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SENIOR HEALTH PRODUCTS—LONG-TERM CARE: ARE THERE ANY ANSWERS?

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The panelists will review long-term care (LTC) products. Discussion topics will include product design, pricing administration, regulation, and marketing.

MS. MARY ANN BROWN: Neil Lund commented on how we have three women on the panel. He said that he thought that women had all the answers to long-term care, and that's why we are here. We don't purport to have all the answers, but certainly, by the end of this session, we hope you'll have fewer questions.

To start off, we'd like to get a feel for the audience's experience in long-term care. Could we see a show of hands of those of you who have experience in pricing or designing long-term care plans? Quite a lot. Now a show of hands of people who have no experience, but are just interested in learning about it. It's more slanted toward those with experience.

Our first speaker is Jan Soppe, who is the president of the long-term care division at Aegon USA. Susanne Bowman is director of insurance services of the American Association of Retired Persons (AARP). First I'll introduce Jan. She has been at Aegon for 23 years and has worked in many capacities. It's hard to believe when you see her that she has already had a 23-year-long career. As many of you know, Aegon is one of the top sellers in the long-term-care area. It earns more than $100 million in annual premiums.

MS. JANET M. SOPPE: I will talk about the product design and marketing of long-term care. There are basically four ways that people are designing long-term care products. First, is the stand-alone nursing home product, which is probably the original product and the most common one. Most companies at least offer that type of product. We have a few companies that are interested in doing a stand-alone home health care product. I think from a marketing standpoint, it is a product that many people would like to see available. I'm not convinced yet how well you can price that type of product. It's very difficult today. It depends largely on some of the triggers that you put into it. It probably depends also on your marketing organization and how you market it. I've seen a number of companies recently get into that market, and I've seen a couple of companies get out of that market. So, it's something that you need to think about long and hard, and you must be careful about how you would design that type of product.

I think it is very dependent on how you structure the activities of daily living (ADLs) in your product. I would recommend that you not require anything less than two of five ADLs and the five should probably not include bathing. If you did include bathing you

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would probably want your trigger to be based on three of six ADLs. I'm also assuming you would put a cognitive impairment trigger in there.

There's a combination of plans. You can structure it where you have separate benefit periods for your nursing home and for your home health care. It gives you some flexibility in what your agents have available and probably more flexibility in terms of pricing, whereas, they could sell a lifetime nursing home plan, and they could sell a one- or two-year home health care rider that goes with that. That would probably be significantly less costly than if they were to purchase a lifetime plan for both nursing home and home health care.

The last type that we're seeing a lot of now in the market is what I call a pooled or a pot-of-dollars plan. The pot of dollars is basically just what it sounds like. You have a benefit period that is translated into a pot of dollars. So, if a person were to take $100 per day of benefits, and bought a two-year benefit period plan, essentially that person would have $73,000 to work with. The insured could use those dollars for both nursing home and home health care, or one or the other exclusively. I think, from a marketing standpoint, that has been a big bonanza for marketers. I think that people want to know that if they paid a certain premium, that they could use those dollars however they want; that they're not tied into either using a certain amount of them for nursing home care or a certain amount for home health care. They can use them from whichever type of provider that they'd like.

I think it's a dilemma for the pricing actuary to figure out how to price those types of plans because there are people who are interested in only receiving home health care. If they were to buy a two-year plan, for instance, that generally would translate into half the daily benefit amount. That would be equivalent to four years of home health care, four years of visits, (four times 365 visits), which could go on almost forever. I think the pricing of those products is probably fairly difficult today.

The next thing I want to get into are just the nursing policy features and basically what you'll see on the market today. The assisted living, Alzheimer's, and hospice facilities are usually covered in many contracts today under the nursing home section. The Alzheimer and the hospice facilities may be covered even if they're not specifically indicated in the contract.

The assisted living facility is probably only going to be covered if it's specifically listed in the contract. What we're seeing for assisted living facilities varies tremendously in each state. You have some states who do very little regulation of them, and they end up with facilities that provide very few benefits for people. They're basically residential facilities. You see other states where they do quite a bit of regulation of these facilities and you see facilities that provide a great deal of benefits. In fact, some of these facilities take care of many Alzheimer's patients and they will take care of them almost until the very end. They get very close to providing the very same type of benefits that you'll see in a nursing home but that's not true across the board, so there is a great deal of variability in the types of services that are provided in assisted living facilities.

The assisted living may not always be provided in the nursing home part of the contract. It may be provided under the home and community benefits part of the contract, and thus, it's in the rider rather then in the base plan. There are some advantages to doing that,

particularly if your marketing organization tends to sell lifetime nursing home benefits to cover that huge catastrophic risk, but maybe only one- or two-year home health and community care benefits. If that's how it's being marketed, then your risk as an insurer tends to be less because you have your assisted living benefit sitting in that one- or two-year benefit period part of the plan; it's not in the lifetime nursing home plan. That's something to consider when we have a feature that is very difficult to price in today's market.

We don't have much insured data specifically on nursing homes, or home health care. We have almost no insured data when it comes to assisted living facilities. There isn't much government data either, because generally, these types of facilities have not been covered by any sort of government program. We're seeing some of that now because there are some Medicaid waiver programs that are being instituted in some of the states. I think we will get some more government data but these data will be slow in coming. Trying to price that particular product today is very difficult. I think in pricing it, if you're involved in that aspect of it, you need to try to build in some protection in the way the benefits are structured.

The alternate plan of care is a feature that has been in products for awhile. It's handled differently by different companies. Some companies will just pay for or will install an alternate plan of care in lieu of going to a nursing home. Other companies will say you can have the alternate plan of care if you're already in a nursing home. Believe it or not, there's a large difference between those two features and in the way they're worded. It depends on the type of trigger that you have in your contract; most of us home will probably have a triple trigger for nursing home care that is based on medical necessity—loss of two of five or three of six ADLs and cognitive impairment. Probably for every one person that's already in a nursing home, there's two, three, or maybe even four people who qualify under the triggers that don't go into a nursing home. They're very interested, then, if you allow them to have an alternate plan of care without first having to be in a nursing home. In that situation they may be able to get home health care, assisted living care or adult day care. There are a number of things they may be able to get under that contract, if the insurer decides to be fairly liberal in interpreting how the alternate plan of care is going to work.

