RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 1

GROUP LONG-TERM CARE -- WOULD YOU BUY?

Moderator: NIELS H. FISCHER
Panelists: DEBRA L. FULKS
MARK C. ROWLEY
Recorder: ANTHONY L. RENDER

- Current offerings to employer groups
  - -- Products available
  - -- Solicitation methods
  - -- Recent participation results
- Policy and pricing considerations
  - -- Nonforfeiture values
  - -- Inflation riders and upgrades
  - -- Activities of daily living (ADLs)
  - -- Underwriting
  - -- Interest, lapse and expense assumptions
- Continuing care retirement communities (CCRCs): current offerings versus self-insurance

MR. NIELS H. FISCHER: There's been a great deal of interest in long-term care at recent actuarial meetings. I believe it's because the professional interest of actuaries is aroused by a topic which has so many ingredients as does long-term care insurance. There's the great unmet insurance need of our oldest and most vulnerable citizens. There's lack of solid morbidity data for us to do our pricing. There's a cry for equity, and some of the other sessions of this meeting talk about mandated nonforfeiture values. Finally, there's a great public involvement in the process. Indeed, it's those running our social welfare programs who have the great, desperate need to have a say about this product.

Last summer my wife and I had the pleasure of visiting with representatives from an international reinsurance company in Zurich, Switzerland, and at lunch the topic that they were most concerned about in pricing accident and health products in the United States was, Why does Company X charge 40% less than Companies A thru W? So these people know quite a bit about the level of premium rates all around the world. The second question they had was, Are we perhaps picking up some of the reinsurance on Company X? Well, we're not going to try to answer questions of that great financial magnitude, but we will try to cover a wide ranging area including pricing, product features, current day marketing success, and how this product stacks up for residents of continuing care retirement communities.

Debra and Mark will make their presentations, and then I will throw out some questions about CCRCs, and the floor will then be open. We're fortunate to have as panelists two Fellows of the Society of Actuaries who are deeply involved in product pricing and marketing long-term care for two of our largest insurance companies. Mark Rowley is assistant actuary of The Principal Financial Group. He's taken a leading role during the

last two years in developing Principal's long-term care product including product design, pricing and internal financial reporting. Mark brings to this session the additional value of working with groups as small as two lives, which is a marketing area in which Principal is the only player. Debra Fulks is associate actuary of the CNA Group where she was the project director for its entry into group long-term care, and she continues to play a large part in enhancing that product. I also know she travels widely as a speaker on long-term care marketing matters because I've bumped into her frequently, as have others, in this business. She is quite proficient at describing long-term care to such diverse groups as insurers, consultants, nursing home operators and, of course, actuaries.

MS. DEBRA L. FULKS: We all have our own personal opinions about whether we would buy or not buy long-term care insurance, and it is a personal decision. Those of us in the group marketplace have found that just about the time we think we've figured out who will buy and for what reason, our enrollment statistics prove us wrong. We've been pretty lucky at CNA, because in most cases our surprises have come in the form of higher-than-expected enrollment among younger employees and lower-paid employees, and I'll talk about some of those enrollment statistics later.

First, I'd like to go over very quickly the kinds of products that are currently available on the group side and some of the methods being used to enroll the employees. Group products for the employee benefits market are now offered by about ten insurance companies and several Blue Cross/Blue Shield plans. Everyone seems to take a slightly different approach, but we all offer a daily or monthly maximum. We all offer fairly comprehensive products that cover nursing home confinements, home care, adult day care, all within one umbrella of total dollars available to pay for those benefits. Most have higher payouts if you are in a nursing home rather than in a community situation. None that I know of require any kind of prior hospital stay or higher level of care before being eligible for other home care or lower levels of care.

Inflation is dealt with either through a built-in mechanism that uses a prearranged schedule of increases with a level premium throughout or through a series of future purchase options. One other thing that has been done is just simply indexing both the premium and the benefits to go up together.

I found that most employees who are offered long-term care insurance are really not influenced by the benefit structure of the plan, with the possible exception of the home health care benefit. The presence of home health care is definitely a facilitator to the sale. It allows the person who really doesn't want to think about this to say, "Well, if I ever do need this kind of care, at least I can stay at home."

Consumers, especially the young ones, are well-aware of the fact that they need to keep their contracts current, yet given the choice between spending more money up front and buying a plan that has a built-in escalator or buying a level benefit plan, with or without the guarantee of future purchase option, they tend to go with the lower cost level benefit plan. It remains to be seen how many of those people will, in fact, purchase the upgrades as they're offered because, to my knowledge, none of the group plans sold have offered their first upgrade.

