RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 4B

LONG-TERM CARE -- WHO NEEDS IT, WANTS IT, OR CAN PAY FOR IT?

Moderator: MARY ANN BROWN
Panelists: RONALD D. HAGEN*
BARTLEY L. MUNSON
SUSAN I. VAN GELDER†
Recorder: RACHEL M. HANCOCK

This session will explore the following issues in the long-term-care (LTC) marketplace:

- Consumer issues -- coverage needs versus affordability
- Sales trends
- Regulation trends
- Insurer issues -- profitability versus regulation

MS. MARY ANN BROWN: This product, as you all know, probably has the biggest potential for growth and longevity of any insurance product, even more than variable life and annuities in which I saw a lot of potential for growth about nine years ago. Long-term care (even combined with annuities) has tremendous potential. We're very fortunate to have several of the top people in the industry on this topic. Right now I'll give you an overview of how we're going to structure the program. First, Susan Van Gelder of the Health Insurance Association of America (HIAA) will discuss the highlights of the recent research that HIAA has completed on long-term care. Second, Ron Hagen of AMEX will discuss the regulatory developments of long-term care such as the recent state legislation on nonforfeiture. I guess you're all interested in that as well as some of the Congressional activity and tax policy. We also have Bart Munson from William M. Mercer. Bart's been involved in some very important research on affordability of various long-term-care products and nonforfeiture options, and the results have just come out. We also have Rachel Hancock, our recorder from Tillinghast in New York, one of the firm's brightest young actuaries.

A lot of people have said that they thought this was a nonactuarial topic, but I'm going to try to cover some pricing issues so that you'll get your money's worth. I'll go through the sales survey that Shereen Sayre of Tillinghast's New York office just completed. Many of you probably received some phone calls from her asking for your premium data. We broke it down by company, by group and individual premium, home care versus nursing home, and new and renewal. So we didn't get too many companies. We used data from 12 of the top 16 companies, and wanted to get enough breakdown in the data so we could analyze some of the trends by year, as well as estimate what the average premiums are for the different components.

* Mr. Hagen, not a member of the Society, is Vice President of Product Development and Governmental Relations of AMEX Life Assurance Company in San Rafael, California.

† Ms. Van Gelder, not a member of the Society, is Associate Director of Policy Development and Research at Health Insurance Association of America in Washington, District of Columbia.

First, I'll start out with LTC pricing. To make sure we're all on a level playing field, let's just first review what all of us know about long-term-care pricing. Recently, we were helping a client who made a somewhat glib comment about the underlying home care claim assumptions; the client said he thought the new actuarial motto needs to be something like "substituting gut feelings for appearances." As we all know, pricing can't be done in a vacuum – we have to work with all the other areas; the regulation cloud (I don't mean to imply that it's such a negative) is one of the biggest compromises that we need to deal with. Ron Hagen will be covering that later.

Long-term care is the only product that has its own actuarial standard of practice -- No. 18. It goes through the assumptions and guidelines for pricing long-term care.

One of the more important or unusual points is that you can't use either optimistic or pessimistic pricing assumptions. I guess this is to remove what some people call hidden actuarial margins, but many of us would like to know what is optimistic or pessimistic in order to determine if we are pricing as realistically as we can. Of course, we're not supposed to plan any increases in premiums, and this is largely to present a fair premium for the elderly who are on a fixed income and do not want to be low-balled on their premiums, and have them raised later. We have run across some companies using 10-15% ultimate lapse rates, and you can expect that they may have to increase their premiums later, if they have lapses similar to the rest of the industry. This puts a lot of responsibility on us actuaries in our pricing, reserving, and monitoring of experience. We're supposed to be true to the profession and try to make sure that the premiums don't increase later. Also, actuaries are to notify the management of a company if they feel some of the assumptions or the methodology and experience is not up to standard or if they're uncomfortable with them. An actuary is supposed to go to a higher authority and cannot be removed from blame if a boss is forcing him or her to do this. So we're supposed to be truer to our profession in the industry and have more concern over the solvency of the company long-term, rather than our current job.

Cash-flow testing has become more important because we do receive the premiums many years in advance of when the liabilities occur. It is important to check out the impact of the interest scenarios. Of course, all of you probably realize that one of the big risks is disintermediation, but with interest rates so low, that doesn't seem to be as big a concern. What we've been finding is that even without the cash nonforfeiture benefits, the biggest risk is if interest rates continue going down and we currently have reserves at 5.5%, we have a problem with our liabilities being sufficient. This shows up in cash-flow testing.

I'd actually like to make a plea to many of you about this aggressive pricing on the home care benefits. I've been seeing a lot of it out there without valid insurance experience on the home care side. Let's be careful. We have been asked frequently to make the second, third or even fourth consulting opinion on the level of home care morbidity. We have seen a huge range of assumptions, but this is understandable. We have much more industry experience for nursing homes than we do for home care, and we have been seeing incidence assumptions congregating close to experience on the nursing home side, but length of stay and home care are less predictable.

Some of the biggest challenges an actuary has today are developing assumptions and modifying data so that it is appropriate for the insurance policy. For data sources, many companies have been using John Wilkin's adjustments to the 1985 Nursing Home Study which appears in the *Record*, Volume 17, No. 3B, 1991, page 1409. There are many different adjustments, as John can tell you, and many companies start with the last chart and make further adjustments. We should try to share information as much as we can so that we can monitor what the emerging experience is compared to the assumptions. I would like to ask any of you for recommendations on sources of information. I've been put in charge of the Professional Actuarial Specialty Guide on long-term care. Some of you out there may know some sources that have been particularly helpful, if you'd provide them to me so that we could include that in the specialty guide bibliography.