The postconfinement benefit is basically a way of giving dollars to people who have been confined either in a hospital or in a nursing home. It makes that transition to coming home a little easier to do and it gives them some money to do some things. It may encourage people to go home rather than to go to a nursing home, or to a different type of facility, and the dollars are just available to match the number of days that they were in the facility.

An ambulance service benefit just pays for the ambulance, that is, the cost of the ambulance up to some amount per ambulance trip. A bed reservation is a feature that holds your bed while you're in the hospital. Many people that are in a nursing home have to go to the hospital. When they come back to that nursing home, they want to have their bed back. They don't want that bed to have been given away during those days. When they come back they might be in a different room, or maybe they're not even in the same facility. This feature encourages the nursing home to hold the bed for that individual.

There are two types of respite care. In respite care, the person has to go to the nursing home while the family caretaker goes on vacation or needs a break from that daily routine. If they have to go to a nursing home, that's considered a little more restrictive than if they can have someone come into their home and take care of them. If they come into the home it does not even have to be on sequential days. Generally, respite care benefits are for a period of 14 or 21 days a year. And, in some cases, you could use one day every two weeks if you wanted to do that. It would just give somebody who's taking care of a person an opportunity to get out and have a day by themselves and someone else would come into the house and take care of them. Also, you could take them to an adult care facility.

Restoration of benefits is fairly common. It may have different types of wording in different contracts. It essentially restores the benefit period after a certain period of time. It would generally be 180 days where you were free of treatment for the condition that originally caused you to go into the nursing home. After you go through that 180-day period, then they restore your full benefits as if you had never used any benefits at all. If you have a lifetime benefit period, it essentially makes no difference. It comes into play where you have shorter benefit periods. Some companies have put that into their home health care provision. That's a little more difficult to administer from the claim side because you can't always tell when people are treatment free. They may receive home health care for a year and to the insurer, it might appear like they're treatment free. They didn't get any obvious benefits and they didn't have to tell you about any types of services they were receiving. After a six-month period, they may come back and say, "Oh, I'd like to start my benefits over again." It can be an expensive situation when you price for a one-year benefit period, and they figure out how to make that into a two-year or three-year benefit, just by restarting the benefit period.

The waiver of premium, of course, is very common. It's in all nursing home policies. Some companies do waive it when you're receiving home health care, or when you're in an assisted living facility. If you're going to do that, it, of course, is going to add to the price. It also, if you waive it for home health care, may encourage people to stay on home health care, even though they're receiving very sporadic services. They have the added incentive of not paying premiums during that period of time.

Extended reinstatement for cognitive impairments is something that makes some sense because many of these people that are paying the premiums on long-term care contracts eventually do become cognitively impaired. Just at the point when they're about ready to need benefits they forget to pay the premium. It is not our intention to have someone like that not receive the benefits under the policy, so there is a feature where, within so many months after the person discontinued paying premiums, if benefits are needed and someone is able to show that the person was cognitively impaired at the time that he or she discontinued the premium payments, we will pay benefits. Those back premiums must be paid during that interim period, but the person would be able to get benefits. There are a certain number of states where the NAIC requires insurers to offer cognitive reinstatement. I believe the NAIC requirement is that the period of time be at least five or six months.

Third party notification is also something that can protect people against that very same type of thing. If the insured forgets to pay the premiums, there is a third party that is notified that their friend or relative did not pay the premium on the long-term care policy.

It may turn out that the reason the insured didn't pay was because of a cognitive impairment. Then that third party person will hopefully get involved and make sure that premium payment is made. That is also an NAIC requirement in some states, but it's also a good thing for companies to do in all states. I think to offer that type of service to your clients indicates a level of integrity. If they pay premiums, you don't want to eliminate coverage just at the time when they can use it the most.

Now, there are some rider features that I want to go into. Of course, one of the basic riders that you'll see is the home health care rider. Home health care, of course, covers skilled home health care that might be provided by an RN, an LPN or a physical/respiratory/occupational therapist. It also would pay for a home health care aide or other people sent by a home health care agency. Along with those basic home health care benefits and services, you also will see adult day care. That probably has not grown to the level that I expected to see it at by now. I don't see it available in that many areas, and I don't think it's too common in rural areas. It may be somewhat more common in urban areas than it was a few years ago. Part of the reason may be that people don't like the name. The term *adult day care* makes them feel like a kid again, and somebody must look after them all the time.

Another thing about adult day care is that it's probably not something that works in many cases. It really appears that it would have to be used in a situation where a caregiver works outside the home. That caregiver takes the person to an adult day care center for those working hours. That may not be the situation very often, so maybe there's just not demand for that. We don't see much usage yet of that particular benefit in the products that we have available.

Nonprofessional care is something that we've seen in some of the contracts. Some contracts have a disability trigger and will just pay benefits if a person is disabled, but not necessarily receiving actual services. With this feature in your contract, you could go to a family member or friend or a neighbor and ask them to come in and provide services to you. You could actually get some sort of reimbursement from the insurance company for that.

A homemaker and chore services benefit is typically part of home health care. Some companies have set up a situation where in one week you can get homemaker and chore services twice, rather than allowing you to use it up to seven times a week.

Professional care paid at double benefits makes some sense because, obviously, it is more expensive to send out a therapist or send out an RN or LPN than it is to send out a home health care aide. This type of a benefit makes more sense than a person having out-of-pocket expenses. The durable medical equipment benefit, of course, just pays for different types of medical equipment that you may need that helps you with your inability to perform ADLs.