Most of the group long-term care plans use impairment in activities of daily living or ADLs as the benefit trigger, but there's no standard set of ADLs. Both researchers and insurers continue to try new configurations, trying to find the one that's the best predictor of need and yet controls the risk involved. Nor are there different sets of equal value. While the consultants and the employers are beginning to recognize this differential, it's certainly not a factor in whether an individual employee buys or does not buy the product, at least at this time.

Another area of divergence of opinion concerns how the benefits will be paid out -- as disability payments with no requirements for paid services or as reimbursements for services received and paid for by the insured. There's really little difference when we're talking about a nursing home confinement, but when you get into the home situation the disability income model is expected to pay out much higher amounts of money and should cost more. That faster, less restrictive payout under the disability income policy is very attractive to potential insureds, in the absence of a premium differential. Cost is a critical factor in the enrollment decision so that I would expect lower participation on those more expensive, disability-based plans.

In December 1988, there were only seven employer-sponsored long-term care plans sold. Today, there are over 125. According to the Health Insurance Association of America the average participation for cases that were enrolled through the end of 1989 was 5.3%. Now, that number may seem dismally low, yet I don't see it as cause for alarm. That number includes some very large, early cases that had extremely low participation. However, it does point out that the solicitation method used has an impact on the success of the plan, and we've learned that as we've gone along and seen how you go about increasing participation. Many of the earliest plans were enrolled on a very passive basis. Employees received a packet of information and an enrollment form, and that was it. This benefit is simply too new and too costly to use a mail order approach, especially among the younger employees who still think they're invincible.

It's important that a variety of methods be used to get the information out including articles in the company newsletter, mailings, payroll stuffers, posters, videos, employee meetings, and 800 numbers for questions that may come up. One of our clients is even planning to use an interactive telephone data base that's accessed through personal identification numbers which will provide each employee with the opportunity to get answers to their own "what if" questions about premiums. Some insurers even plan to use professional enrollers on a one-on-one basis.

Whatever method is used, you've got to have sufficient time for that open enrollment period following the "preheat" period. It appears that two weeks is the minimum, but in a lot of situations you really need 30 days, and in some cases you need even more than that.

Obviously, what works for one employer is not going to necessarily transfer over to another employer because of differences in the corporate culture. Each solicitation plan has to be individually tailored to meet the particular needs of that employer. CNA's average participation on the eight cases that we've enrolled through 1989 was over 15%. It would have been much higher, but a couple of the cases chose to ignore our advice

and had only 5% and 6% of their employees enrolled. For many employees the decision to buy or not to buy seems to depend a great deal on the amount of information they receive as well as how that information is delivered.

A related factor is the amount of management commitment to the new benefit offering, and I measure this in terms of the amount of time and resources that the employer is willing to commit. Employers who are truly committed to the concept are sure that their employees are making informed decisions. These are the employers who not only want but also require that their benefit staff be fully trained to support the new offering, and in most cases they also require that the employees attend mandatory information meetings.

As examples of employers in this category I have to include my own, CNA, and Levitz Furniture among others. Using a fairly comprehensive pre-enrollment campaign, CNA enrolled 23% of its 14,500 eligible employees, and in spite of having a very scattered and low-paid work force, Levitz was able to enroll almost 18% of its employees.

I've analyzed the CNA data, and I've got some numbers to share with you. All of the participation numbers that I show are calculated using the employees who signed up divided by the eligible employees. Some companies like to calculate the enrollment percentages another way in order to give a feel for total enrollment. In that case they include the spouses and the parents who signed up in the numerator and then still divide by the eligible employees. If we had done this here, the 22.5% enrollment number would have gone to 35% because we'd add in 1,600-some spouses and 150 parents to the 3,300 employees who had signed up (Table 1).

TABLE 1

Solicitation Results CNA Employees August 1989

	Number Eligible	Percent Enrolled
All Employees	14,516	22.6%
By Sex		
Males	5,061	20.0
Females	9,455	24.1
By Location		
Large Field Location	8,820	26.1
Small Field Location	624	21.2
Home Office	5,072	16.8

Table 1 shows two splits, by sex and by location within CNA. Women were more likely to sign up probably because historically we've been closer to the problem. We are traditionally the care-givers, and we're more likely to live alone or in nursing homes in later life. Yet the spread, 24% for females, 20% for males, is really not as wide as I might have expected it to be. The split by location is very revealing. It shows how varying the solicitation techniques can affect participation. We didn't do the same thing with all of our employees. Everyone received a packet of information that covered the

basics of the plan, and everyone got a copy of the company newsletter that had an article in it.