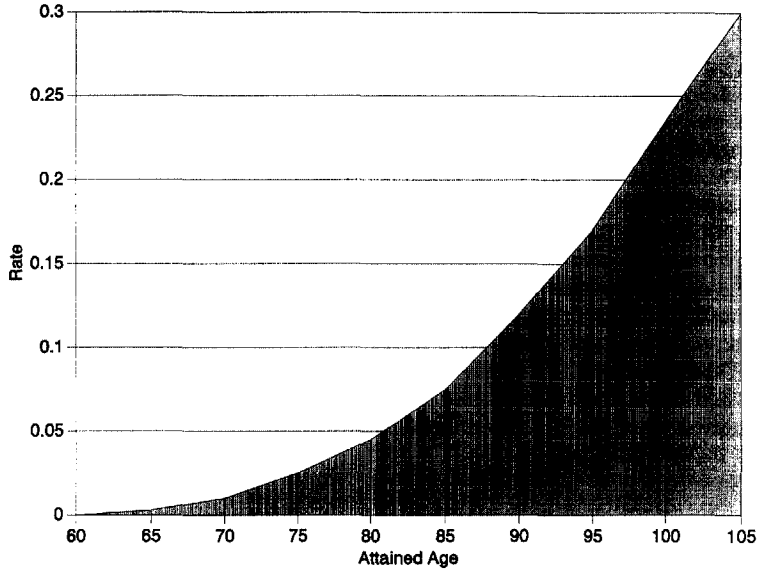
We've been noticing that the experience on the nursing home incidence side has been somewhat close to what many companies are assuming; of course, the verdict is still out on the terminations. This is going to be affected by the length of the benefit period. We all expect selection associated with someone who would buy a lifetime policy versus a two year policy, but we haven't had enough experience to tell how the lifetime experience is coming in compared with what was assumed for terminations. On the underwriting selection, most companies assume 4-10 years worth of underwriting selection, and we see anywhere from 20-60% of a discount the first year, grading up to 100%. Some companies then put adverse selection on top of that for an insurance product. And for recidivism, this is an important consideration – what happens to your benefit period when it's partly used up.

Chart 1 is an example of incidence rates. It shows how extremely high the slope is at the older ages. When you translate that into claims costs after you've used the continuance tables for the termination rates, you get a different kind of graph. At the high ages the shorter length of stay that occurs due to death is one of the things that brings the claim cost curve down and makes it flatter. I know for this one, Rachel had to graduate it quite a few times because when you move from attained age to duration on the continuance tables, you have to be careful because you get some anomalies; you can get some humps in your claims cost curves if you don't graph them out and actually see what they look like.

For "voluntary" lapses in pricing assumptions (voluntary termination is a term only an actuary would use), we've been seeing rates ranging from 8% to 15% the first year with 5-10% ultimate rates. Two companies have much higher ultimate rates. Involuntary terminations, meaning death, is another assumption that is uncertain. We still don't have very good data on mortality rates of long-term-care policyholders, but generally we've been finding 1983 Group Annuity Tables (GAT) or 1980 Commissioners Standard Ordinary (CSO) basic being used. You have to be aware when using selection on the mortality that it offsets your morbidity selection; so you have two things counteracting each other. We're trying to figure out how much mortality anti-selection would occur on long-term care, and if any of you have some comments, we'd appreciate it. When someone buys an annuity, they're betting they're going to live longer; when they buy life insurance, they're betting they're not going to live as long, and there's probably as much as a 30% differential on average for these. We're trying to figure out exactly how a long-term-care buyer is going to adverse select. Are they going to think, "Well, I'm going to live longer but I'm not going to

live very well?" (I'll be disabled.) It's a very tough thing for them to have control over; it's unlike living versus dying.

CHART 1
LTC Morbidity
Incidence Rates



Source: *Sales Survey on LTC*, Health Insurance Association of American (HIAA), 1992, Washington, D.C.

The two most important pricing assumptions other than the claims costs are lapses and the earned rate. They have the biggest sensitivity in your profits. You really need to test several earned rates because so much of the profitability is driven by the investment earnings rate on this product. On commissions, we're seeing something near 40-70% the first year, and 5-15% at renewal. Of course, this may change with the NAIC levelized commissions rulings. We may see the first year come down quite a bit and renewal go up, although the trade-off is less on LTC than for a life or accident and health (A&H) product with higher lapses.

On expenses, the NAIC nonforfeiture report lists high, medium, and low. One thing we have noticed is that the companies that put more expense on their underwriting up front have been having better experience overall because "post claims underwriting," as we all know, is out of favor. Average issue age has been coming down a few years. Susan's statistics will show more on that later. The distribution seems to be 60% female, 40% male. It used to be lower on the male side. It's been steady in the last couple of years. As I said, the companies doing effective underwriting seem to be profitable, but we're going to have to be monitoring this very closely in the future to see how it compares to lifetime loss ratios. We may want to make sure

we have the flexibility to change benefits or premiums if we have to in the future because of the long-term duration of the liabilities.

Reinsurance has become more popular on these products, especially as people are getting more into lifetime and home-care benefits. For profit goals, we've been surprised at how many companies look primarily at before-tax profits. The tax reserves in the Internal Revenue Code are two-year preliminary term, while the statutory are one year; this causes a tax disadvantage on this product, and it's the only one that I know of with such a penalty. We're hoping this will be changed in the future. Bart, I'm still lobbying for that, but the committee on valuation has now agreed to at least consider the possibility of having one-year or two-year preliminary term as the NAIC valuation standard. The theory behind this is that long-term-care expenses really are much greater than expenses for most products, especially for an individual product. It's more justified to allow the two-year preliminary term. On the group side, first year commissions are lower so most companies are using one-year preliminary term. On this active life reserve basis, companies don't use selection on the mortality. One company uses spouse distinct reserves. Most companies will use gender distinct reserves even though premiums are unisex.

Some product innovations that have been developed are listed below: I won't spend a lot of time on this except to point out that the immediate annuity is gaining much more popularity. We've been seeing a lot more companies packaging immediate annuities and other types of annuities with long-term care, and there are some advantages. For instance, on the immediate annuity, you get a tax deferral of the deposit, it's similar to replicating a single-premium long-term-care product. If someone retired at 65 and had a lump sum, this would be an ideal product for them to consider. You have to make sure the immediate annuity has enough room in the payments to be able to pay for the long-term-care premium, even if it increased significantly. You need to assign the immediate annuity premiums over to the company to pay for long-term-care insurance to make sure the whole thing works, and it's a simple sale to a senior citizen. Another advantage is that immediate annuities have cash refund options or an installment refund, so you can build in a nonforfeiture return of premium upon death, if you'd like to call it that.

LTC PRODUCT INNOVATIONS

- Disability income -- conversion to LTC at age 65
- Life insurance rider – advance death benefit
- Deferred annuity – waive surrender charges for confinement in nursing home or other LTC facility
- Immediate annuity – combine with LTC
- "Variable universal" LTC -- flexible premiums with separate account investment options (will out-perform inflation)

My own pet project is variable universal long-term care. I've had many companies agree that, especially for the group and the lifetime accumulation products, it does make sense. We'll see regulatory-wise who's willing to help push this through the SEC. I know with my variable experience in the past, the SEC has become more flexible and open to considering more creative insurance products. This may be one of the few LTC products that outperforms inflation and accumulates in a fund,

especially for younger sales or group-type policies. For the more senior market, it might not be so appropriate because they don't need the investment risk.