Nonforfeiture riders are something that are becoming more common. If the NAIC has its way, it will not be really an optional rider, it will be a requirement in policies. We have seen companies have return-of-premium riders in their contracts for quite a while. Those have been triggered either by lapse or death or a combination of both. When you do that for a death, it makes sense for those of you who might be doing group insurance.

Younger people want to know that they're going to use their benefits or, if they die prematurely, someone could get their premiums back. I think it helps on the marketing side to have that available. If you do it at lapse, it can be very expensive. You'll probably want to have some sort of incrementally increased in the amount of premium that you would return.

How many sales do we see of that type of product? We see it sold approximately 5% of the time and we've had it available for probably four or five years. The shortened benefit period is something that has just really evolved during the last two or three years. Basically what that does is create a pool of dollars that are available to be used as you incur long-term care services. So you're not actually getting money back; you only get benefits paid when you're actually receiving services.

The NAIC formula for this takes the premiums that you've paid and sets those aside in a fund. So, if you lapse any time after the third policy year, 100% of your premiums are sitting over in a fund that you can access. It's not inexpensive to do that. At the upper ages, it's the lowest percentage of premium. It probably would run 15% or 17% for those in their 70s or low 80s. At the younger ages, that type of a benefit probably runs 80–120% of extra premium and that's expensive. We're trying to make a change at the NAIC level. We feel that people should have the option of paying that much more of a premium or deciding that their premiums would be better placed elsewhere. Maybe they would prefer to buy an inflation benefit or they would prefer to buy more home health care or a longer benefit period.

We look at that from the insurance industry side as something that should be available. People should be made aware of what it is and what it does for you but it still should be up to the individual persons to decide whether or not he or she is going to pay out the premiums for that.

The last rider is inflation protection benefits. You find these as compound inflation protection, simple and the guaranteed insurability option, which essentially you have to elect each time it becomes available. Some companies may do options every year, some may make it available every two years and some companies may make more benefits available every three or more years. When it is available, the extra premium is based on your attained age at that point, so that it becomes a more expensive benefit. Compound benefits do make a big difference, particularly for younger people, and it makes sense that younger people ought to purchase those.

We see that our marketing groups, at older ages, tend to recommend that people buy additional dollars per day immediately, rather then buying the compound inflation. It is probably not a bad idea for those older people to do it that way.

The next thing I want to discuss are the premium features that we're seeing in different plans. We are seeing rate guarantees and for some plans, those typically are three to five years. It's difficult to tell at this point how long rates could be guaranteed. I think that nursing home costs—claim costs are probably not going to have a tremendous increase in the near term, unless something dramatic changes. At this point, states have a lot of control over how many nursing home beds are available in their state. The reason they have a lot of control is that for every bed that is available in their state, they're going to probably pay 60% or 70% of the dollars to keep somebody in that bed. Most states don't

have that money available to them, so they don't add additional beds. That will probably put some sort of a brake on the increase in nursing home claim costs.

Other types of new features like the home health care, the assisted living facility care, and adult day care are very difficult to know how to price. I don't know that we're going to have enough experience in three to five years to know whether we're in the ball park on our pricing or not.

We also have some plans available that offer different premium paying options, rather than lifetime. There are single-premium plans, 10 or 20 pay plans and I believe there might be some plans paid up at age 65, 70, or 75. To some people it makes a lot of sense to have that available. I think financial planners, as opposed to general long-term care salespeople perhaps, will be more drawn by a plan like that. If you are pricing a plan like that you have to be sure to build in a rate guarantee cost because it does cost money.

Let me just go through the rest of these premium features quickly. A couples discount is something that many companies make available. It makes sense; it shows up as being a good feature. Lifestyle discounts for active people, nonsmokers, or people who work outside the home make sense, but it's difficult, in many situations, to tell just how much they're working outside the home and how active they are. Another speaker said that maybe only about 10% of those people are really active; the rest of them are not active at all!

Health rating discounts are used by certain companies. They will actually look at the medical conditions and then base their premium on that. With a survivorship benefit, if your spouse dies, your premiums will be paid up after a period of years.

In a Farside cartoon, Gary Larson recognized our dilemma a long time ago. It said it's tough enough for a monster to get into the house, but if he's dressed as an insurance salesperson, it's almost impossible. Well, this is really true if you're trying to sell long-term care.

The types of agents selling long-term care generally tend to be brokers, independent agents or captive agents. On the broker and independent agent side, we have some senior specialists and they'll sell long-term care, annuities, burial life, etc. Those who consistently sell long-term care tend to send you the best type of business but they usually carry multiple products. It depends on whether you're getting their best sales and their best applicants or not.

You also have brokers who are generalists and then long-term care is an accommodation product. They don't promote it, they basically respond when one of their customers is interested in long-term care. You get an idea of what that means to your underwriting when that happens!

Captive agents may be company tied, such as John Hancock or New York Life. They're not long-term care specialists. The amount of sales that you get from that type of captive agent will depend somewhat on how much the company is promoting the long-term care product, i.e., the sales promotions and the training the agents receive.

Another type of captive agent is one who is a long-term-care specialist. That may be because they're part of a company-owned agency or they're part of an independent marketing agency. They typically sell one long-term care product or maybe they have two products, and one is more heavily underwritten than the other one.

Most agents will tell you the trick to selling long-term care is leads. If you can get them good leads, they can make a lot of sales. If they have leads that aren't very good, or they're just knocking on doors, it's tough to make a long-term-care sale.

On the group side, we tend to see employer groups, association endorsements, credit union, and bank endorsements. Sue will be able to talk to us about AARP which carries a very strong association endorsement. It can have a strong impact on the amount of sales that you'll get. The sales methods typically used for group members are on-sight meetings, direct mail with a seminar or direct mail only. At this point, trying to do direct mail only for long-term care is unsuccessful. I think it's because people don't recognize the need and it's hard to get that across in your mailing. Also, it's an expensive product and that's hard to sell with a direct mail piece.