Employees in the large field locations were required to attend information meetings given by the personnel manager in that location. Our special risk division helped train those managers, and they also worked with employee benefits to develop a script for the meetings. Videos were shown, and then there was a question and answer period. Participation in some of those locations exceeded 50%. The overall average was 26.1%.

In the Home Office there was a voluntary drop-in center that was open during lunch-time. You could go there and take a look at the video, and there would be someone there to answer your questions if you had any, but very few people took advantage of it. They'd rather eat lunch than go to this meeting. One of the recurring criticisms we got when we held focus groups with the Home Office employees subsequent to the enrollment period was that they didn't get enough examples. Unfortunately, the purpose of the videos was to give the examples, and no one went to see the videos. We now realizethat if we had required mandatory meetings in the Home Office, we probably would have gotten 5-10% more participation.

The small field locations fell in between, both in terms of participation and in terms of what they got. In some locations they did hold meetings, and in others they didn't. It was really left up to the personnel manager who was usually not on site.

Table 2 shows how the average participant stacks up against the average eligible employee in terms of age, salary, length of service. We will go into detail on age in a bit, but let me talk a little bit more on salary right now. I think one of the biggest surprises was that about 11% of our employees earning less than $15,000 a year signed up, along with 16% in the $15-20,000 range. Participation did go up with salary and with length of service, but those also go up with age. All three things are intermingled. It's hard to tell which is the best predictor. We offered $60, $80, and $100 daily benefits.

TABLE 2

Solicitation Results CNA Employees August 1989

	Eligible	Enrolled
Average Age	38	39
Average Salary	$31,000	$34,000
Average Years of Service	7.4	8.8
Average Benefit per NH Day	---	$89
Average Premium Per Insured Per Month	---	$20

Most of the younger employees took the $100 benefit, and people in their 50s tended toward the $60 plan. The overall average was $89, with an average monthly premium of $20 per insured.

One other item of interest is that married employees showed just about the same inclination to sign up as single people, but of the married employees who did sign up, 86% enrolled their spouses as well.

Table 3 shows two different ways of looking at participation by age. The first column shows what percent of each age group enrolled, and the second shows how participants were distributed by age. The distribution of participants themselves shows that 85% of the enrollment was among those under age 50, but that's not too far out of line with our distribution of eligible employees.

TABLE 3

Solicitation Results CNA Employees August 1989

Age	Percent Enrolled	Enrollee Distribution
<30	14.5	15.0%
30-39	22.6	37.8
40-49	29.1	32.2
50-59	26.5	12.0
60+	20.2	3.0
Total	22.6	100.0%

I was going to talk some on the results of the focus groups that we held with CNA employees, but we can explore that more during the discussion part. I'd like to just summarize at this point and say that what I see as the most important factors in the purchase decision of an employee are:

1. An employer commitment to the program
2. Adequate information on which to base a buying decision
3. A personal experience in care-giving (a very powerful element)
4. Cost
5. Benefits

I don't know that these go in any particular order, except that benefit structure seems to be the least important for employees. It's probably the most important factor in the prior sale to the broker or consultant and to the employer. Mark is going to be covering those policy considerations as well as their pricing impacts.

MR. MARK C. ROWLEY: I'm not sure if I'm going into a lot of pricing considerations about the different features. From that I thought I should focus on the things that are specifically unique to group and, in doing that, compare some of those items to individual products.

I guess to answer the question, you first have to ask the question, Would you buy any kind of long-term care insurance? Most of what's been written on this topic is that, if someone's making a rational decision about the whole thing, and by rational I mean that they're focusing on what's going to be the best financial decision for them, just about everyone would buy it unless they're in certain kinds of income groups. There are some people so affluent that it makes more sense for them to self-insure this risk, and then there are the people at a lower income level where it makes the most sense for them financially to just spend down to Medicaid, but generally, if you're in that middle income group, and I think it's a pretty wide middle income group, it makes sense to buy some kind of long-term care insurance. Of course, people also make decisions, what you might call irrationally, that they might be trying to perhaps avoid welfare and the statement that's attached to that. So, I guess I'm going to assume that you've pretty much answered that first question yes. I guess if you hadn't, then it doesn't really make any sense for me to go on, but I'm going to.

