think the same emphasis will be required in the long-term care area. I see this as a tool to enhance our abilities in the financial monitoring area of long-term care insurance.

CHART 1

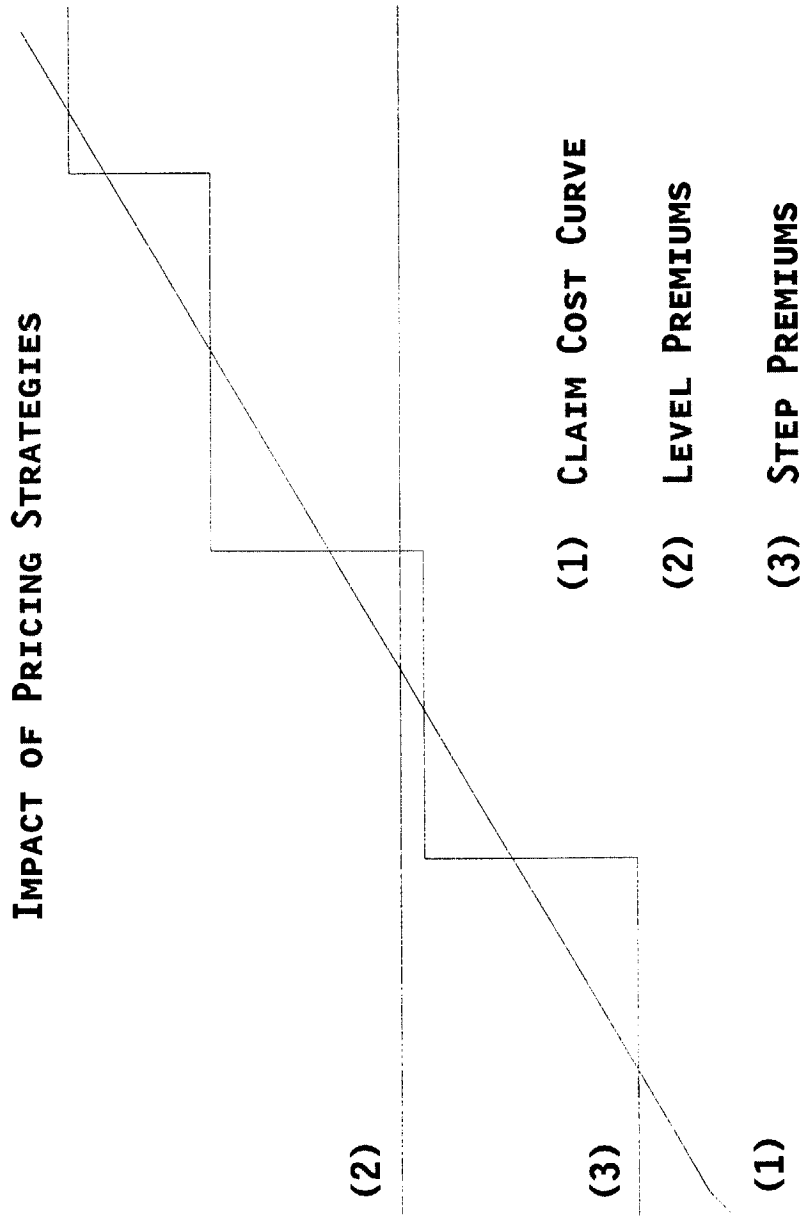

IMPACT OF PRICING STRATEGIES
(1) CLAIM COST CURVE
(2) LEVEL PREMIUMS
(3) STEP PREMIUMS
(2)
(3)
(1)

CHART 2
Long-Term Care Experience Reporting Form -- A
Claim Experience
by Calendar Duration

Policy Form	First Year Issued	Calendar Duration	Earned Premiums by Duration	Incurred and Paid	Reserve for Incurred but Unpaid	Anticipated Calendar Duration Loss Ratio	Number of Insured Lives
		0 1 2 3 4 5-9 10+					

Instructions

1. Experience on all long-term care insurance policies and contracts except for accelerated death benefit-type products should be reported separately by policy form using nationwide experience.

2. Policy forms should be grouped by individual, group direct response and other group with experience reported separately for each form. Experience under forms which provide substantially similar coverage and provisions, which are issued to substantially similar risk classes and which are issued under similar underwriting standards, may be combined.