MS. BROWN: Jan did a great job discussing the marketing side. I get to discuss some of the actuarial implications. One thing everyone always asks is who are the leading players? It's often hard to find them in *Best's Insurance Reports* because they're not in the clearest place under A&H-other. Its difficult to know who's in individual, and who is really in group, due to filing discrepancies; some get filed as group that are sold as individual. We did a sales survey about two years ago. Table 1 shows the ranking according to volume. It has changed since the survey; Aegon has probably moved up some and we're missing New York Life, which should be in here. Also some of the parties are changing. John Hancock has sold an incredible amount of group in the last couple of years. You can kind of see who the major group carriers are, and who the major individual carriers are.

The total market is more than four billion of premium right now. It has been growing 20–40% a year; it's the fastest growing insurance product. And there are about three million policies in force with about 120 companies offering long-term care. These are base policy premiums. The steep slope on the median doubles about every five years after the age of 65. So it's very important for people to buy the policy as soon as they can so that the issue age premium isn't too large. Now this is without inflation or nonforfeiture, which, as Jan said, could easily double or triple the premiums.

Jan mentioned the ADLs. Cognitional alone can be an ADL trigger. And in fact, when we analyzed some of the claims of some of our clients, about 20% had a cognition trigger just by themselves. The claimant could prefer all those other ADLs, but they just didn't remember to do them. You can see that the progression of every one of these ADLs is in reverse order of the way a child learns it. You'll notice that bathing and dressing are the more complex functions and the ones that tend to fail first.

- Activities of daily living (ADLs)
  —bathing —eating
  —dressing —continence
  —toileting —transferring
  —COGNITION
- Certification of need
- IADLS

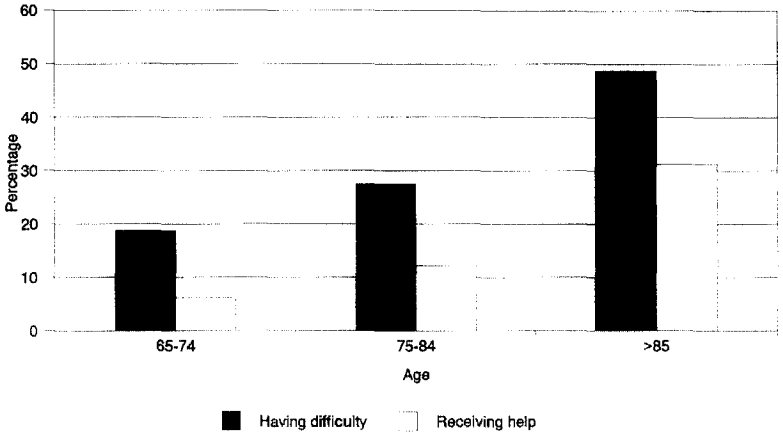
TABLE 1
LEADING SELLERS: LTC AND HC

Company	Individual	Group
AMEX Life	X	
CNA	X	X
Bankers Life and Casualty	X	
Transport Life	X	
Aegon USA	X	
Prudential (AARP)		X
Metropolitan		X
Aetna		X
American Travellers	X	
Penn Treaty	X	
John Hancock	X	X
Pioneer Life	X	
Kansas City Life	X	
UNUM	X	X
Principal Financial	X	X
Mutual of Omaha	X	X
Mutual Protective	X	

Physician certification of need is full of antiselection because physicians are motivated to make sure their patient gets care. So an insurance company should independently monitor the ADLs with someone who has training in that area.

Chart 1 shows the activities of daily living in different age groups. So you can see who really needs to get care, and who is getting care. About half the people that need care are not receiving it now.

CHART 1
ACTIVITIES OF DAILY LIVING



Source: U.S. Department of Health and Human Services.

As far as pricing, I saw another slide with a cloud on regulation. But most of us feel that pricing can't be done in a vacuum, (much to the chagrin of some of us actuaries who would like to just design a product ourselves). We must interact with other areas of the company when pricing long-term care, because so much of it has to do with the underwriting and the claims adjudication. (It's sort of like disability insurance (DI)).

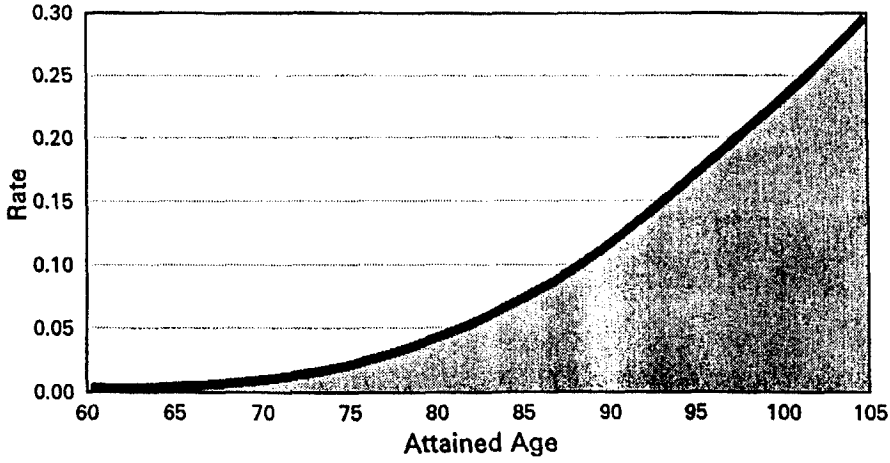
The pricing assumptions are probably one of the biggest actuarial challenges we've ever had: to design products and come up with incidence rates and termination rates on product features whose delivery system is not even known at the time. Probably ten years from now would be the average time that you'd get a claim on an older person if you underwrite correctly. And you're not sure what the delivery system will look like then. We don't have good insurable data on the home care side. But we do the best we can, and we look at lots of experience from different companies. And we look at other experience that we can modify to reflect insurance-type business. It also depends, as Jan said, on whether the benefit is one where it offsets: for example, can the home care use up some of the nursing home benefit. It actually gives you some cushion in your pricing. So far, in the industry, most companies we've looked at have had a little under the expected experience in the nursing home incidents; it looks like it could be higher than expected on the home care side. Of course, it depends on the company's pricing of the premiums.