I think Debbie alluded a little bit to what the definition of group long-term care insurance is, but I'm going to talk about that just to make sure we're all on the same wavelength. Group long-term care insurance is a lot more similar in its features to a traditional kind of individual product than it would be to a traditional kind of group product. In fact, it's like individual except for the way it's marketed. At Principal we've had a group product out since last summer, and we'll have an individual product soon. Those two products have identical benefit provisions. When I think about the nature of group long-term care insurance versus individual long-term care insurance, it's not obvious to me that one or the other of those should have more or less liberal benefit provisions. To me they're very much the same thing. As Debbie has explained thoroughly, with group long-term care insurance you get an employer to agree to allow you to go solicit its employees. There have been very few cases where it's been more of a true group product in the sense that its employer pays in even a small extent. So, with this background and with an understanding of what I mean when I say group long-term care, let's go on to answer the question posed in our session, Would you buy group long-term care?

I've only been able to find one answer to that question, and that is that it's cheaper than individual long-term care insurance. This may sound like I'm contradicting myself a little bit here because I just went through how similar it is to individual long-term care insurance. When you price a product, and you go through a laundry list of all the different cost factors you need to include in pricing a product, the majority of the factors are going to be identical for individual and group products, but the ones that are different are significant enough to make the premiums lower for group long-term care insurance.

Now, if you had picked up a random sample of the group long-term care policies and the individual long-term care policies that are out there, it would have been very difficult to conclude in a very obvious way that group products are cheaper. That's because the state-of-the-art in the industry yet isn't such that there's a standard product. The products vary significantly. They're probably coming a little bit closer together than they were a few years ago, but there are still significant differences. So, the benefit differences basically make it impossible to compare things. The second factor that makes it

difficult to compare premiums is the pricing philosophy that individual companies have used. It's hard to tell how aggressive you can be in setting that initial premium with the great majority of these products being guaranteed renewable. You do have some recourse to go back and change premiums later, and different companies have taken different approaches as to how you go about doing that.

Now I want to go through a list of the main cost factors in pricing a product. First, I'm going to go through three which would be different between group and individual products. Then I'll go through the longer list of cost factors that are the same.

The first difference and by far the largest cost difference is in the area of field marketing costs. My definition of field marketing costs includes agent and broker commissions and also the wholesaler cost overrides that go along with those commissions. At this point I'm breaking things into what might happen in a small group case and also in a large group case. With small group cases, you're usually able to pay a smaller commission than you would on an individual product. Along with the small commissions would come smaller wholesaler costs. Large group cases are usually handled on a fee basis. So, their field marketing costs are even more significantly reduced.

The second area of cost is in underwriting. From what I've heard, we're the only carrier that goes down to two lives. The way we've done this is that we've assumed that the underwriting costs and claim costs are going to be identical in our small group and our individual products. We underwrite them exactly the same way, with a full form application and so forth. On the large group basis, Debbie's company and others have used the simplified application or gone all the way to guaranteed issue. It's certainly way too early in this game to see what effect that's going to have on claims. I would assume that the argument made is the same argument that's been made in going to more limited underwriting on other products. You have to compare the higher morbidity expected in underwriting this way, with the expenses you're going to save by not doing the underwriting.

The last cost difference I could find, which might not be that significant, is that you can bill in a different way. You can have some kind of list bill to save you a little bit in costs. So, those are the three cost differences that I thought made sense.

Now I'm going to go to the longer list of the cost similarities between individual and group. The first item I think is arguable in pricing our group versus our individual product. We've used the same set of lapse rates. Payroll deduction products have had the reputation of having fairly high lapse rates, and that's what our group product is. We've determined that the payroll deduction in individual products would have the same lapse experience. I think the other four items are not as arguable. You'd like to be able to build in some profit margin, and it'd be about the same on group and individual. Federal income taxes, other taxes and fees, and claim administration expenses, I think, would be about the same.

Interest rates would be about the same. I've listed after that the cost of some extra features that might be included on a policy, inflation benefits, upgrades, and nonforfeiture benefits. I think the cost between individual and group, which is what I wanted to

focus on this afternoon, is about the same. It's hard to make a blanket statement about nonforfeiture benefits because you can do them in so many different ways. One way you might do it is that the value of the nonforfeiture benefit at each duration of your policy is about equal to the asset share. I did observe that the asset share build-up on a group product would be different than the asset share buildup on an individual product. The early acquisition costs, which include the field marketing costs as a major factor, would be different. So, the group product wouldn't dig as big of a hole there. That's just kind of a curiosity, because what you would be pricing is really two different nonforfeiture benefits.

So, the two points I want everyone to recognize are that, administratively, group products are a lot closer to individual insurance than group insurance, especially after the sale. The way you'd administer them over time is certificate by certificate. They're going to be administered very much like an individual product. The main difference in cost is due to the field marketing. It is a significant difference, as we're going to see in one premium comparison I've worked up.