3. The anticipated calendar duration loss ratio must be calculated as a weighted average of the policy duration loss ratios that were filed in conjunction with the original rates for the respective policy forms. The weights should be based on the relative proportion of earned premium by policy duration within each calendar duration.

4. The change in policy reserves should not be deducted from the earned premiums or added to incurred claims.

5. Claims incurred and paid during the observation period and the reserve for claims, both reported and unreported, incurred during the observation but unpaid at the end of the observation period should be allocated to the appropriate calendar duration cell.

6. The observation period shall be the last completed calendar year.

7. The number of insured lives should be reported for all policy durations combined.

8. Calendar duration is defined to be the reporting year (RY) minus the year of issue (IY) of the policy or certificate, i.e., RY - IY.

OPEN FORUM

CHART 3

Long-Term Care Experience Reporting Form -- B

Policy Form	First Year Issued	Cumulative Earned Premiums	Cumulative Incurred Claims

Instructions

1. Experience on all long-term care insurance policies and contracts except for accelerated death benefit-type products should be reported separately by policy forms using nationwide experience.

2. Policy forms should be grouped by individual, group direct response and other group with experience reported separately for each form. Experience under forms which provide substantially similar coverage and provisions, which are issued to substantially similar risk classes and which are issued under similar underwriting standards, may be combined.

3. The change in policy reserves should not be deducted from either the earned premiums or added to incurred claims.

4. Incurred claims are to be determined by adding the claims incurred and paid during the observation period plus the reserve for claims unpaid, both reported and unreported, at the end of the observation period.

5. The observation period shall be the period since the policy form was first issued to the end of the last completed calendar year.

6. Cumulative experience should be obtained by accumulating calendar year experience at an interest rate of 6% per year.

To get back to the form itself, there are actually two forms. One form is from a calendar year standpoint that tries to analyze experience on a durational basis. The other form is a cumulative experience form. Both of them go hand-in-hand. These forms were first introduced probably about six or nine months ago.

Peter Thexton and I have tried to narrow some of the differences in views. There's probably three or four items that are major differences. Clearly, one of them is the inclusion or exclusion in the change in active life reserves. From my perspective, loss ratio monitoring should be based on an actual to expected where the expected does not include the change in active life reserves, and similarly, the actual loss ratio should be on the same basis. I personally think that including the change in active life reserves has more of a distorting impact on experience analysis than excluding them, and so from that standpoint we have some difference of opinion. One of the other issues is the complexity of the form. It's not a simple form. It's not like the Medicare supplement experience reporting form or other reporting forms. It does get into complex reporting of

experience, but in this area I think that's necessary. Again, going back to my experience I come across many companies that are involved in health insurance, and when we start asking for information in the claim reserve area, there's a lack of good experience. There's no way to really support the company's pricing and/or reserving of those products. And, again, because of my perception that regulators are supportive of the long-term care product, I view that experience reporting requirements have to be somewhat more comprehensive because of our different viewpoint towards the product. I won't run through the form, as it has been published in the NAIC proceedings. Please take a look at it, and please get your comments to me.

Now, I'll move to the subject of inflation protection. I've already said I believe nonforfeiture values are an actuarial equity issue and should be required. However, I believe inflation protection is really a mandated benefit, and because of my views towards mandated benefits, I don't suggest that inflation benefits should be required. The issue here is really more of disclosure. I think there needs to be much more disclosure of the impact of inflation on nursing home costs at the consumer level, and the cost of financing long term with inflation protection. It seems to me that a consumer, given information about inflation, his own needs and inflation protection coverage available, can make rational decisions in that area. So, I don't believe that mandated benefits are appropriate in this area. I'd rather work towards proper disclosure of inflation protection benefits available.