On the morbidity sources, *the 1985 National Nursing Home Study* is the base off which most actuaries price. We make adjustments for transfers from one nursing home to another. Before adjustments, it would understate the length of stay, and it would overstate the incidence; you would have to adjust both of those. To make it insurable, because there are many people in those studies that would never qualify for individual insurance, or wouldn't be actively at work.

There's a home care study from the national center for health statistics (NCHS), and there are also studies from Stone and Murtaugh, so there is home care information available. You look at providers and how much they charge per hour. On the home care side, there's a whole range from custodial all the way up to skilled registered nursing care for which hourly rates vary. You calculate how many expected visits you would have.

Chart 2 is an example of one incidence assumption that we've used. If you look at the national nursing home tables, it's steeper than this. We thought it was too steep. This is already doubling every five years after 75. Then you take the incidence rates, and you multiply by the present value of the length of stay, and the dollar amount of average daily benefit that's available.

CHART 2
LTC MORBIDITY
INCIDENCE RATES



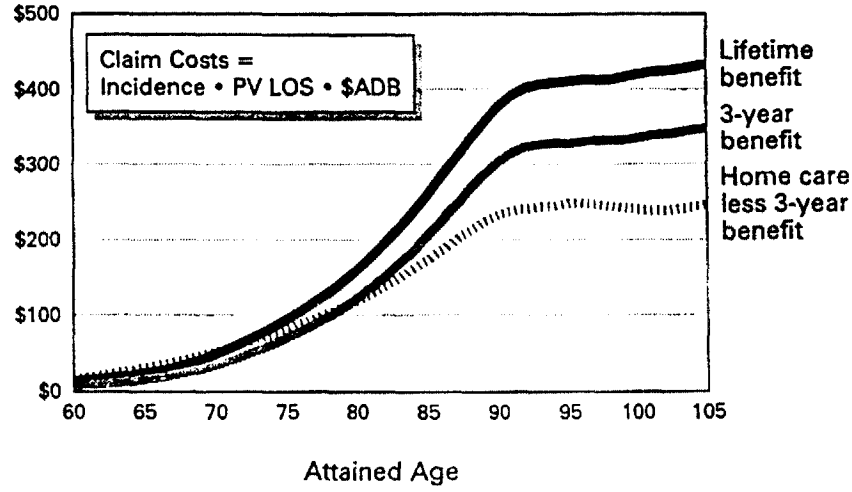
In Chart 3, the lifetime benefits, the top line, shows the slope of the claim cost. Can anyone hazard a guess as to why the graph has humps rather than steadily going up at the older ages?

FROM THE FLOOR: Is it due to high mortality at the older ages?

MS. BROWN: Right. The length of stay is drastically shortening, at the same time that the incidence is going up. The pattern of these two forces together creates the shape of curve.

The reason the home care line is so much lower is because usually home care benefits are one-half to two-thirds of the nursing home daily amount of benefit. It doesn't mean that the actual claim costs per dollar are lower.

CHART 3
LTC MORBIDITY
CLAIM COSTS



On the pricing assumptions, the average issue age is important. The group carriers will usually be more competitive in the actively-at-work ages. And the individual carriers will be more so at age 70 and above.

The average issue age on group is about 44, and on individual it use to be 70, but now it has gone down to 67 in the last couple of years. The distribution is usually about 40% male, 60% female. And spouses account for anywhere from 10% to 50% of the total insured population.

Of course, that depends on whether you give a discount for it and how big it is. Average size is about $85 a day, and the premium is about $1,200 right now on the individual side, and about $600 on the group, because of the lower average age.

For pricing, the two most important assumptions are lapse rates and earned rates. One problem is that many companies started out with higher assumed lapse rates than they've actually experienced, causing the need to increase premiums. Then, at the same time, the interest rates went down.

Both of these things were going in a negative direction. In fact, I had to go to a large employer group on behalf of a carrier and explain that even though they had little or no claims, the carrier had to raise the premiums, because they had better than expected persistency and interest rates went down. That was a tough job.

I guess only actuaries would call mortality involuntary lapse. It's very important to make that distinction. Usually in monitoring long-term care experience (like DI) companies will track total terminations, and they don't really break out death rates separately as much as in life insurance.

Many companies and those involved in the SOA long-term care experience study are now trying to break mortality out because it's not clear which table should be used. We always knew that people who bought annuities gambled that they'd live longer than average, and people who bought life insurance were likely to die sooner. But I think long-term care is kind of a tough one to gamble and win on. How do you know if you'd live longer, be sicker or die sooner?

So far it looks like mortality may come in closer to the basic experience, underlying the 83A table or the 1980 Commissioners Standard Ordinary (CSO). Again, this does vary by company and underwriting.

The earned rate is also important. It's now increasing, which is very good for the long-term-care businesses. If it kept going down the way it was, we'd be getting into trouble at the valuation rate.

On commissions, on the individual side we've usually seen 40–65% first year, and 5–15% for renewal. Issue expenses have ranged from $150 to $300, depending on how much underwriting and the age. It usually is a lot higher at the older ages. And the maintenance expense is $50–85 a year, inflated at 2–5%. The range on the cost for adjudicating a claim is from $100 to $400. This is actually a very good investment because case management is so critical when searching for the most appropriate care. There are many free community services and if you can get someone in a lower-cost situation, it actually does save you claim dollars compared with the more expensive skilled nursing home.

For the group side, the higher the participation, obviously, the better. We've seen anywhere from 2% to 30% participation by company averaging around 8%. And it's tough to get enough retention on the group products. So much of long-term care costs reflect the time value of money. The active life reserve and risk-based capital (RBC) cost of setting them up at 5%, when they pay off ten or more years later, is quite a big cost that isn't usually recognized by someone who is buying the policy.