In my comparison of premiums, the assumption I've made is that the only cost difference is in field marketing. So, we're underwriting all these in the same way. The individual is paying a 50% commission. I've priced in Principal's level of wholesaler costs for our individual agency force. Small group assumes half of that commission and the average of our individual and group field force wholesaler costs.

Our large group assumes no commission. I probably should have put something in for wholesaler costs here, but I neglected to do that. The fee that's paid is usually not included in the premiums in this situation. This work is at one age, age 50. There's no benefit escalator or inflation option. The premiums are annual premiums per $10 of daily benefit. A couple of other assumptions are that this is for a fictitious plan with a 60-day elimination period and a four-year maximum.

Well, for each of the individual, small group, and large group numbers I've listed four relevant factors: the gross annual premium for a $10 daily benefit, the present value of these future premiums at issue, the present value of policy benefits at issue, and the loss ratio. The loss ratio is the present value of benefits divided by the present value of premium. The point here is that the benefits, the present value of the benefits in this case, are going to be about the same for the products. The only difference in them is the waiver of premium costs, which are a little different because the premium itself is different. I have about a $45 premium and a loss ratio of 58%.

FROM THE FLOOR: What age is that?

MR. ROWLEY: Age 50. The present value of benefits is about $143.

FROM THE FLOOR: Does that differentiate between male and female?

MR. ROWLEY: No, that's unisex. The small group numbers show about $5 or $6 less in premium. Present value of benefits has only gone down by about a dollar due to the waiver of premium difference and a loss ratio of 66%. Finally, in the large group

example the premium's down to $34. Present value of benefits went down another dollar, and you have a loss ratio of about 75%. What I'm trying to illustrate here is the relationship that you might find between these different products. This doesn't represent a real plan of any kind. I think the important thing is maybe putting these into a ratio and seeing what the percentage difference is based on the assumptions I've used in my pricing.

So, in closing, I'll reiterate the main points one more time. Group long-term care is more of a franchise group, where it has more individual features than true group features, but the costs that do differ are fairly significant.

MR. FISCHER: Consider as a final topic the marketing of long-term care products to continuing care retirement communities, and, as moderator, I'm not going to make a presentation as such but thought that I would allow you to do that and just ask three questions.

CCRCs, by whatever name called, have been in existence for a hundred years or more primarily as religious-based institutions. The cost of financing skilled nursing care in a nursing facility has almost always been covered by most of these as a condition of admittance and as a condition of the residents turning over to the community their worldly assets. There's been no conscious recognition of actuarial liabilities.

Today, CCRCs are a burgeoning industry attracting the attention of landowners and builders and many types of consultants and insurers. Most of the newer, nonprofit models offer long-term care as a condition of residence, and they establish actuarial liabilities for this benefit, the same as for all other benefits of residence. Other communities require residents to buy long-term care insurance from a handful of insurance companies that are active in this field. So, I'm just going to throw these three questions out because I learned that this area for group long-term care insurance comprises about 3% of the market, that is, long-term care to CCRC residents.

The questions are:

1. Is the insurance route preferable to the prevailing self-insurance route considered in the actuarial risk to the community on the one hand and the insurer's expense, risk and profit charges on the other?
2. Given the ability of most insurers to raise rates under their long-term care policies, does insurance, in fact, exist except for the smallest communities?
3. What role should regulators play to see that promises are kept whether the plan is insured or uninsured?

MR. CHRIS L. SIPES: What is the size break of small group versus large group?

MR. ROWLEY: I don't think I really had a particular size break in mind. It's the size break where you can get away with paying that commission. The other cost factors -- expenses, for example -- don't really vary by the size of the group because you're having to watch all of these certificate by certificate. So the only cost involves the 25% commission.

MS. FULKS: The carriers who consider themselves to be in the large group market have varying minimum requirements. We started out with a thousand eligible lives as being the minimum size group that we would go to because we were expecting 7-8% participation. Once we saw that we could get well over that, we dropped it to 500 lives. There are still several carriers who require 10,000 lives or more, and some have moved back up from having first gone down to 2,000 lives and have now gone back up to 5,000 lives.

MR. ROWLEY: I think we are about the only carrier offering something we're calling group insurance down to two lives. Interesting thing about that, though, is we haven't sold anything down in the small group categories. The marketing people tell me that the problem is getting the agents and brokers and the people who would sell in those age categories interested in the product. What we've sold so far is the real small and the real big. We've sold some two-life cases which basically sold because the individuals were interested from having experienced the same kinds of reasons that prompt individuals to buy. Then we've sold some 10,000-life cases. I guess the thing that's holding it back wouldn't be the employee interest as much as just getting the agents and brokers excited about it with all the other things they have to keep up with.

