RECORD OF SOCIETY OF ACTUARIES
1995 VOL. 21 NO. 3B

LONG-TERM CARE (LTC): CURRENT ISSUES/HOT TOPICS

Moderator: DAWN E. HELWIG
Panelists: JACK STRAYER*
KIM H. TILLMANN
Recorder: ELLEN R. COLE

This session will include a discussion of current LTC health, including nonforfeiture, federal requirements, rate stabilization, and other emerging issues.

MS. DAWN E. HELWIG: Several of the sessions at this meeting that have been on the long-term-care track have been very actuarial in nature. We have been looking at incidence rates in home health care, what valuation requirements are, results of experience studies, etc. We are going to take a step back and get into some of the practical issues regarding long-term care. Three of the driving forces of long-term care right now are on the nonactuarial side: what is going on in the market, on the federal side and on the state side. That is what we are going to cover.

I would like to introduce the panelists that I have. We are privileged to have a guest speaker, Jack Strayer, who is currently the director of federal affairs for the Council on Affordable Health Insurance (CAHI). Jack is a lobbyist and has been described by *The Washington Post* as "the affable archenemy of national health insurance." He has been very directly involved in lobbying and in working on many of the current long-term-care issues on the federal side. He actually has some very up-to-the-minute developments on what is happening with the various bills that are pending dealing with long-term care, taxation, benefit triggers, etc. Jack has served as executive assistant to U.S. Representative David Stockman and as Press Secretary to the Michigan House of Representatives. He has a bachelor's degree in political science and will be able to give us a different slant on the issues.

Our second panelist is Kim Tillmann from Lutheran Brotherhood. Kim is the product management actuary at Lutheran Brotherhood. She has worked there since 1985 and has been working with long-term care since 1989. Kim will fill us in on what is happening at the National Association of Insurance Commissioners (NAIC) and on the state side, what types of model regulations are specifically dealing with suitability, benefit triggers, etc.

I would like to start out by describing what I would call a typical or standard long-term-care policy that is in the market. Gone are the days when policies were based on medical necessity. We have even moved past the point where it was based on triple triggers. Most of the policies that are coming on the market now seem to be based primarily on activities of daily living (ADLs) or on a combination of ADLs and cognitive impairment. There are significant pricing implications depending on what set of ADLs is being used in the benefit descriptions. It has been shown that the majority of the time, 80–85%, ADLs fail in a specific order. Bathing is the first of the ADLs to go when someone starts becoming impaired. The order is usually bathing, dressing, toileting, transfer, incontinence, feeding, and mobility.

---

*Mr. Strayer, not a member of the sponsoring organizations, is Director of Federal Affairs for the Council for Affordable Healthcare in Alexandria, VA.

Because bathing is the first ADL to go, there are significant pricing implications based on whether or not bathing is included as one of the ADLs in your benefit triggers. A benefit trigger that is based upon two out of five ADLs with bathing being excluded from the list is generally going to be pretty close in price to a policy that has three out of six ADLs with bathing being included as one of the ADLs. If a policy is based on two out of six ADLs with bathing being included, the pricing should be considerably higher. That is more equivalent to a one-out-of-five ADL policy.

There is also a significant difference in policies and, as a result, there's significant difference in pricing depending upon what degree of assistance is required. More and more policies are starting to require a very direct and definite hands-on type of assistance be given for it to qualify for care in the policy. In fact, the NAIC, in its definition of assistance for ADLs, is using that type of strict definition of what will constitute help.

Most policies are using a double trigger of ADLs or cognitive impairment. If you are going to have a cognitive impairment screen or cognitive impairment requirement in your policy, then you better have some way of underwriting for that, such as asking questions using the short portable mental status questionnaire, etc.

Policies today are typically being done on an expense incurred basis. A conservative way of pricing an expense incurred policy is to assume the maximum daily benefit is used at all times. Generally, the slippage that occurs due to using an expense incurred definition will disappear over a short period of time. In addition, there is some evidence that nursing homes and home health care agencies are finding out what a person's level of coverage is and billing for that amount so the slippage is disappearing anyway.