Other factors affect profitability: you've got your usual 7.7% deferred acquisition cost (DAC) tax. Not much reinsurance is being used on long-term care. When it is, it's usually co-insurance. Before-tax profits need to be relatively larger on this product than some other products, because of the high cost of tax reserves. Statutory active life reserves were already relatively large, and now the valuation rate has gone down to 4.5%.

Some companies are holding two-year preliminary term statutory reserves, which will need to be changed to one-year statutory reserves. So there's a mismatch between tax and statutory reserves, and because of this mismatch, you have a set up of statutory reserve at the end of year two, and you don't get to deduct it from taxes. It looks like this is going to change in the near future.

Therefore other active life reserve features. You usually use pricing morbidity with maybe a margin added. Underwriting selection can be used in the morbidity.

Usually 80% of your lapses are allowed up to 80% of the pricing terminations with other conditions. The NAIC has this in the new A&H valuation model, which can reduce the reserves. Sometimes companies are holding gender-distinct reserves even though the premiums are usually unisex.

On the claim reserves, DI usually has an average claim reserve. But on long-term care, you probably do need to evaluate the diagnosis to judge the appropriate case reserve. If you have a lot of young Alzheimer's cases, or some sort of debilitating illness, where the person is likely to live a long time, an average claim reserve would probably be insufficient.

Chart 4 shows the nonforfeiture side. At age 45, the premium would be about double (1.92 times) the premium without nonforfeiture (NF). This is the Health Insurance Association of America (HIAA) proposal which is close to being adopted now. The way the proposal is structured, it doesn't increase the premiums as significantly at the higher ages because the minimum NF benefit requirement isn't as great. At age 75, for instance, 113% of premium would be the result of adding the nonforfeiture benefit.

CHART 4
NONFORFEITURE SBP PREMIUM INCREASE (WITHOUT INFLATION)

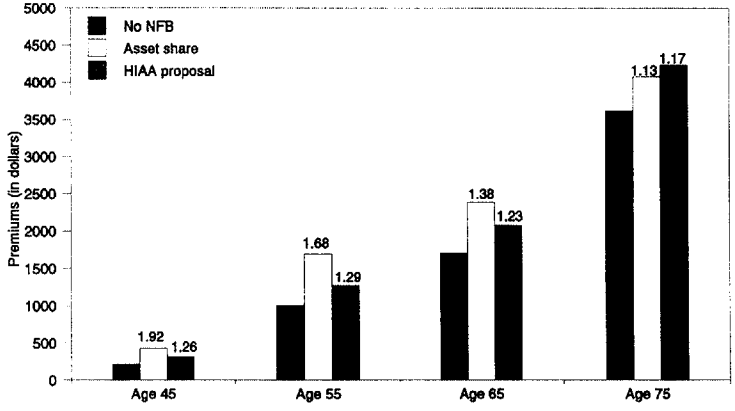
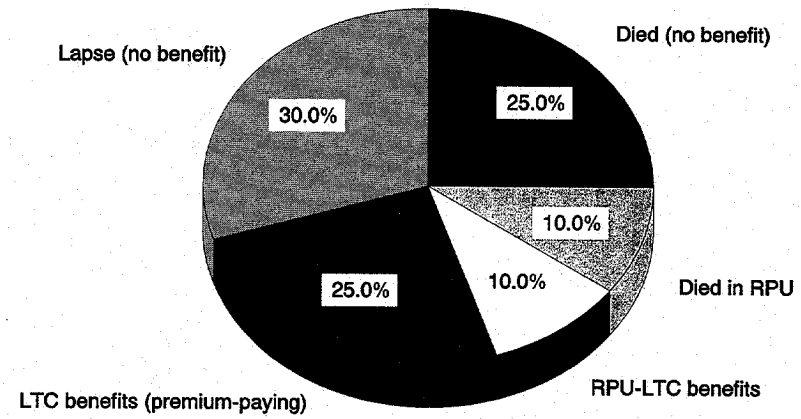


Chart 5 shows a few companies' experience. What percent of the total population insured for long-term care received benefits? In this case, you see 55% (30% plus 25%) get no benefit. In the pricing, they are subsidizing those who do get the benefit (the 45%). If you were required to have a nonforfeiture benefit, then it's not going to be as cheap for those who persist without the nonforfeiture benefit.

CHART 5
WHO RECEIVES BENEFITS?



Estimate: NAIC LTC Nonforfeiture Benefit Group

For underwriting, these are the tools used. Face-to-face interviews pay for themselves, from what we've seen, especially at the older ages. The short-term memory loss, or the cognition side is very important in underwriting on this product.

We found the telephone followup seems to be critical here as well. Regulation is usually well-intentioned, but it's making the premiums much more expensive. If you do not allow someone the option to add the nonforfeiture, it's probably going to be a problem.

This NAIC minimum requirement lists the standardized provisions that have been around for about four years. The latest NAIC development is the rate stabilization model. At age 80, it's the most restrictive, where it only allows the 10% premium increase over a four-year period.

However, you could argue that the delivery system is less likely to change drastically from age 80 to when they receive a claim. And so, some companies think the younger age limitations are even more restrictive, because of the long-term nature before you have a claim.

The loss-ratio requirements seem to be the most onerous. It varies by state from about 55% to 65%. Most of the definitions are typical: paid claims plus an increase in claim reserve are divided by earned premium. But a couple of states are very difficult and allow paid claims only in the numerator, and this is prohibitive at the younger ages. You almost can't get there at ages under 55, because of the delayed time for present value of claims. In those states, some companies are forced either to cut commissions at the young ages or just don't offer long-term care.

Also on the Medicare side, there is an offset that used to be factored into your pricing and into your claims so that you don't pay for the same things Medicare covers (it helps reduce the cost).