The fourth area I'll cover is valuation. Even though it's the fourth area, I don't want to imply it's the least important of all areas. It might very well be the most important of the areas that I'm going to discuss. Pricing actuaries have problems with data for pricing assumptions. Valuation actuaries have problems with data for valuation. Regulators have the same problem. I personally feel very uncomfortable with the whole issue of valuation as it is right now. It just seems to me that there needs to be some minimum standard. The viewpoint I had been trying to move along with is to start with the TPF&C valuation tables, and to modify them with whatever insurance industry data is available. The TPF&C tables are based on general population data and this has been a criticism. The Society of Actuaries has started to collect experience data for long-term care insurance and this could be used to modify the incidence rates or termination rates that are the basis for the TPF&C valuation tables. It just seems to me that sitting around waiting to get data is probably the wrong thing to do. I think it would be much more constructive if we moved ahead with a table, recognizing it's an interim table, adjusting it where it's necessary, but adopting it as the minimum standard. I don't want to downplay the importance of actuarial opinion in this area, because it's very important, but I do think some minimum standard for valuation, both in the active life reserve area and the claim reserve area, is very important.

In conclusion, I'd like to say that over the past two or three years the whole area of long-term care insurance has evolved dramatically at the NAIC level. I think that the easier regulatory problems have been addressed. I think now we're moving into an era where more difficult problems are surfacing. It's going to take longer to solve these. I think changes in the model regulation will start to slow. I begin to see some stability in the model regulation, but because the tough issues are really starting to come out now I

would hope that people who are interested will take a very active role in trying to address some of these tough questions.

MR. JOHN B. KLEIMAN: Working for an investment firm requires that one have a different perspective on the life industry. I look at things from the outside and second-guess everybody. One thing to remember when dealing with investors, and one thing to remember when talking about investors, is that you have to differentiate between a company investing in a product versus an individual investor or shareholder who is looking at a company. This is no different where long-term care is a major part of their business. A company that decides to write long-term care insurance will have a slightly different view of the issues I will discuss.

To an investor, perception is reality. It doesn't matter if a company has the greatest basics and fundamentals of the business. Their product can be the best thing in the world, but if somehow they get that bad press, it scares investors. The stock will go to pieces just like the insurance stocks that have gone south because of the recent concern about asset quality. So, that has to be kept in mind when we look at long-term care from an investor's perspective and what my people have to look at when they're doing a stock analysis.

By any estimate, caring for America's aging population could be the nation's most costliest challenge. And while awareness of the issue is growing, there is little consensus about the best way to meet this challenge. For advocates of an expanded public sector role, long-term care services, in their view, is simply a logical extension of what many Americans receive, and even more expect to have paid for by the federal government. Whether or not this logic yields an appropriate public policy, fiscal constraints are effectively blocking any bold moves for the foreseeable future. I was glad to hear Larry say that he really viewed it as a private sector initiative. The government can talk all they want about what is needed, but they can't come up with the money needed to fund it, and that's why the private sector is desperately needed to fill this void.

The development of long-term care may have a parallel to the development of the HMO industry, except that long-term care doesn't have the same priority as healthcare in most people's minds. This is a product in its infancy. Not too many people know about it. They think there's a possibility that this could be a real gold mine as we go forward. But from an investment standpoint I would say to wait a minute. Let's look at what did happen in the HMO industry. Those who invested early and then exited before the mid-eighties did well. Growth was dramatic. HMOs looked like the greatest thing since sliced bread. Earnings were looking good. Optimism was so high that I remember seeing a business plan that projected earnings in the second or third year of development. Companies were so eager to get into the business that they were willing to buy HMOs at just about any price without looking at the fundamentals of the business. In 1985 I remember doing some analysis and saying that prices were ridiculously low especially when you were dealing with a population that hadn't demonstrated any loyalty at that point. What were you really buying? So, I thought about this from a long-term care perspective and wondered if the investor might think, boy, this is great, let's jump into it. But remember that investors who hung on suddenly saw their values decreasing. However, the early years were very much false prophets (no pun intended) of what was

to come. The earnings were supported by growth, and quite possibly underreserving in some cases. The lack of reliable data most likely contributed to what was going on. And, as the losses evolved, provider groups got very upset as they had seen others take their money and run. This created negativism in the health care community and made it difficult for HMOs to convince providers to cut their fees leading to more losses. Not everyone got burned, but there were enough casualties. Long-term care risks a similar experience but on a smaller scale.

From an insurance company standpoint, I would say that the long-term care product is a strategically sound bet. I think companies view it as a way of building shareholder value over the long term. However, investors do not share the same definition of short term or long term as an insurance company. They are very much focused on what is going to happen in the next two years.