MR. FISCHER: What types of employers are buying group long-term care these days?

MS. FULKS: It's really a wide variety. I think several of the states started it off -- Alaska, Connecticut, New Jersey, Maryland, and Illinois. So they're interested. We've gotten a lot of interest from universities, and we've sold to two universities so far. Those aren't particularly prime candidates for us because of the kind of solicitation package we like to put together. Universities don't like to ask their professors to come to meetings. So they want you to mail it out, and you don't see the participation there. We've also sold plans to accounting firms and large law firms. I told you about Levitz Furniture. We sold to Johnson & Johnson. The requests for bids are coming in from all sectors, really. So, there's a lot of interest out there.

MR. ROWLEY: We had 25 individual certificates in force at the end of last year. So, there hasn't been a great mix. I can tell you more about three large cases that look as though we'll be able to enroll before the middle of the year. We're going to enroll the State of Missouri employees soon, which goes along with the state cases that Debbie mentioned. We also enrolled our Home Office. That's going on right now, so it's preliminary to say how successful that's going to be. We have Sevron Financial Corporation, which is out on the East Coast, with 14,000 employees, or something like that.

MS. CAROLINE S. CARLIN: Have either of you worked with long-term care in the context of a flexible benefits program, and, if so, what are the special considerations involved in enrollment there?

MS. FULKS: The newness of the benefit and the amount of education that needs to go on has caused us to recommend to clients that they not try to do it at the same time. However, Levitz Furniture did introduce a lot of benefit changes within their flexible benefits program, along with this new introduction of group long-term care, and that seemed to work out really well. We do not advise clients to, for example, fund the

premiums through a flexible spending account because of the tax implications, but we also point out to them that it's something that they can investigate with their own legal counsel and do with it what they please. We try to have the initial enrollment in the plan be off-cycle from all the other kinds of plan benefit changes in a particular company.

MR. FISCHER: There was a meeting in Massachusetts recently at which the prevailing mood was that you could not use long-term care as a part of Section 125 because it was not really a reimbursement account. There was one company that did.

MS. FULKS: Right, for their own employees.

MR. FISCHER: Their own employees. That was John Hancock.

MS. LYNETTE L. TRYGSTAD: Have either of you made any arrangement with your groups concerning what you would do if something like the Pepper Commission would come into play and the benefits would be replaced through public benefits?

MR. ROWLEY: There's no specific contingency in our plan. What we would probably try to do is offer our clients a downgrade so that we could change their benefits to a gap-filling type of benefit if something like that came in. I doubt the government's going to come and take it 100% away. So, there'd still be something to do with the downgrade.

MS. FULKS: We try not to get too specific about what we would do because we feel that if something like that were to happen, most likely we'll be told what to do, much as we were all told what to do with our Medicare supplement policies when catastrophic went in. Yes, we certainly are dealing with that issue with clients and making arrangements for that contingency.

MR. ELLIOTT I. COBIN: Are any of the policies available to retirees, and, if so, what are the eligibility restrictions?

MS. FULKS: Our policies are made available to active employees, their spouses, their parents, and retirees and their spouses. We use guaranteed issue for active employees. For spouses we essentially use a nonunderwritten approach in that we do require they certify that they can currently perform all of the activities of daily living. Retirees and parents are underwritten.

MR. PETER A. HINRICHS: What sort of lapse rates are you experiencing and/or assuming in your pricing? If you offer cash value, nonforfeiture benefits, how do you see that affecting the lapse rates?

MS. FULKS: The lapse rate is somewhat dependent upon the turnover rate of a particular employer. Because you're using payroll deduction, that seems to be a significant factor. We are assuming significantly lower lapses for the group product than we do for our individual product. We have a couple groups now that are into their second year, and in fact, the lapses are coming in somewhat lower than we had

anticipated. They're coming in under 10%, but, again, those groups are groups with very low turnover rate among their employees.

We have not sold any contracts with nonforfeiture values. We've priced out a lot of different nonforfeiture configurations and find that in most cases they either cost a lot of money or they don't really provide a whole lot of value. Nonforfeiture values have not really been a factor at the employee decision level. In our focus groups among purchasers and nonpurchasers, we really didn't get any feedback on that. You get one or two people saying, "Well, what about cash values?" You didn't even need to say anything. Someone else in the group would say, "Well, that would cost money. If you want a Cadillac, go out and buy a Cadillac, but I just want insurance, thank you very much." So, we get a lot of requests about nonforfeiture values from consultants and employers, but we don't see the interest there among employees. It does introduce a myriad of additional problems into both the pricing and the administration, especially when you go to the reduced paid-ups which effectively cause the product to be a noncancellable product. You've got to track to find out when these people are gone because you're not necessarily going to get a claim. We try to keep the product as simple as we can, because even in its simplest form it's still something that's very new and needs a lot of education.