Long-term care is the only product that has its own Actuarial Standard of Practice (ASP). It shows how the Academy of Actuaries (AAA) is concerned over long-term care related to the solvency of insurance companies. One thing that I found perplexing is that it says that long-term care assumptions can't be optimistic or pessimistic.

Time will tell whether they were or not. I guess what they're trying to say is that they don't want any hidden actuarial margins. On the other hand, they don't want us to understate the pricing and project planned increases and premium later. It's very important to set these assumptions expecting to have a level premium for life.

On cash-flow testing, any of you who saw the last presentation on the disabled life reserves, and average duration, probably understand that the only real risk with long-term care is that interest rates decrease below the valuation rate on the active life reserves. For cash-flow testing, a pop down test of 3% may be appropriate for a severe test. It's probably not realistically possible to invest long enough for long-term-care liability durations, which could exceed ten years. Investing as long as you can is prudent.

All of you have probably heard about the "Contract with America." Just recently, Congress passed a bill, and the important part about long-term care is that they're bringing the public awareness up to a level so that people realize they need long-term-care insurance.

The government wants the whole population to pay for their own long-term care. They know they're having trouble funding Social Security and Medicare now. It's quite a promotion for the insurance industry that the government is being proactive by encouraging us to offer long-term care to the public. There's another part of the bill that basically treats long-term care as A&H. This helps for tax deductibility of employer contributions.

I'll go over a couple of product innovations. Some of these have been around awhile. The life-cycle-type product is fairly expensive, so it hasn't sold very much. Another is when you combine an immediate annuity with long-term care, and you have a portion of the immediate annuity payments paying for the long-term care premium, so it covers both risks: if you live long to be healthy and if you live long but aren't healthy.

The other idea that I thought of about five years ago isn't picking up yet. No doubt it's due to the regulatory challenges, variable universal long-term care. I just happen to work in both those areas, and I thought it was an obvious fit. I thought the long-term accumulation of the assets able to outperform inflation would be very attractive. And you could protect the separate account assets from insurance insolvency, which is attractive for long-term care as well. It would reduce the RBC asset requirements. Unfortunately there's some regulatory pioneering that would have to happen. We've had precedents in both areas, so it shouldn't be totally new for the IRS and the SEC.

We are seeing a great deal of group variable universal life insurance (VULI) development, as companies are now starting to realize that the baby boomers need to save in a variable investment environment. To cover the catastrophic long-term-care risk, in addition to savings, a tax-favored medical savings account would be a good option as well.

Now I'll introduce Susanne Bowman. She is the director of insurance services at AARP and will talk about long-term care from the consumers perspective, which will include some background on AARP. It has done some interesting buyers' research. She's been at AARP for 13 years. They have over six million health insurance members. They have group health, auto, homeowners, and mobile home insurance. Before AARP, she was at the American Pharmaceutical Association and was responsible for its insurance. She also served as a personal underwriter at Firemans' Fund Insurance. We're fortunate to have a nonactuary here.

MS. SUSANNE C. BOWMAN: I intend to talk to you about the current insureds who are insured today with long-term-care products. What makes them tick? When I look around this room, I don't see many people who have the potential of being AARP members. Are there any AARP members who'd like to admit it in the crowd? Three, OK.

AARP is the largest voluntary membership organization in the world, unless you want to count the Catholic church, but we're not going to debate that. We have 22 million households who are members of AARP and that translates into 34 million members. Even though I'm not a statistician, I think I can say that gives you a representative view of the over-50 population.

Our role is really to focus on the needs of the over-50 population, and we do provide access to financial and insurance services. At the present time, we have about 70,000 long-term-care insureds, and we have about $90 million in premiums. All of the products that we have, whether it's the mobile home product, the brand new life insurance product, or our health products, are all based on member feedback. We do a tremendous amount of market research before, during and after a product introduction. And if you look back at our long-term-care history, since 1986, research has been the number one thing that we've relied on.

I want to spend some time talking about what has and has not been successful from our vantage point. I'll also include some brief discussion about consumer behavior. Everything that we have tried, done, or stopped doing has been based on member feedback.

We find, generally speaking, that the awareness and understanding of the product is tremendously low. I really I think that's due to the complexity of the product construction, and while it may not be complex from your perspective as an actuary, it certainly is from the customers perspective. I think that's based on a lack of understanding of the system.

Most folks don't know how to access long-term care. They don't know how the health care works. Sometimes they don't know how to get to a home health care provider. Adult day care is not a term that anybody really understands. Perhaps they think that it's a derogatory term–sort of like day care for children. To gain a whole understanding of the system and how to work it is very difficult for a person as a purchaser. What we see compounded here is that many times it has been managed by a third party, perhaps by a child who's not even in the same city as their parent.

I'm going to come back to another factor, which I would call a Bowmanism, which is the not-me barrier. This is never going to happen to me. I'm in perfect health. I'm never going to need this kind of a product. So, when you talk about the challenges of direct mail marketing, or even agent base marketing, you have a tremendous psychological barrier to overcome. Also, affordability is clearly an issue for people. This is the most expensive product that AARP offers, and it is the product with which we have had the least amount of success. So we're going to circle back to these as time allows.

I want to share what our personal experience has been with buyers versus nonbuyers. We find that the buyer of an AARP long-term-care product is very different than any other buyer of a service that AARP offers. So who buys long-term care? They are slightly older then most purchasers in the AARP service. Even when I look at the health insurance products as a category, these folks have a tendency to be a little bit older. The average age of an AARP member is about 63 or 64. So when you look at the buyers of this particular product, you're looking at a group that is significantly older (65–79). Most of them are married. Our membership does not necessarily reflect these particular demographics. About half of the AARP membership is married.