One thing that prompted us to perform our long-term-care premium survey was the decrease in 1991 average premiums as reported in the *Life Insurance Selling* magazine; at age 70, which was close to the average age at this time, the premium was about $1,100. The premiums increase very steeply. About every five issue ages the premiums double at the high ages. *Life Insurance Selling* showed that from 1990-91, there was a decrease in median premiums. We had originally been thinking that some of the decrease was due to lower average ages. Well, it turned out that was not true, and we were surprised at the decrease because of the more comprehensive policies developed. Also, no valid experience proved that rates should come down. So we decided to do a survey by company to find out what was happening. Actually, I think the *Life Insurance Selling* results might have been heavily weighted by one company who decreased their home-care rates in 1991.

The Tillinghast LTC Sales Survey was conducted during October 1992 to supplement the 1991 HIAA survey. It includes individual company data as well as group versus individual information. The survey covers approximately 25% of the total LTC market. All of the top 16 companies would cover approximately 33% of the market. AMEX didn't want to participate, because their size would prevent them from being anonymous; but their results may be similar.

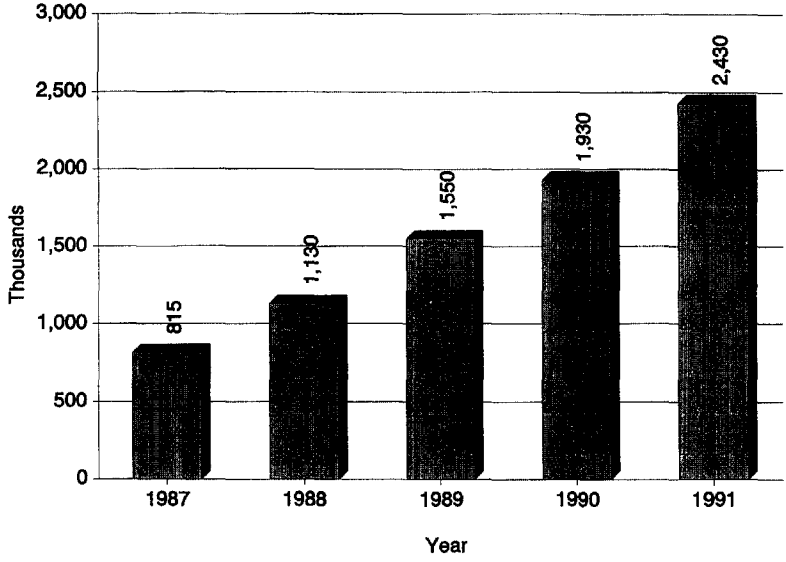
All companies who sold updated, more comprehensive LTC products had premium volume increases of more than 30% from 1991-92; those with older, more limited benefit policies experienced a slight decline. The combined average growth rate of companies in this survey was approximately 20%. Generally, average new annual premiums for the same issue age increased more than 15% between 1991-92 (due to higher premiums on new, more comprehensive products); however, the decrease in average issue age diminished the average premium increase. This also caused a lower average new (versus renewal) premium for group. Group LTC is growing very rapidly (more than individual LTC's 40% annual growth rate a few years ago). Group LTC is expected to continue at a high rate of growth, at least through the next few years, based on sold cases and current employer procurement plans.

Next we'll move to Susan Van Gelder. Many of you know Susan already. She's the associate director of policy development and research at the Health Insurance Association of America. She helps to formulate industry policy in this area and conducts research on elderly health care issues including a significant amount of industry research that you've read about on long-term care. She's the coeditor of a book on long-term care, entitled "Long-Term-Care Needs, Costs and Financing." She conducts analyses and staffs the HIAA board committee that develops a vision for the future of these health care systems.

MS. SUSAN I. VAN GELDER: I will try to relate the findings of the survey to Mary Ann's most recent survey because there are some things that are a little different, some things that seem the same, and I think a lot of it might come down to definitions of what's group, what's individual, and what's a group association.

In terms of the market, we've been trying to survey the companies that have sold long-term-care insurance since 1987, and we've identified what we think is the universe of companies starting with a report that the Department of Health and Human Services did in 1987. From there, we really just keep an eye on things and talk to people and companies calling us and survey state insurance departments. We think we know who the companies are. We also include in the survey companies that sell accelerated death benefits but only for long-term care. We don't include those for terminal illness, dread disease and permanent confinement to a nursing home (Chart 2).

CHART 2
Long-Term-Care Policies Sold
(1987-91)



Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

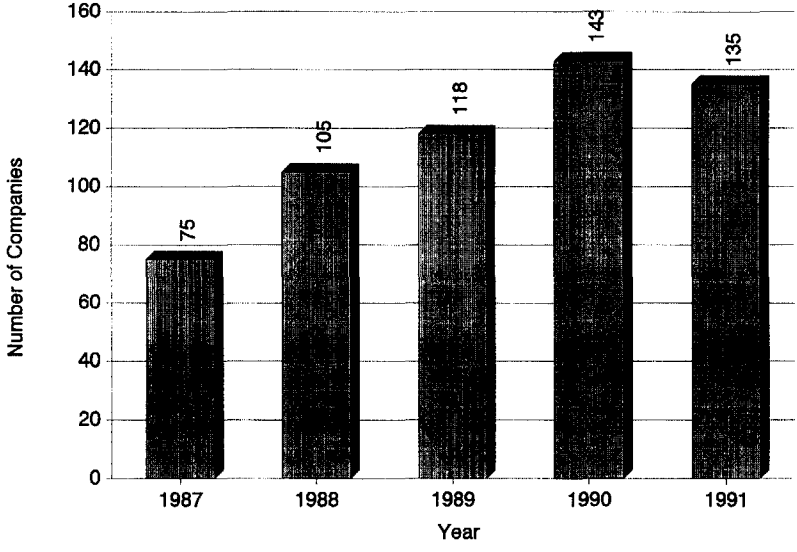
As of December 1991, more than 2.4 million policies had been purchased, a growth in the market of over 500,000 policies in one year. About 100,000 of these policies were existing life insurance policies which added long-term care-coverage in 1991. The number of policies sold has grown an average of 31.5% annually between 1987 and 1991. Long-term-care policies include individual, group association, CCRC, employer-sponsored and accelerated death benefits specifically for long-term care.

The most recent numbers we have are as of the end of 1991, and frankly, what they show is steady but slow growth. We count the policies that have been sold, meaning that the certificate's been delivered and the free look period has gone by. They're not in-force numbers, we don't know how many of those policies are replacement sales, and we exclude policies sold by companies who have left the market. So what we find at the end of 1991 is that about 2.4 million policies have

been sold. What's a little discouraging is that about 100,000 of those policies are represented by one insurance company who retroactively converted their life insurance products to include an accelerated death benefit for long-term care; that's 20% of the total for 1991. When you take that group out, about 400,000 policies were sold from 1990-91, and that's about the number of policies that have been sold since we've been tracking this since 1987 -- it's about 400,000 give or take a few thousand policies. We queried people about whether the sales in 1991 met, exceeded, or fell short of their projections. About 60% said that they met or exceeded what they had expected to sell in that year.