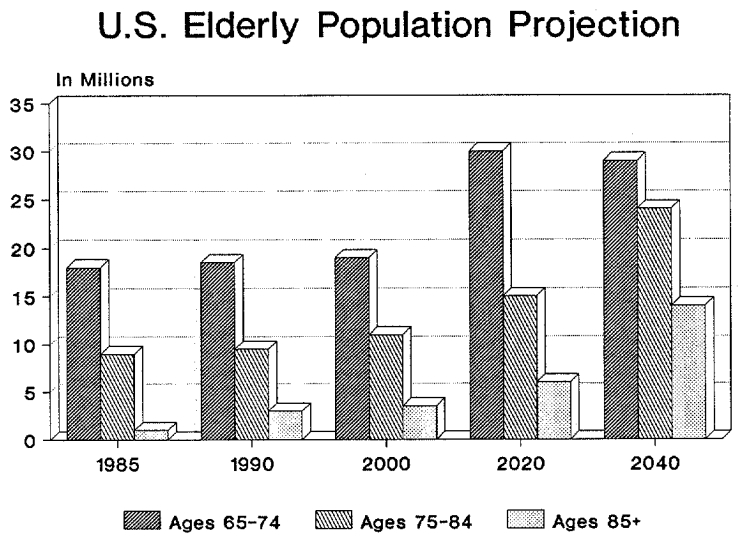
We need to focus on the short-term considerations of the product. The speakers before me did address some of the issues of the need for the product. It was especially interesting to hear an agent's view. There is a place for long-term care as a part of planning. There is a legitimate insurance need here that really isn't solved by other products. People can talk about using annuities, but they can't guarantee that the money is going to be there at the right time. There is definitely a need. We see consumer demand increasing due to a number of positive factors including the graying of America, the high cost of care, the fear of personal devastation, the inadequacy of financing alternatives.

Let's look at aging (Table 1). We look at the growth in the number of people age 65 and older, in the next 10 years there will be a slight increase; and in the next 20 years a bigger increase to about 30 million people. The real growth spurt is going to occur into the next century as the "baby boomers," people in the mid-40s, reach retirement age.

In 1989 there were about 1.3 million Americans age 65 or older living in nursing homes. In addition, there were 3.4 million more elderly living at home but needing some form of assistance. This translates to 4% needing institutional care and another 11% needing some form of assistance. That's 15% of the population, and, as the population grows, the low side. People will live longer, but they won't necessarily keep from wearing out. Thus, the percentage of people needing assistance should grow.

We're all familiar that nursing homes are not inexpensive with the average tab running about $1800 a month or over $22,000 a year. There are few retired Americans with more than that level of income. Not many can afford to segregate $22,000. The cost of nursing homes will naturally increase. We see the strikes going on in nursing homes around the country as nurses and other workers demand better wages. So, labor costs will increase and demand will also drive some of the increase. The one major misconception, and one that will inhibit sales, is that some people think that the government will pay for nursing home stays. They believe Medicare will pay because they don't understand Medicare benefits very well. Chart 4 from the Health Care Financing Administration (HCFA) clearly shows that Medicare is only covering about 2% of the cost of nursing homes while Medicaid provides 42% of the funds. The message has to

TABLE 1

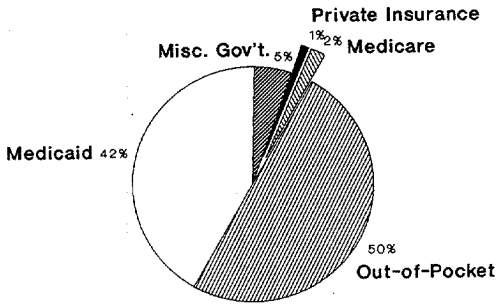


Source: Spencer, Gregory, Current Population Reports, Series P-25, No. 1018. "Projections of the Population of the U.S. by Age, Sex and Race 1988-2080." U.S. Bureau of Census, Washington, D.C. 1987.

CHART 4

Current Financing of Nursing Home Care

Medicare Pays Only 2%, Private Insurance Pays Only 1%



Source: Health Care Financing Administration

get out that Medicare will not cover long-term care expenses. We have to do something on our own or be eligible for Medicaid.