MR. ROWLEY: I agree with all that Debbie said about nonforfeiture. We haven't offered a nonforfeiture product yet. What we've done with lapse rates is looked at some of our other payroll deduction products and used about the same assumptions.

MR. FISCHER: In pricing your product, the thing that I would think about is you have to make an assumption as to the lapse rate. There must be some gain that is distributed unevenly without nonforfeiture values, because it'd almost naturally be of some type of value to the customer. Is that hard to quantify?

MR. ROWLEY: You mean it's distributed inequitably among the various people?

MR. FISCHER: Yes. In other words, the difference between the rate that you get if you assume everybody keeps his or her policy and the rate that you get if you assume that they lapse at certain rates.

MR. ROWLEY: Yes. With no nonforfeiture values in the benefit design, of course, the pricing is extremely sensitive to what lapse rates you use. I think that certainly over the last couple of days we've heard a lot about why we should have nonforfeiture benefits to make equity between policyholders better. All the arguments that have been made about life insurance for that I think hold pretty well here, too.

MS. FULKS: I just realized I never really finished answering the gentleman's question. When we do price a nonforfeiture value into a product we make adjustments to the lapse assumptions. For example, if the reduced paid-up table doesn't go into effect until the tenth year, we would have our lapse scale dip slightly prior to when the nonforfeiture value becomes available and then have a bump in it at the time that the nonforfeiture value becomes available, not as significant as you would with some other coverages, but you do have to make an adjustment to the lapse rates.

MR. FISCHER: Mark, when you were speaking you mentioned the fact that the assumption at The Principal Financial Group is that the claim costs for group and individual products are the same because it's the same underwriting method. I think Debra said it was different. It would seem to me that, first, it's very difficult to get this information in a short period of time, and, second, I would think that the situation as regards the individual sale might involve more of an underwriting risk than there being a limited enrollment period that a group would be subject to. Do you have any thoughts in that direction?

MR. ROWLEY: I'm not sure if I heard Debbie say that. My observation of CNA is they do underwrite differently on their group product than their individual product. So, of course, you would expect different morbidity there. We underwrite exactly the same on group versus individual, and the assumption we've made is that the overriding factor in what your claim costs are going to look like is the underwriting because we do a pretty full individual application and underwriting process where we'll also go out and get attending physicians statements in certain situations. So, there may be some impact of the enrollment period, the actively-at-work requirement, but the overriding thing was how long the application was and how much work we went to, since it was an individual style of underwriting.

MR. FISCHER: Yes, that would be about whether the group underwriting technique of having an open enrollment period for a group would produce a better quality, perhaps, of risks than the individual underwriting process.

MS. FULKS: Since we're guaranteeing issue, we know that there's going to be anti-selection involved. It's really hard to compare the people you get because we're getting average age, 38-39, in the group, and average age, 70-72, on the individual stuff.

MR. FISCHER: So, there's no real comparison there.

MS. FULKS: It's really very difficult to compare.

MR. ROWLEY: Another thing with your comment, Niels, was dealing with experience. I certainly haven't made this assumption based on experience yet.

MS. ELIZABETH M. JABEK: I was wondering what sort of issues you're highlighting to employers to get them to agree to sponsor a plan for their employees.

MS. FULKS: It's the typical presentation of need. It's the initial education effort, and in fact, we're finding we have to do less and less of that as the consultants are really entering the field, doing that part of the education process for us. It's that and the fact that this is a new benefit. Some employers just want to be the first on the block to have something that's new. You do get that, but it's mostly, "This is what the need is, and this is what we propose is the solution." It won't cost you very much because it's employee pay-all," although we do have one employer that pays the entire cost.

MR. BRUCE E. OLSON: I had attended a previous session that was on home health care, and, as I came away from that, I had a feeling that there were a lot of "ifs." It

probably is hard to price a stand-alone, home health care. The way the model bills have unfolded, it's not much different on a lot of the long-term care products when they contained home health care. It's almost as if it was a stand-alone home health care. I know that the federal government can't get involved because of its deficit problems, but I was thinking maybe the state insurance departments could take over the issuance of the home health care. Then insurance companies would be left with just the institutional care. That probably wouldn't happen, but I was just wondering. You said that your sales are highly contingent on home health care. How extensive is your benefit, and what sort of determination characteristics do you have to pay benefits under that? In general, are you somewhat scared of the home health care benefit?