Also, 1991 had the largest number of companies that stopped selling a product in any given year since 1987 (Chart 3). There were 22 companies that left the market and 12 entered the market, but the overall number declined. So there are about 135 companies now in total, and about 25% of those sell just accelerated death benefits for long-term care. The 22 companies represented about 5% of all policies sold, and the most frequently cited reason for leaving the market was that they couldn't keep up with all the regulatory changes that were required in changing their product design to remain competitive (Chart 4). They also were fairly small. Three-fourths had an A. M. Best rating below A, so financially they weren't too well off. I think about 90% had financial holdings under $25 million according to the A. M. Best ratings.

CHART 3
Companies Selling Long-Term Care Insurance
(1987-91)



Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

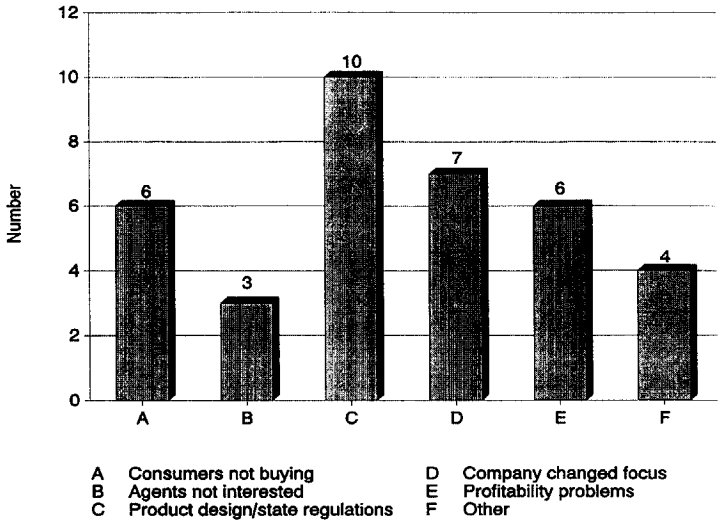
In 1991, 135 companies sold long-term-care insurance. This includes companies that sold life insurance policies that accelerate the death benefit specifically for long-term

care. Although 12 companies entered the market in 1991, over 20 companies left the market that year.

When we looked at the composition of the long-term-care market and how it's changing, the proportion of the total that's represented by individual and group association sales is definitely declining as a percentage of the slice of the pie (Table 1). They represent about 85% of the 2.4 million policies. We define employer group plans as plans offered by employers, either individual plans offered through employers or group plans.

CHART 4

Reasons Why Companies Stopped Selling a Long-Term-Care Policy in 1991



Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

In 1991, 22 companies that accounted for roughly 5% of all long-term-care policies sold, left the market. The most frequently cited reason for terminating their product was that they could not keep up with changes in product design due to changes in state regulation and remain competitive in the market.

We count group association plans as discretionary group plans, and all the other kinds of groups defined in the model act, as a group with individual sales. Employer group plans represented about 8.5-9% of all policies sold, and between 1990-91 they represented 11% of sales. So they're growing as a percentage of the total. Accelerated death benefits are also becoming a bigger slice of the pie.

In terms of the employer market, the number of employers selling is growing astronomically (Chart 5).

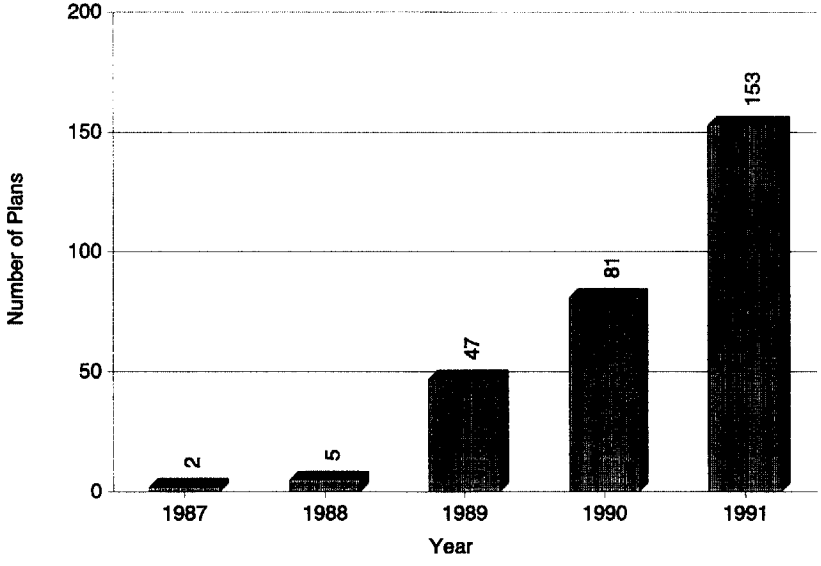
TABLE 1
Long-Term-Care Products by
Percentage of Companies
Policies Sold and Average Age, 1991

LTC Products*	Percentage of Companies†	Percentage of Policies Sold	Average Age in 1991
Individual & Group Association	74.8	85.5	69
Employer-Sponsored	14.8	8.7	43
LTC as Part of Life Policy	33.3	5.8	37

* Does not include information on continuing care retirement communities.
† Does not total 100% because some companies sell their LTC policy in more than one type of market.

Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

CHART 5
Employer-Sponsored Long-Term-Care Plans Introduced Each Year (1987-91)



Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

By the end of 1991, 288 employers had offered a long-term-care insurance plan. As of December 1991, another 72 plans were reported for 1992 enrollment.