Another factor in determining if there is a need for the product is to look at the alternatives to nursing homes. I think nursing home care is the last resort for most people. They don't want to be there but if they can't live in their homes alone, what do they do? One possibility is to live with their children. Well, caring for an elderly parent can be a very emotionally draining experience for a family, and especially these days when there are two working adults in the family. There might not be anybody home during the day to provide care, and even if someone can cover the time you are gone, can you really provide reasonable care after a stressful day at the office? Home care may help, but there are availability problems. Elder day care is being talked about more and is even covered by some policies. However, that industry is very much in its infancy. I'm the head of a church-building committee, and one of our key issues from a social standpoint is elder care. Should we provide space for an elder day care program? It is a major item from a social responsibility standpoint. So, the end result is that unless a person has the resources or long-term care protection, they are basically going to end up either on Medicaid or qualifying for Medicaid as resources are depleted. We have to hope that when faced with the alternatives of Medicaid or private insurance, people will take the insurance. That's assuming that they still do not want the stigma of being on a social welfare program and that they will do what they can to avoid it.

There are about 118 companies selling stand-alone, long-term care products and the number of policies in force has grown from about 130,000 in 1986 to over 1.5 million in 1989. This is a very dramatic growth, but still reaches only a small part of the population. As Table 2 shows, the majority of policies sold so far have been on an individual basis. The average age has been about 72 according to Health Insurance Association of America (HIAA) figures. When I first looked at the figures and the average ages, my

TABLE 2

Type of Long-Term Care Product
By Percentage of Companies in Market and
Policies Sold by Average Age

LTC Product*	% of Companies **	% of Policies Sold	Average Age
	N = 118	N = 1.5 mill.	
Individual	70	79	72
Group Association	17	17	70
Employer-Sponsored	8	3	43
Life Riders	13	1	51

* Does not include information on continuing care retirement communities.

** Does not total 100% because six companies sold an individual policy and another form of coverage.

Source: Health Insurance Association of America, *Highlights of HIAA Long-Term Care Insurance Survey*, March 1990.

first thought was that it looked like we had tapped the "easy" part of the individual market. We have sold policies to 5% of the market and I wonder what's left when you consider that 40% of people age 65 and older have less than $10,000 coming in. We have some disagreement within our firm as to how much potential is really left. So, I leave it as a question of whether we've really tapped the easy part or not.

The biggest market in terms of numbers is naturally the baby boomer group. However, they are 20 years away from retirement, and if they are like me, they have more pressing concerns. I've got college education costs for the next eight years for two children and you know how expensive that can be. They are also concerned about medical care. There are higher priorities than trying to think about needing nursing home coverage at age 70. Also, newspaper articles fuel apathy towards the product. I remember one such article in *Money* magazine a couple of months ago inferred that long-term care insurance is not needed. It only affects 4% of the population. The essence of the article was that there are better things to do with your money.

I believe that if long-term care is to grow, it will have to come from the group market. But there are a lot of changes that will have to happen in order for this area to really grow. The typical approach is for employers to offer it as a benefit on an employee pay-all basis. One insurer has offered long-term care to its employees as part of a cafeteria plan, even though the tax consequences of that action are unknown at this time. Out of the group plans sold so far penetration rates have generally ranged between 7-14%. One carrier offered a plan that included parents and found the acceptance rate of parents to be only 1%. The company is thinking about ending that feature. One exception to the 7-15% range was CNA for their own company account where they were able to enroll one in four employees. That represents the highest that I have seen of any enrollment. But, in order to achieve any greater growth, tax policy will need to be more favorable, and employers will have to subsidize some of the cost.

State regulation of the product will also help determine the demand for the product. It's refreshing to hear Larry talk about limiting mandates because the more benefits in the product, the higher will be its cost, resulting in lower sales. Therefore, you have a number of factors over the short term that will inhibit sales, including the widespread misunderstanding about Medicare, unresolved federal tax policy, the unwillingness of many customers to confront the need, and possibly a leveling off of companies offering the product. On this latter point, it's a good and bad situation. Price competition will dampen for a while, but, on the other hand, it doesn't necessarily mean that you will have growth in people covered. The pot might be shared among fewer companies. From an investment standpoint, that's good.

Now, let's look at long-term care through the analyst's eyes. What are the key considerations? Quality of earnings should be the sole investor concern. Will the product produce earnings and at what return? Is this a good place to put money? Let's look at factors we consider very important when analyzing this product.