The state-of-the-art policy today quite often uses a pot-of-money approach where, if a person uses a cheaper level of care or goes to a nursing home that charges less than the daily maximum, it will extend the benefit period. Most policies today are beginning to cover types of facilities other than those falling under the standard definition of nursing home. Assisted living facilities are being covered more often. I've seen estimates that assisted living facilities could potentially add 10–15% to the cost of the standard nursing home benefit. We typically do not use numbers that are quite that high in pricing. Our assumption is that if someone was using a policy that did not cover an assisted living facility before, they would have gone into another nursing home. So, many of these people are already included in our numbers and covered by them. We have typically seen loads for assisted living facilities that are in the 5–10% range.

Other common benefits that we are seeing are bed reservation benefits, where the person can leave, go into the hospital or go back home for a period of time and the company will continue paying the nursing home during that period of time so that the bed is reserved for them. Respite and hospice care are becoming very common. All of these benefits have relatively minor cost implications in comparison to the basic benefits of the policy. Adult day care often is included in the definition of care.

There has been a fair amount of discussion at this meeting about home health care benefits that are either being included in a comprehensive type of policy or in a stand-alone home health care policy. There can be significant cost differentials depending upon the services covered, such as homemaker services, meals on wheels, or the basic therapist, nurse, home

health aide, etc. The cost varies depending on whether a calendar period or a service period definition is used.

Most of the comprehensive policies that are on the market have integration between the home health care and the nursing home benefits. From a practical standpoint, what we have seen is that you are typically going to see anywhere from about a -12% to 2% adjustment to your separate nursing home and home health care claim costs when they are combined under integration.

Managed care is starting to come into the long-term-care arena. Managed care is becoming more prevalent because there have been some situations of abuse on the utilization side, particularly with home health care policies and home health care benefits in comprehensive policies. Many newer policies on the market will have some type of managed care to try to curb those abuses. Typically the type of managed care most frequently seen is where the policy will require a person to go through a case manager who is employed by or paid by the company to analyze the care that is given and to recommend the appropriate mode of care.

I mentioned that we have seen some utilization problems. One particular one that I want to mention is something that we have recently seen in the state of Florida where home health care utilization, particularly on a stand-alone home health care policy, has gone through the roof. The cause appears to be significant overutilization by the home health care agencies that are involved. The typical scenario is that the agent is referring the policyholder to a particular agency and the agency is ordering a certain set of services. For example, seven services a week are ordered for the insured, but only three services are delivered. The insured was asked to assign all of their claims to the agency, which then submits to the insurance company claims for seven services per week. The insured is not getting the care that the insurance companies thinks he or she is getting—the agencies are defrauding the companies, to put it bluntly. Very stringent language must be in the policy to be able to stop that sort of thing. Many of the older generation policies out there do not have the stringent language to stop this abuse. This is obviously one of the impetuses leading towards managed care.

Last, I want to talk a little bit about what is happening in underwriting. Most companies in the long-term care market have gone through a learning curve on these types of products. Initially, they may have started out with very little or no underwriting and may have been using a yes/no application without a lot of extra checking. As the need increases for more competitive premiums, and partially because they start learning from their mistakes on the claim side, companies have progressed to having more open-ended questions with medical conditions, asking for attending physician statements, doing telephone verifications and doing cognitive tests at the time of the introduction of the policy. Most companies have discovered that, when they are getting into this market, they need to hire some sort of long-term-care specialist in their underwriting department to avoid that sort of learning curve.

Something that I just want to mention briefly is that there is at least one situation in the state of California where a certain mode of underwriting has been legislated into existence. The California regulations require that if the application for the policy asks for the medications a person is using or the name of the doctor and if the company does not follow through on that information, then they are basically "stuck" with anything that they did not

find out about. Specifically, they say the only way that you can rescind a policy at claim time, in that situation, is if the particular condition that you missed was the one that caused the claim and if you can prove that there was fraud.