MS. FULKS: I'm more scared now than I was when I came to this meeting, but I guess the sale itself may not be contingent on the existence of home health care. I say that in response to what I've heard from purchasers and even from nonpurchasers, is that what they saw as the most important aspect of the policy was the provision that they be allowed to stay at home and receive benefits. In our product, based on the early focus group studies that we did, we chose to, and this is pretty standard, allow the full lifetime maximum benefit to be accessible from home health care, adult day care, and nursing home care. There's $200,000, and it can be spent in various ways. The home health care benefit is typically 50% of the nursing home benefit. In our case we offer 30-, 60-, and 90-day waiting periods on the nursing home part of the policy, but as a standard offering we ask for 15 service days on the home health care side. Those elimination periods are offsetting so that if you're in the nursing home first, it counts toward the home care benefit and vice versa. What else was there?

MR. OLSON: It was the type of benefits you offer -- are there ADL determinations, and are you scared about it?

MS. FULKS: We're using ADLs to do the home care. Our five ADLs are managing medications independently, dressing, toileting, mobility, and eating. Am I scared about it? I don't know. We are using a pretty aggressive care management process along with it, and one of the things that the care managers keep coming back to is the fact that they need to be involved as early as possible. I think by having a very open home care benefit we're going to get those claims in early enough to have some influence on how they progress. Especially among younger accident victims, we want to be able to use our LTD rehabilitation people to help get them back. So, we felt that having a 90-day wait means that in most cases you're not going to see the claim until the elimination period has passed. We wanted to get those claims in as early as possible for the care management to be effective.

MR. OLSON: Is it one ADL that qualifies?

MS. FULKS: Two out of five.

MR. ROWLEY: I could add just a little bit to that. Our ADL trigger for any of our benefits is the same. We don't have a lower ADL trigger for home care than other kinds of things. There is a very wide range of services that can be called home care. I really question whether a lot of those are insurable, especially when you get to mowing the

lawn, picking up the house, and that kind of thing. I think it hasn't been demonstrated to my satisfaction yet, that it's an insurable benefit, mostly because we haven't been doing it long enough. I would think that over time we're going to figure out what you can and cannot include while keeping it insurable.

MS. FULKS: Mark alluded to policies where the home care kicks in at a lower ADL level, and there are several carriers that are doing that. For instance, with two out of six you can get the home care benefit, but you need three out of six to get the nursing home. We use the two out of five for both levels of care.

MR. PETER GATENBY*: Really two comments rather than questions. We've got the first two CCRCs being developed in the U.K. at the moment, and both of them are looking for the insurance route rather than self-insurance. Having looked at CCRCs myself, I would have thought, for the 200-300 size of community, that the self-insured, pooled approach better reflects the actual care provision in that community. Once you start going with insurance policies, you have to start fitting in with their way of providing the care rather than the actual characteristics of different communities. I would imagine that most communities have very different care provision characteristics. On the group long-term care products I was actually very surprised to hear of the low participation rates. It wasn't something that I'd particularly thought of before. I suppose that one reason could be due to the fact that you're going in with lower marketing expenses and, therefore, not putting enough marketing effort into it. Perhaps you need to spend just as much on marketing to those groups as you do to individuals. Therefore, that destroys the "it is cheaper" route. The real advantage of going to groups is the fact that you can go to a lot of people at one time and, therefore, by the end of the day, sign up more policies than you would presenting them one at a time.

MR. FISCHER: Good observations. Did you want to follow up on Peter's observations on marketing? I guess my own thought would be that the marketing expense in a group case now is really spent by the employer, isn't it?

MS. FULKS: No.

MR. FISCHER: I know that there are a few dollars involved, but I mean as far as making the cafeteria available for the presentation and so on, that's really an employer function.

MS. FULKS: That's correct, but we're printing the materials, providing the posters, and doing the videos for them.

MR. ROWLEY: One other reaction is that sometimes you have to talk the employer into allowing you to spend enough money in marketing to be effective.

MS. FULKS: That's very true.

* Mr. Gatenby, not a member of the sponsoring organizations, is a consultant with William M. Mercer Fraser, LTD, in London, England.

MR. FISCHER: Yes, because the employer is picking it up.

MS. FULKS: Now, there is one company that's coming out and issuing professional enrollers. Those who are interested will come and they'll sit down at the personal computer, showing them exactly what's going on.

MR. ROWLEY: I was just going back to one example that Debbie had used, that a couple of clients didn't take her company's advice, wanting to do it on a direct mail basis. They didn't allow CNA to produce a video or do any other kinds of things that would have made it more effective.