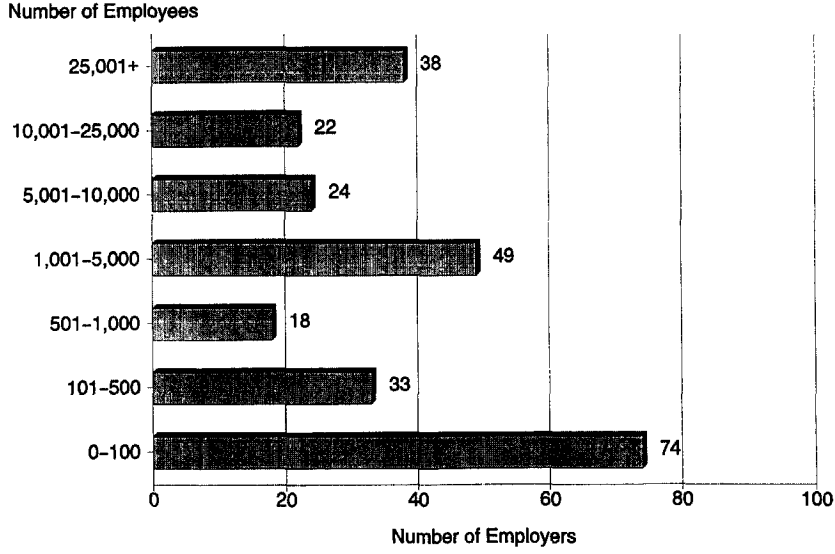
In 1989-90, 80 employers offered a plan in 1990-91, 153 employers offered a plan; we're up to 288 employers of all different sizes offering plans. When you look at the distribution of employers that have offered plans, the three biggest chunks are employers with more than 25,000 employees, employers with 1,000-5,000 employees, and employers with less than 100 employees (Chart 6). So it's evenly

distributed among all different sizes, but the number of policies sold last year was not any greater than the year before in the employer market. For the companies that provided the data, weighted by the percentage of policies they represent in that group market, the average enrollment was about 5.3-6% of active employees. That seems to be remaining fairly stable.

The commercial sellers tend to be A+ rated and relatively small. Over half of the commercial sellers have an A+ rating according to A. M. Best, and 85% of them have financial holdings of less then $750 million; 30% have less than $25 million.

This year we looked at the policies sold by the leading sellers in 1991, which was a little different than what we've done in the past, when we've looked at the leading sellers of all time. We looked at just those who sold the most policies in 1991 and what kinds of products were available from them. Fifteen companies represented 80% of the policies sold in 1991.

CHART 6
Size of Employers Offering Long-Term-Care Insurance, 1991*



* Based on 360 plans sold as of 12/91. Data not available for 102 plans.

Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

Since mid-1980, the largest increase in employers offering coverage has come from three categories of employers: Small firms (0–100 employees) experienced the biggest growth, an increase of 47 plans; medium-sized firms (1,001–5,000 employees) increased by 30; and large firms (25,001+) increased by 25.

I'll just highlight four different features of the products. One is that the types of benefits offered are definitely expanding. Nine out of the 15 had an alternate care

benefit, six out of the 15 had a respite benefit, and this is in addition to all of them having home health care and adult day care coverage. The benefit eligibility criteria is changing significantly. Ten out of the 15 used medical necessity, need for assistance in activities of daily living (ADLs) or cognitive impairment (they offered one of three choices). Four of the 15 used just medical necessity, and one used medical necessity and need for assistance with ADLs or cognitive impairment. So we're definitely seeing a shift going on. It's kind of a Chinese menu as to how one qualifies. All of them offered a compounded 5% inflation for life feature, and all of them offered a nonforfeiture benefit which was primarily a return of premium.

We compared that to data from our 1990 buyer survey where we sampled six companies representing 45% of individual policies sold in 1990, to give us some idea of what people actually bought. That survey found that 60% are buying nursing home only coverage, 40% include a home health care benefit. The average nursing home benefit was $72 a day, and the average elimination period was 34 days. The average premium was $1,071, with and without inflation options, so that comes close to Mary Ann's average. About 40% chose an inflation option. In 1990, the inflation features available were generally 5% simple, usually for 20 years, and that definitely varied by age. Over half of those that were 55-64 elected an inflation option, for those over 75, it was 17%, so there's a linear relationship directly related to age.

Our findings differ from Mary Ann's in that we also calculate a weighted average premium for these top sellers every year, and we always calculate it for the same kind of base plan: $80 a day for nursing home care, four years of coverage, 20-day deductible. We're not seeing these base premiums going up. Surprisingly, the benefit triggers are changing, and the benefits are being expanded, but the premiums seem to be remaining fairly similar on the individual policies. Of course, when you add a 5% compounded inflation protection feature and you add a nonforfeiture benefit on top of that, the premiums go through the roof, but for that base plan, we're not seeing a big difference (Table 2).

TABLE 2
Average Annual Premiums for Leading Long-Term Care Sellers in 1991

Age	Base Plan	With Lifetime 5% Compounded Inflation Protection Only	With Nonforfeiture Only	With Nonforfeiture and Lifetime 5% Compounded Inflation Protection
50	$ 477	$ 852	$ 776	$1,252
65	1,103	1,781	1,690	2,525
79	3,989	5,627	5,709	7,675

* Generally, for $80/40 a day nursing home/home health coverage, 20-day elim., and four years coverage.
† Premium data not available for two insurers and nonforfeiture not available for three insurers.

Source: *Sales Survey on LTC*, HIAA, 1992, Washington, D.C.

MS. BROWN: I would like to clarify some of Susan's earlier comments. We're not disagreeing, Susan's data covers 1990-91. Tillinghast data was more recent, 1991-92, so we saw a significant increase there. Also the group data grew tremendously from 1991-92, so we're talking about different years.

MS. VAN GELDER: Some general observations would be that I think the products are stabilizing somewhat in terms of design, but maybe in 1992 we're going to see many different changes. I do think areas of change include more development of cognitive impairment benefit triggers, some refinement of ADL definitions (perhaps being tied back to medical necessity) growth in assisted living benefits and expansion in home care both in terms of how you qualify for benefits (maybe a separate criteria than for nursing home care) and an expansion of actual benefits themselves. Bart and Ron will address the nonforfeiture issue.

I also see increasing pressure for greater standardization of policies. We almost received federal standards from this past Congressional session. I do think that part of Congress's intent is to standardize the products. They may still allow states to exceed or have variations from those federal standards, but there are many people on Capitol Hill who see this as Medigap, and they want standardized policies similar to Medigap legislation. I also see the pressures coming from the state public-private partnerships with the Robert Wood Johnson Foundation. Those of you who are familiar with those projects know the pressure for standardization is coming more from the industry than the states. The companies are realizing that if there are too many partnerships there will be 100 policies to be filed and approved instead of 50.

Let me skip to an analysis we just did of how states and companies look in terms of state regulation. Project Hope did a study for the American Association of Retired Persons (AARP) about 18 months ago, and they identified 15 provisions in the model act and regulation that they thought were most important for products to have and for states to adopt. To demonstrate how quickly this is moving, we looked at those 15 provisions, and the majority of states, 35, had adopted at least 10 out of the 15 provisions. The provisions where state compliance is the lowest in adopting the post claims underwriting provisions, the home health care standards, the 5% compounded inflation offer with a rejection notice, and what's absolutely the lowest is the reporting of lapse and rescission rates. Very few states have adopted that. Since that AARP study 18 months ago, where they found 13 states were in compliance with at least 80% of those provisions, we counted 29 states that are at least 80% in compliance. I think, contrary to what the consumer groups and others are telling the NAIC and the federal government, the states are moving fairly rapidly. There was a lull while they were focusing on Medicare Supplement, and now I think there is some effort under way to really get up to speed and comply with the provisions in the model.