That concludes what I wanted to say about where the market is going. At this point, we can open the discussion up to any questions or comments.

MS. PATRICIA J. FAY: You really did not mention anything about disability versus service models. Are you seeing any trends in the movement to or away from those types of models?

MS. HELWIG: I personally have not seen a strong market trend towards the disability type of model. There definitely are companies out there that are doing it. There is more of it now than was seen a few years ago, but I guess most of the new policies that I have worked with are still using the claims type of model.

MS. LINDA P. ZIEGLER: You mentioned that there were problems in Florida with agencies reporting incorrectly. Please have companies call us at the Florida Department of Insurance because that is insurance fraud.

MS. HELWIG: Yes, we actually have had some significant discussions with Tom Foley who is aware of it. Tom has been very helpful in the one particular situation that I have been involved in. We have sat down with Tom, and he is in the process or is planning to bring together a consortium of companies doing business in home health care in Florida to discuss what can be done about this problem. I know there are at least a couple of companies that are banding together and doing some serious fraud investigative work; they plan to bring the names of the agencies and the agents involved before the Florida Department.

MS. ZIEGLER: That is something our Insurance Fraud Division would like to get into.

MS. HELWIG: You have to believe that if they are doing this kind of thing to insurance companies, then they are doing it to Medicaid. I am sure it is the tip of the iceberg. I think we will move on to Jack. He is going to tell us a little bit of what is happening on the federal side.

MR. JACK STRAYER: I am director of federal affairs for the Council for Affordable Health Insurance. Many of you may not be aware of who we are. We are the free market voice of health reform in the state and in the federal government in Washington, D.C. We were created by about 14 companies involved in the individual and the small group market three years ago. Up against the Clinton clan, no one gave our thinking much thought. However, on November 9, things changed for everyone in the U.S., as far as politics goes, and particularly as far as insurance, health reform, long-term care and reform of Medicare and Medicaid.

All of this is colliding as we speak. By about mid-July, which is just about two weeks away, Congress is going to have to decide what they are going to do about Medicare, Medicaid, long-term care and health reform in general. There are 535 members of Congress, including Senators and Congressional Representatives, who are very leery of the three words health care reform. They jump under their desk whenever I walk into their

offices. They are very confused about the way the American people feel about health reform. It is a very confusing issue because members of Congress are brand new players in health care reform. This is something, as you all know, that has been the jurisdiction of the state, so these members of Congress are actually rookies when it comes to health care reform and regulation in particular.

In order to make this a very timely speech, I spent the last couple of days speaking with some of the pertinent players in health reform on Capitol Hill; their thinking has changed dramatically in just the last six weeks. I was very surprised at some of the things that I discovered.

As you know, the Contract for America, which was an idea of the House Republicans, included a bill called House Resolution (HR) 8, the Senior Citizen Equity Act. I know many of you think that HR 8 still exists and has passed the House, and in fact it has passed. However, HR 8 does not exist any more. They have taken HR 8 and divided it into many different parcels. The one that I want to speak to you about is the tax changes that were included in HR 8. They have been folded into a larger bill called HR 1215. This bill passed the house in early April of 1995 and was sent over to the Senate where it sits and sits and sits. There are many good things in this bill. Some of the changes that have been brought forward in the original HR 8 are good news. The Senate agrees with that as well; however, the Senate moves much more slowly.