Larry talked about the dearth of utilization data that the industry has on long-term care. This is of great concern because there are so many unknowns going forward. Any assumptions can be put together that are reasonable. However, the past probably won't

be a good predictor of the future. To the extent that people have a product that will pay for a certain event, expect utilization to go up. That's just common sense.

It already has happened in acute health care. We don't know what companies are doing to predict changes in utilization for the future. There are other forces that will impact utilization including aging and mortality improvements. The onset of long-term care may be delayed but care may be needed for longer than five years. We are going on the assumption that people who live in nursing homes don't generally stay there more than five years. It could be that with medical science people might be kept alive for ten years in a nursing home resulting in payments for longer benefit periods.

Company reserving practices will naturally influence the pattern of earnings. There can be much manipulation over time here. We know that some action will be taken over the near term that, while not requiring minimum standards, will at least provide for disclosure. Texas has a proposal to require companies to state their methodology. Larry told me that this is a common theme throughout all the states. That helps us from an investment standpoint. At least we will get more information. Right now we're operating very much in the blind.

For individual policies, there is a wide range of commissions being paid. We realize that long-term care is a very technical and possibly a very different sale. But one has to question whether a 70% first-year commission followed by 10-20% renewals is legitimate. It certainly places a lot of financial strain on the product and pushes the price up. Also, you wonder about the focus of the company when they're offering such high commissions. What is their real intent? Is it just to get the business on the books and hope it lapses within a couple years so they can cover costs before the claims begin? The group product should have a lower cost of acquisition. It will be just a different product with a different earnings pattern, and so it has some definite pluses.

Reinsurance is another factor in analyzing a company. Are they trying to do the whole product on their own or are they reinsuring part of it? If they are reinsuring 80% of their long-term care book of business, then why bother investing with them? You might as well go with a reinsurance company. If they're not reinsuring at all, and they're a small company, then you may be taking a lot more risk than you want to. We think that a small company that is getting into this business should have some reinsurance. I think a lot of them realize that to get into the market they need a relationship with somebody who has more expertise in the field.

I mentioned that we think there will be a leveling off of companies issuing long-term care until we get more information on regulations and what the federal government might do. Once the picture is made clearer, I expect to see more companies enter the market. This could bring on a round of premium cuts resulting in lower earnings due to increased competition. As with the HMO industry in the eighties, companies might buy the business in order to establish market share.

Any of these factors can and will influence the profit pattern, and this is what makes it so difficult for an investor or an investment analyst to look at long-term care. One really needs to understand all these elements and have access to information on each in order

to have any success in evaluating a company. Having a high premium, low premium, or earnings in the first year tells us absolutely nothing unless we really understand all the pieces that went into it. We want to be careful that we're not recommending a high commission company that's growing by leaps and bounds or a company producing earnings that depends on the business lapsing in two years.

Another issue from an investment standpoint is to differentiate the small from the large companies. While long-term care may be a good bet for the large companies long term, you need to remember that long-term care is not going to be a significant element in their bottom lines for the next few years. It's not the reason you invest with those companies. There are too many other things driving their earnings at this time. If you are looking for an opportunity, you need to look at the small or niche company and in great detail.

Even though there are many concerns and unknowns, investors should not avoid this business. Rather, the point is to be very careful. A stock analyst needs to get inside the company and ask the right questions. An understanding of each of the areas I mentioned will allow an analyst to evaluate the future potential of the company. There is too much variability in pricing to state that long-term care is a good investment, in general. However, there are quality companies out there. Good intensive analysis will help find the diamond in the rough.

In addition to long-term care, we see other products that may present opportunities for insurance companies and investors. I'll go through just a few of these:

Home Care -- Policies are being expanded to include other features including home care. Insurers are realizing that people would rather stay home than be either institutionalized or live with their children. People want to maintain their independence as long as possible. *USA Today* recently reported on a survey done by AARP. More than half the people age 55 or older have not given any thought to their future housing needs and 86% of those over 60 don't ever want to move. The mindset is that people assume that they will always be able to keep their homes. Given that environment, home care will be a very important element and possibly a very good investment for the future.

Continuing Care Communities -- Early development in continuing care communities were undercapitalized and didn't fare well. But now there are several financially stable corporations, including Mariott, developing them. The reason I see continuing care communities as a good investment is that people can feel more comfortable there. It's like a home. They can have independence but also know that they can be taken care of in the future. They don't necessarily have to move out if they have a problem. Services can be tailored to their changing needs. There's more flexibility. This could also lead to significant growth for long-term care policies. Some insurance companies are specializing in selling to retirement communities.