Now I will highlight some of the findings from the buyer survey. The market survey will be published in about a month or two. The buyer survey I mentioned earlier was a sample of people who bought a long-term care policy in 1990. It looked at people who bought and people who chose not to buy. The nonbuyers were defined as people who were approached by an agent but declined to purchase a policy. What was most interesting about the findings, I think, is that it confirmed common sense. The buyers and the nonbuyers don't look that different in terms of sociodemographic variables. Their income, their asset levels, and their education levels are the same;

they're married and they tend to be younger than their cohorts in the population relative to the elderly. They have an attitudinal difference in terms of why they buy and why they don't buy. The attitude differences that separate the buyers from the nonbuyers make sense too. The buyers perceive their risk of needing nursing home care to be much higher than the nonbuyers, even though they both heard the same information from the agent. Buyers tend to believe that planning for future long-term-care needs is very important; they're planners by nature. They're less likely to believe that there's some other source of government funding or insurance funding if they ever need long-term care.

When asked how they would pay for more than six months of care in a nursing home, buyers were most likely to say out-of-pocket as opposed to some other source. What's still disturbing about this finding though is that among buyers of long-term care, 33% of them said Medicare, a Medicare Supplement or their retiree health plan would pay for more than six months of care in a nursing home. The percentage for the nonbuyers was almost 50%. It's disturbing that both have this misconception, especially the buyers. The nonbuyers cite the expense of long-term care as the primary reason they don't want to buy even though their income and assets look a lot like the buyers. So it's difficult to know if that's a valid reason or just a convenient reason. But when you look beyond expense and affordability, what they're saying is they're waiting for better products and they either believe the government ought to do this. Nonbuyers are much more likely to say there ought to be a government long-term-care program for everyone, not just the most needy.

In conclusion, I think the long-term-care industry is in a tough position right now. The economy's bad, interest rates are low, unearned income for the elderly has really decreased their disposable income for long-term-care insurance, and employers are not really looking to offer new benefits to their employees. I think the NAIC and Congress are engaged in some kind of arms race to see who can "out-protect" the consumer in terms of what kind of standards ought to be established. I think the term crossroads is used over and over again and it's a hackneyed expression, but I think we are reaching that point where the balance between affordability and who's going to benefit from this product is reaching some sort of head.

On top of that is the likelihood of Clinton being elected. Long-term care is in his health care financing reform proposal, and whether or not you believe that long-term care can be picked up by the government (and I don't believe the Clinton people believe that for a moment either), the fact that it's in there keeps the issue alive. AARP is about to begin a major campaign effort using the opportunity for health care reform to have long-term-care included. I think it provides a false hope to the elderly because they believe a government program is on the way when, in fact, no one believes we can fund it. That tends to dampen the demand for private alternatives because people are waiting for something to happen.

In *The Washington Post*, in the Health Section, there was a whole issue devoted to the elderly. They were asked what their two biggest health concerns were, and they were prescription drug coverage and long-term care. Maybe the 1992 data looks positive, and I think the public-private partnerships in those four states offer some promise too. I think the demand for the product would be raised if people were aware that there's a product they can buy that has this additional benefit of being tied

to asset protection. And last, I think that we'll probably get federal standards, but perhaps they'll be reasonable and perhaps they'll also be tied to tax clarification. Those two things could do a lot to legitimize the market and the product and perhaps raise the awareness of people that it's an option.

MS. BROWN: Next we have Ron Hagen. If you know much about long-term-care regulatory development, you certainly have heard his name before. Since 1988, he's been at Amex Life which is the largest seller of individual long-term-care insurance. He's the vice president of marketing, product development, and government relations. In the past, Ron was a legislative representative for AARP, and he was their director of insurance services. He's a member of many professional organizations and committees such as the NAIC Advisory Committee on Long-Term-Care Task Force, the HIAA Long-Term-Care Legislative and Regulatory Sub-Group, the National Association of Life Underwriters (NALU), the American Public Health Association and the Direct Marketing Association's Insurance Section.

MR. RONALD D. HAGEN: Our business has not fallen off nearly to the extent that Susan's comments might have led you to believe. The real risk to this marketplace is a Clinton administration and the perception of the government's role in the area of long-term care. I don't believe with $900 million a day in national debt service alone that there's a lot of money sitting around to develop and offer a major social entitlement program in this area. But I do believe that just the announcement of a plan will be more than enough to get many people, who are already strongly denying the need and risk for this product, to wait and reevaluate. I think that is the biggest risk we face heading into perhaps a new administration and a new Congress. So HIAA, our coalition, and our company will be working very hard with the next Congress to educate new members as well as old as to the wisdom of a given set of consumer protection standards that encourage and allow the growth of this marketplace. These standards must not push us to the point that we end up with unaffordable (and therefore unavailable) products that no company in their right mind would be willing to write.

I'm going to talk very briefly about long-term-care spending. What we see is a disproportionate amount of spending for formal long-term-care services in the institutional area; Medicaid Title 19 is playing a major public role. On the home health care side, the public funding is predominantly Medicare. Medicare spending for home health care is likely to continue to grow in the absence of Congressional action. Nursing home average per diem nationwide in 1991 was about $83 a day for skilled nursing facilities, and $68 a day for intermediate and custodial care facilities. Home health care costs are averaging $60 per visit.

One of the other things that I think we have to keep in mind when we talk about gatekeepers and cognitive disability levels is that 4 million individuals in this country now suffer from, or are being diagnosed with, Alzheimer's and other forms of senile dementia. I think that's important for the industry since the average severity of a claim for Alzheimer's or senile dementia is probably about twice the average for noncognitive claims. Nursing home payments coming out of the private insurance sector in 1990 were only about $600 million. That certainly will increase significantly as we start to see some major growth in this marketplace. In 1990, Medicare paid about 5% of all nursing home expenditures. That's about $2.5 billion. On the home

care side they are certainly a more significant player; we're looking at 35-40%. This is an area that is exploding within the federal budget, and it's something that probably will be getting a lot more attention.