These folks are significantly more educated than the AARP member in general. About 50.2% are college graduates or have some college education and 26.5% have done postgraduate work. When I talk about the AARP member in general, I have to say that it's very hard to generalize about 34 million people, but we do that. When you look at long-term-care purchasers versus health insurance purchasers, most of our health insurance purchasers have barely finished high school. In this category of health insurance purchasers, there's a significantly different picture.

Most purchasers are retired. It's AARP, so what's the big surprise? A full third of our members work full time. So our name is a bit of a misnomer when it comes to an actual description of association members. Sales of this particular product is a function of the age of the buyer and the fact that they aren't working.

Household income also skews to the higher elements. The average income of an AARP member is about $27,000. So here again, those with higher income have a significantly higher appeal. Again, when you look at this statistic in relationship to our other health

insureds, most of those people are in the less than $20,000 category. So clearly, we are managing a completely different set of relationships.

Where do long-term care buyers live? Most of them live in the suburbs. This is not a product that has a tremendous amount of rural appeal. And again, I think it goes back to the fact that there needs to be some exposure to or a personal experience with long-term care. Most of the purchasers are female, although not to the extent that was already mentioned.

So generally speaking, the buyers are more educated and are shoppers. These people know what they are looking for and they are looking for value. I think one of the single most important factors, unfortunately one you cannot find on a database, is these people have had personal experience. They have had a friend, or a family member who has or had some personal experience with the product, and that truly drives them to have the product interest.

When thinking of reasons for purchase, most of them look at coverage design very carefully. We at AARP like to think that people are much more excited by the home health care aspect. In reality, it's really the nursing home benefit that we find they look at. They are looking to protect their assets. People who are looking for this kind of a product don't want to be a burden to their family. They're looking for affordability, and I think up to this point, they've had a hard time satisfying that need. They are also looking for value. Many of the features that were discussed either by Jan or Mary Ann are really things that people are truly interested in looking at.

I want to spend some more time on the not-me barrier. I had sat through hours and hours of focus groups, looking at materials, looking at coverage features, looking at potential products, and listening to what our members have to say. It doesn't really matter how snazzy your package is, whether it has AARP plastered on the front of it, or whether you have an agent who's trying to sell it. It gets down to a very personal discussion, and a very personal sense of whether or not these people can ever come to grip with the fact that they may some day be incontinent. They may have some trouble in bathing or dressing or transferring. This is a tremendous psychological barrier to overcome. It's much different than life insurance. I think we all know we're going to die. At least we know we're going to die someday. There's a difference though—this is much more sensitive and personal, because it's going to happen to you while you might have some semblance of control over the process.

Most of the people to whom the not-me barrier applies are still in good health. You would think, from an underwriters perspective, that this is like the type of people that you would want to attract? They are able to remain independent and have a strong sense of family. I would like to have a focus group of people like this, and then a focus group of their children because I think there may be some disconnects in that particular situation. A mother in one group might say, "Oh, my daughter is going to take care of me," and then in the next group the daughter might say, "No way am I going to take care of her."

I think another very important point is that there are competing priorities for people's resources. As people struggle with how they're going to care for their acute care needs, long-term care becomes something that they shouldn't push off. They have more

immediate needs. Again, if you can't get through that psychological barrier, you're not really going to be able to align your priorities appropriately.

I'm going to mention a couple of comments from AARP members because I think that they say it better than I can. "I'm not going to even think about how I'm going to do it." "Somebody else's problem." "You don't want to think about it, so you procrastinate." We've all said these things whether it's about paying our taxes or paying our bills. But this is a very distinct problem with this particular kind of a product. Most of the non-buyers who've looked at packages can get past the psychological barrier, but then are absolutely disgusted by the price.

They have an expectation that the price is going to be all inclusive. So when you were talking about the amount of money, that has much more appeal than looking at a daily indemnity of $60 or $70, when people know full well that the nursing home costs in their area are going to be significantly higher than that. They're looking at the situation from a pure consumer's perspective. While you folks might have done your best to price a product appropriately, they look at the premium and think it's not going to pay the whole thing. They think, "Why should I pay that much money and still get stuck with part of the bill, even if it's a deductible or a copayment, or anything else?" Here's a few more AARP member comments: "I was afraid of the cost." "We can't afford it, we can't afford not having it." That is truly the buyer's dilemma today.

It would be my job as the consumer-type person to give you a few challenges that I think still need to be addressed with regard to this product. I think the single most important thing for marketing people is making a connection with future needs. I think that flexibility is certainly critical as we move into the next few years and because the emergence of the baby boomers. Affordability is still a critical problem for this particular product.

In terms of meeting future customer needs, obviously everybody says to me, "You work for AARP; in 1996 it is going to be a zillion people strong." That's not necessarily the case. For many years, the silent generation and the GI Joe generation will continue to dominate the purchasers of long-term care. They're going to continue to be the people for whom this product has an appeal. In 1996, I'm going to be 43 years old and I can tell you I'm not going to be looking at this product. You need to be able to engage yourselves in brainstorming about the baby boomers. But also recognize that, for a long time, baby boomers aren't going to be the population that are the buyers of this particular product.

Changes in the delivery system. Obviously what happens on Capitol Hill with Medicare and Medicaid are going to effect this product. And I think we would all do well to spend some time thinking creatively about potential impacts. I would also agree, even though I am a consumerist that regulation is a cloud. It's a cloud to me because it takes away much of the creativity, it takes away much of our ability to really be innovative in terms of meeting people's needs.

I think the challenge will be to try to shift consumer's mind sets from looking at acute care services to chronic care. The challenges for the future really relate to providing access to this type of product. I had a problem with the referral to Dr. Kevorkian as a case manager. I think that you know that AARP's attitude has been, if you can widen the

access, you can also be very successful and very profitable. Affordability is a number one priority. I hope that we don't all end up offering this product in a standardized environment.

I think that differentiation is the key to being able to serve different types of needs. I would encourage you to think flexibly and to be able to offer people sort of a continuum of a product—something that can meet their needs as they progress into their 50s and age on into their 70s and 80s.