Reinsurance -- The reinsurance market is pretty thin at this point, and I think this could be an attractive market. In some cases investing in a reinsurer who specializes in long-term care might be a better bet than trying to find the niche company that's selling

directly. There are very few reinsurers to accommodate the anticipated growth and there could be significant growth for those in the market.

Elder Day Care -- Elder day care provides another investment opportunity. Currently, there's really a lack of availability. Day care centers do provide a good alternative for working couples who must take care of a parent who has some mobility, but just needs some supervision. This type of care is a long way from full development at this point.

Let me mention a few thoughts on the future. I certainly think that we need to get into a form of managed care. If people have the options of being in a nursing home, or having home care or elder care, the insurance companies will have to step in and make decisions about the appropriate level of care. If children find their parent to be too large a burden living with them, they'll push them towards a nursing home, whether that's appropriate or not. So, there will have to be case management. There might also be some opportunity for linking the financial and delivery aspects for long-term care. Whether insurance companies get into running nursing homes or not remains to be seen, but there is an opportunity. The federal government will also impact the future of long-term care but it is unclear just how. The Pepper Commission proposal will certainly perpetuate the myth that the government will provide, but when you look at a $43 billion price tag, we know that long-term care from the government won't happen any time soon.

In conclusion, long-term care appears to be a sound investment for insurance companies. It's a complementary product to the other products they offer. However, from an individual investor's standpoint, they need to be aware that there are many unknowns surrounding the product. The combination of moving targets along with the lack of disclosure (although improving), should be enough to make any investor nervous about long-term care, at least for the near term. If an investor wants to proceed, then I'm sure there are a lot of us who would be willing to help them analyze the companies to find that diamond in the rough.

MR. CORLISS: It's interesting that both speakers addressing financial issues included the importance of reserves and valuation to this product. We need to do everything we can to ensure a proper basis so we know where the industry really is going.

MS. JOAN P. OGDEN: I have a question for Bill. You discussed the problem of activities of daily living as a gatekeeper. What kind of gatekeeper does the agent or purchaser want to see?

MR. MCMORRAN: They don't want to see gatekeeper because they really don't want to ever be in a claim situation. But I think that the ADL gatekeeper approach is the best. Then the next question becomes, who does the assessment? It's very hard to get across to a client the concept of ADLs, but it's even harder to discuss the subject of who will come to his house and do the evaluations or discuss how the claim will be processed. That's why the group product is potentially much cleaner. One can create a continuing care retirement community (CCRC) -- like structure without going for state licensing. This gives the ability to have someone locally empowered to do the reviews and determine the precise level of care. Insurers have a problem building networks around the

country that will have people on call nationwide who can implement a consistent program. However, there are many options -- whether it's social workers, visiting nurse association (VNA) networks, home health care agencies or a third-party management review company -- all of these will have regulations governing health review. There are a lot of alternatives. However, the key is to have someone who's accessible to the individual when he needs help.

MR. WILLIAM B. DANDY: I have a compound question for Larry and Bill on nonforfeiture values. There is some thought that nonforfeiture values are most appropriate for the under-age-65 population because of the lower probability of immediate use and perhaps less appropriate for age 65 and older. I would like Larry's opinion on age being a possible dividing line in providing nonforfeiture values. And Bill, would your clients be prepared to pay 25-50% higher premiums in order to have nonforfeiture values?

MR. GORSKI: In my mind, the under-65 market will probably be more easily served through long-term care riders applied to life insurance policies. So, I still envision the stand-alone products as being the primary product in the over-60 and over-65 market. I don't see an age differentiation in a nonforfeiture value because I don't see this product filtering down to that younger market. If it does filter down to the younger market, then I understand the differentiation. All I could say is that it's one of the things we are considering. I'm not willing to make a commitment one way or the other -- I don't even have a formal view on that. The best way I can express my view is that I think nonforfeiture values are the right way to go, and there are going to be a lot of questions that need to be answered along the way. Probably the best thing I could say about the over-65 market is I'd like to see nonforfeiture values. In the under-65 market, I'm just not sure one way or the other yet.