Just a brief snapshot of the demographics. In 1990, some 10.6 million people in aggregate had some level of functional disability and I'm not just talking about the elderly. I'm talking about the developmentally disabled, the mentally ill, and a variety of people with chronic infectious diseases such as AIDS, tuberculosis, etc.

Let's look at projected nursing home use by individuals reaching 65 years of age in 1990 (Table 3). Interestingly, if you look at long-term risk here, and many of the products that are being sold on the nursing home side are unlimited or lifetime benefit plans, 13% of women and 9% of all individuals reaching age 65 in 1990 will be spending more than five years in an institution. That is fairly significant.

TABLE 3
Projected Nursing Homes Use
for Persons Who Reached 65 Years of Age in 1990

	Men		Women		Total	
Category of Use	No.	%	No.	%	No.	%
Size of Cohort	998	100	1,175	100	2,173	100
≥ 3 Months	219	22	476	41	695	32
≥ 1 Year	143	14	370	31	513	24
≥ 5 Years	42	4	153	13	195	9

All numbers reported in thousands.

There is a very aggressive group of Medicaid estate planners that are working very diligently in many states, counseling people on how they can transfer their assets at less than market value to qualify for Medicaid. It is a growing concern to members of Congress, it is a growing concern at the state level to governors and people that run Medicaid programs in the states, and it is something that is certainly within the guise of the public-private partnerships. Connecticut is the first state to look behind authority, to go after people in the area of estate recoveries when they've transferred assets at less than fair market value. The national standard is 30 months now, and they've gone to five years. I think other states will be making similar efforts.

Let's talk a little bit about some of the issues facing this market and this industry right now. Many of them are driven by legislative and regulatory concerns. Companies are reconsidering whether this marketplace is where they want to be. In many cases, it is a decision that is based on the myriad of different products that one is having to develop (50 different products in 50 different states) and by the very oppressive pressure that many additional state legislative and regulatory mandates are raising. Advocates such as AARP continue to demand a national entitlement program that covers long-term care. Its membership is supposedly crying out to pay more taxes for a real and substantial long-term-care program, and the reason they believe that the Medicare catastrophic legislation was a failed experiment is in part because it didn't provide protection against the real catastrophic risk, long-term care. I will tell you that

I think AARP has been more candid in some of the publications that it puts out. It very clearly said it is in favor of income and asset redistribution and some cost shifting from the elderly to the rest of the population.

Affordability is still an issue. There are price points in this marketplace. There are target premiums that people deal with, and they will adjust their coverage accordingly. If we start to mandate nonforfeiture benefits that the customer sees very little value in and charge anywhere from 30-40% additional premiums, they will simply reduce their coverage in other areas or not buy the product. We've done a disservice to this market and to its customers by getting hung up on issues like mandated nonforfeiture benefits and losing track of some of the more critical issues like what are we paying in the way of benefits, what's the eligibility criteria? Right now there's very little on the model or at the state level in the way of standards for home and community care benefits.

There's an incredible variety of benefits out there. People are buying home care without an understanding of how they access benefits, what the benefit levels are, or what the company's claim payment practices are in that area. There's a need to look at standards in the home and community care area, in particular. We have something Susan mentioned called alternate plan of care. What does that mean? It means if the doctor, the insurer, and the customer agree that this is something that's good for you to have, you'll get it. That's a lot of "ifs." That's a lot of different people having to make a decision about that benefit.

So I think there's a very strong need to look at some standardization here without totally locking in a specific product mix. If you provide home and community care benefits, they should be the same types of benefits. At the same time we have to look very closely at the gatekeepers and how we determine eligibility for those benefits. Right now many companies are moving to ADLs or cognitive impairment or, in some cases, particularly on the institutional benefit, the ability to trigger benefits with injury and sickness criteria. The NAIC model will probably eliminate that as a sole benefit eligibility criteria.

We did an affordability test based on a study done for Families USA. We used our premiums, not some industry-wide average premium that they used, which was astronomically high if I remember. We eliminated the Medicaid eligible population. Using our premium and taking away the Medicaid population, the percentage of folks that could afford Amex Life's average product was almost 66% which is quite a bit different from 16%, which is what the original study said. I guess you can make numbers tell anything you want. We have shared that information with people on Capitol Hill and others as well. I think we probably need to go back and update that.

Table 4 is a very general breakout, per our last claim audit, showing the reasons that claims were denied. Some 97.4% of all claims received, that met our policy deductible or elimination period, were paid benefits. We eliminated prior hospitalization in 1988, although there are obviously still policies on the books. The mental and nervous exclusion was eliminated over a year ago, too. In the 18 years we've been in this business, we've only rescinded four policies.

TABLE 4
Claims Analysis
(Total Claims Paid: 97.4%)

Denials (by reason)	Percent of Total Claims
Care provider not qualified	1.5%
No prior hospital stay	0.9
Mental and nervous exclusion	0.1
Service incurred prior to effective date	0.1
Total denials	2.6%

There is a state legislative trend to require disclosure of claim costs (loss ratios). Mandated loss ratio requirements are clear. We can see a trend now in several states to increase the individual loss ratio as well as the group loss ratio requirements. I'm meeting with the Maryland Department on a regulation they're working on; it has a 65% loss ratio. New Jersey, New York and several other states have required a 65% loss ratio in which the agents are real interested. I think we've convinced these states that there are things beyond compensation limits in these contracts that they need to be concerned about, and this is one of them. Recently Commissioner Garamendi published his list of health and life insurance companies with the best and worst records as far as justified complaints. You have to pay the Department of Insurance to process these complaints now. I believe that this will be something that we'll start to see quite a bit more of. We're also seeing a lot more prior approval of advertising in this marketplace. There are still only about six states that require prior approval on advertising. All of this heaps additional legislative and regulatory burdens on top of the market, the product and the relatively limited resources of the companies to do these things.

Several states are doing some very nasty things with community-based care and home-care mandates. California, in spite of our protest, recently decided that companies who sell home or community-care benefits, which were not mandated, must use two out of seven ADLs as a benefit trigger, without defining those ADLs I might add. They also require personal care services under those contracts in addition to home health, respite, adult day care, and several other benefits. You have to provide what we call individual ADL (IADL) benefits -- things like housekeeping, shopping, transportation services, check writing, medication management -- things that aren't "hands-on care." We're seeing the same situation in Oregon. We provide adult foster care -- items that are part of the social service programs; however, it was never intended that these items be paid for. It is not efficient to pay for these services through a private insurance contract. Idaho requires that you pay for Meals on Wheels now, which is somebody delivering hot meals. There is an issue with mandated benefits in the home and community-care area. The advocates, for the most part, have not been clamoring too loudly for mandated home and community-care benefits. There is a very real issue here about the appropriateness of somebody, in the absence of an informal care giver selling home and community-care benefits to an 80-year old widow. What we're talking about here was not intended to pay for 24-hour-a-day care at home.

The NAIC is again looking at group products that are sold to individuals. It wants to outlaw all discretionary groups in all health product lines. That's something that we and others will fight because there is a role for these out-of-state group products in some states, and those products have to be filed in those states and approved by the commissioner in those states. There are very clear requirements in the NAIC Model to that end.

We all know about prior approval on rates and forms. We're seeing a lot more special licensing in California. With the recent bill that passed, SP1943, we're seeing prelicensing as well as continuing education requirements if you're going to sell long-term-care products. To the best of my knowledge right now, North Carolina and California are the primary examples of states that have passed legislation and/or regulations to that end. With the private-public partnership programs, there are going to be requirements to certify the agents. There's going to be training. In Connecticut, eight hours of education in long-term care is required. A specialized curriculum has to be approved by the department in order for a company to be certified to sell these partnership products. The other alternative here, which we have generally tended to support, is LTC questions on general accident and health licensing as part of the continuing education requirements.

What's the NAIC working on? The LTC task force (I chair the Task Force's steering committee and Bart chairs the actuarial advisory group) decided to approve general policy language mandating nonforfeiture benefits. The NAIC will incorporate that in the act. It has asked the steering committee, advisory committee and other interested parties to come back and make recommendations on the form and structure of the benefit. There's a very strong prejudice among the task force regulators towards a shortened benefit period as a form of nonforfeiture benefit. We have lobbied hard along with HIAA and other member companies against this mandated benefit. We believe it's foolhardy, we believe it provides very little value to the customer, and we believe it will further restrain the growth of this marketplace. There are a lot of other reasons.

Frankly, the other danger here, and we saw this in the waning days of the 102nd Congress as Senators Kennedy and Hatch attempted to push through their consumer protection standards bill, is that Congress is looking very closely at what the NAIC does in the area of mandated benefits, nonforfeiture, rate stability and so on. It's very likely that we'll follow closely on the heels of their legislative proposals. I believe we can fight this issue at the state level. I am quite concerned about federal standards legislation which preempts our ability to do so. Rate stability is a hot issue right now and has been for some time. There are a variety of proposals circulating. The regulators in Cincinnati in September exposed a draft which put a cap of 5% a year on the rate increases that a company could take on a given policy form. They deleted the 50% lifetime cap in the process.

Other issues include a premium disclosure statement that will be part of all outlines and materials that go out. A code of conduct was adopted on what the rules and responsibilities are for associations who endorse these products and for insurers who provide the products. There's a third party notification provision for people who have not paid their premium due to cognitive impairment. They would have the right to reinstate the policy if they can show that they were so impaired and the impairment

is the reason they didn't pay the premium within the time limits. There's a post-claim underwriting provision that was adopted as well. The final thing I would say on the NAIC front is that there is concern among the regulators that there are people who are buying these products who have very minimal asset levels, below $30,000. But people are buying these products for a variety of reasons that don't necessarily relate to asset protection. They're buying it for independence, choice, access, quality of care, and a whole range of reasons. Asset protection is only one reason.

More states are using private partnerships. Connecticut is already up and running. There are three carriers, one of which is AMEX. There are two additional carriers that have recently been certified in Connecticut. Indiana and New York will be next out of the blocks probably in late 1992 or early 1993. Obviously, this is driving a lot of product development at the company level in these states as well as in general, because it is a major burden when we look at developing and making the products available. There are other states that are moving, in the absence of Robert Wood Johnson financial support, to offer the products. It's a very costly and involved process to report the data that they want in these states for these programs. Furthermore, we need to have a clear understanding of these public-private partnerships regarding how success is going to be determined and what the target market should be.

Editor's Note: Due to the few minutes remaining when Mr. Munson was introduced, the following is an edited version of his abbreviated words, so they can convey a reference to what he would have presented given time.

MR. BARTLEY L. MUNSON: Let me very briefly describe the study we are in the midst of doing called the "Affordability of Private Long-Term-Care Insurance -- New Perspectives for the Public Policy Institute" conducted by the American Association of Retired Persons. Perhaps that way I can best serve your interests and informational needs by whetting your appetite for the eventual report. You can obtain a copy from me or from AARP's Mr. Van Ellet, as soon as it's ready to be distributed.

As you might expect from actuaries, the study is based on facts. It has few opinions. We study factual information to help answer the questions: What does private LTC insurance cost? What percentage of citizens, in quinquennial age groups, and by gender and marital status, would have to pay what percentage of their income, or income and an amortized portion of their assets, in order to purchase each of many various policies?

The study is different from several studies on affordability of LTC insurance, in that:

- It does not forecast income or assets of purchasers as they age, but looks only at the time of purchase. That makes for a more manageable, understandable, and focused study. It reveals data regarding the initial difficult decision, though it admittedly ignores affordability as a policyholder ages.

- We do not address the slippery issue of why people buy.

- We look at income, or income and a portion of assets. That way whichever side of that debate one is on, one can find data to analyze.

- We consider several different income levels as affordability thresholds and leave to the observer the decision as to which cohorts are potential buyers.

- Perhaps most notably, the study prices a wide range of LTC benefits and many policies, some new (e.g., with nonforfeiture benefits and/or inflation protection). Premiums are presented for quinquennial issue ages 42-82.

The income and asset data is drawn from the Survey of Income and Program Participation (SIPP) released in August 1992, by the Bureau of the Census. SIPP provides a vast amount of information. The population we sorted out for this study were the 82,238,000 citizens age 40 and over who were noninstitutionalized, were not functionally disabled, and were not Medicaid enrollees. For the large portion of the study which measures what percent of a person's income (or income and annuitized assets) a specific LTC premium represents, think of SIPP as providing the denominator for each cell (age, sex, marital status).

The numerator is a premium we calculated according to the pricing assumptions we used in prior research published by the AARP Public Policy Institute last June. The specifications produced a set of policies with nursing home-only (NH) coverage, home health care-only (HHC coverage) or both. Some 18 different policies across a wide premium range are priced, and those prices are tested as to their affordability.

The study comes at the subject from two basic directions:

- What percentage of a person's income does an LTC policy consume?

- If it is assumed a given percentage of income can or will be spent on an LTC insurance premium, what percent of a given age/sex/marital status cell can afford the policy, if that allowable income percent is 3%, 5% or 7%?

Without time to take you usefully through some slides to answer those questions, I can only offer to send you the report when it's published. Suffice it to say that the affordability of the product varies greatly by age considered and even more by the specific coverages and benefits provided.