MR. MCMORRAN: First, there's a philosophical question. We really have maybe a 20-year window of opportunity to prove the value and validity of the long-term care insurance product. If we do a good job in educating and convincing people (which has been impossible heretofore) that they should plan ahead for not only retirement, but an overall financial picture, then only long-term care costs should be built in. Then people can purchase programs where they have resources available so that the cost of long-term care insurance becomes subsumed into a variety of products for financial control. Therefore, currently we are really targeting a 50-on-up population where insurance is the best vehicle because they haven't been able to prepare for long-term care costs. But on the realistic side, as people get older, in the 75-80 range, it's much easier to sell a plan that will give them money back. They're worried about their estate as well as the cost. And so, we're talking about putting it in charitable remainder trusts for a population that wants to have assurance that the money will come back if they don't use it. So, people buy the insurance, pure and simple.

MR. THOMAS M. INCHALIK*: Bill, I was intrigued with your comment that a lot of people don't want these products to succeed. There is a large consensus in the private

* Mr. Inchalik, not a member of the sponsoring organizations, is Senior Analyst with Howard Johnson & Company in Seattle, Washington.

community and among regulators such as Larry, private insurance is definitely going to have to play a significant role in financing these future costs, are you talking about crackpots who don't want the product to succeed or am I missing something?

MR. MCMORRAN: I have a foot in two worlds. One is a high purity consumer market where no product is perfect because they aren't taking care of all old people, and, on the other hand, a very realistic system. So, there's a tension because there are always problems with this product or that product, and older people will not get the benefits they need, and they're being misled by the insurance companies. It's the same kind of thing that we've seen in the Medigap industry continually since AARP first introduced its product in 1957, even before Medicare. There's always a concern about ripping off older people. This product falls right into the sights of that kind of mindset.

MR. HARRY L. SUTTON, JR.: I would like to comment on John's discussion about insurance companies managing long-term care. There are a couple of federal experiments called SHMOs, Social Health Maintenance Organizations, which have had mixed results so far in trying to really manage long-term care, and one of them is in Minneapolis. They have been able to control the cost of a fragile, old population probably within 10% of the current Medicare cost. However, when they sell it in the about $10 a month more than the regular Medicare supplement which is a federal risk market, it costs contract, but, interestingly, even at age 70 the people won't buy it unless they are immediately going to spend the $10. They won't even spend the $10 to do that. Almost all their expenditures are home-care-related. They have limited benefits of six months on the long-term care portion. We have some question as to whether this is an insurance benefit or a health insurance benefit or a health care benefit or a long-term-disability-type benefit, although the home care is clearly at least partially health care. There have been very few efforts to manage, and it would appear that only the group practice clients where they hire staff can really integrate. I'm not sure that in a fee-for-service system we would ever find anybody to coordinate well enough to control the cost of it.

MR. KLEIMAN: That might be a true statement as far as the ability to manage it down the road on a fee-for-service basis. My point about managed care is that I think we're going to reach a point of critical mass where you can't ignore it anymore. I think we're still debating the issue of whether or not we are managing care properly today. We are going to have to manage care in some form if we expect to control claim costs. What form that takes is anybody's guess at this point. I think we have to get there eventually. You're right about the practice plan as probably being in better shape. In many cases, entry to a nursing home occurs after hospitalization or after using a skilled nursing facility. The group practice HMO can follow the person and can make a recommendation on where they should be. Long-term care just becomes another follow-through on a patient.

MR. BRADLEY J. JOERN: I'm in the reinsurance business, and I've seen lots of policy forms for long-term care coverage from prospective reinsurance clients. I'd like to pick up on the point Bill made about confusing language. I've seen a variety of language used in long-term care policies that I think attempts to describe the same benefits, and it occurs to me that, Bill, you probably hit on something that's really important. If we can

start designing our policy language to make it clear to the prospective purchaser exactly what the benefits are -- what is meant by covered care? when do benefits start? when do benefits stop -- we may do ourselves a better service in terms of pricing and protecting our own interests as well as providing a product that is more saleable and amendable to the purchasing public.

MR. CORLISS: I think that if we do accomplish the ideas that were just expressed, then when our policyholders do have a situation arrive, they'll have that moment of magic, and their needs will be met and hopefully even exceeded.