Last year there was a countermeasure that dealt with long-term care. Maybe some of you are familiar with it. It was called the Packwood-Dole Bill. It had many things in it that we are all very interested in. People expected Packwood-Dole to be offered as an alternative in the Senate to HR 1215. A couple of curious things have happened. I am not making any of this up. I am a lobbyist. I know a lot of you might have feelings that are not real sweet about lobbyists, but one thing a lobbyist could never do is lie. A lobbyist could never exaggerate the facts. A lobbyist has to be straightforward as a resource. I see some grins in the audience. If you are ever caught, you can never be a lobbyist again. That is kind of the rule in the land in Washington. You have to believe me when I tell you all this stuff, or I lose my job; it is that simple. I do not mean to be smug, but there is a problem with the Senate leadership. Senator Robert Dole (R-KS) is running very aggressively for President of the United States. Senator Bob Packwood (R-OR) is not under suspicion any more. I guess he is going to have a hearing in front of his peers in the Senate, but he has 26 very specific charges of some pretty heavy sexual harassment being levied against him. It is unfortunate, because I sort of embrace the way Senator Packwood thinks about health reform insurance reform and long-term care. However, Bob Dole does not want anything in Washington in the summer of 1995 or certainly in the fall of 1996 to be called Dole-Packwood. Talk about strange bedfellows. I think that probably means that you are going to see two competing versions of long-term care reforms emerge, probably within the next six to eight business days, as I understand it. Senator Packwood will come forward with his proposal. Senator Dole will come forward with his, which will be quite a bit different. The Senate Finance Committee, which in fact will be drafting these two separate bills, does not know who is on what side of each issue. I beg all of you to pay very close attention to what goes on in Washington in the next two weeks. I think there will be some exciting developments, to say the least.

If you do not think that's exciting, the House Ways and Means Committee completed a hearing; the only thing they will have is HR 1818. This is a bill that was sponsored by

Chairman of the Ways and Means Committee, Representative Bill Archer, a Republican from Texas. He now has the same position that Dan Rostenkowski had in the previous Congress. Bill Archer is progressing very rapidly in the passage of what he wants to term the keystone of his political career. It's called, "The Medical Family and Savings and Investment Act of 1995."

Many of you know that there is medical savings account legislation. I know there are mixed feelings within your profession about the advisability or enactment of medical savings accounts. The reality of the situation is nearly all the Republican leadership and probably about a third of the Democrats in the House and Senate will be supporting HR 1818. What is pertinent about that is that the hearing itself is today and all of the actuaries and many of the witnesses they wanted to testify in Washington are here. I think that makes for a very interesting hearing. I think what will become of HR 1818 is best left up to the experts. There's a provision in HR 1818 that is very pertinent to this presentation: it allows 100% deductibility for the purchase of long-term-care insurance through the medical savings account device. What this means is you can use your savings in your medical savings account to purchase a long-term care policy. This means that long-term care insurance, which is defined in this bill, is a qualified medical expense. This is something big and this is something new. It is something we worked very hard to get in this bill and did not expect to see it there. It was one of those surprises that we get in Washington every now and then.

The impetus behind HR 1818 is not effective lobbying by the Council for Affordable Health Insurance. What is driving all of this is the cost of Medicaid and to some degree the cost of Medicare. There is one thing that startles me the most, although I am sure it does not startle any of you. Anytime I go into a Congressional office and meet with someone who has a master's degree or an advanced degree in the health profession, and I speak to them about how 70% of the money that flows into that nursing home comes from Medicaid, they always say, "Excuse me, you mean Medicare?" The people who have drafted some of our legislation do not understand that long-term care is a *Medicaid* issue. It is not a Medicare issue. There are certain elements where long-term care plays a role in Medicare, but once they started reforming Medicare and Medicaid, they kept coming across this very large group of middle income Americans. Actually 50% of Medicaid goes to long-term care, but of all the people getting long-term care, about 25% of them are depending on Medicaid, even though they are middle income Americans who have assets, who have homes, who have money in the bank. For some reason Congress evidently was not aware of the mass buy-down that people go through when they become disabled which qualifies them for Medicaid. Fortunately, Bill Archer, the Chairman of the Ways and Means Committee, understood what was going on with the Medicaid program and felt that, before it is chopped up into 50 block grants to the states, some changes must be made.

Congress has to help the insurance industry begin marketing long-term care for all Americans on a very large scale. However, whenever Congress gives you something, they put little codicils on it and they try to take away a little bit of it. What we feared back in February and March was that, if Congress was to begin actively developing legislation to make it easy to purchase long-term care, then these policies would become so overregulated they would be priced out of the market before they were even offered. No one would want them, no one would want to sell them and no one could use them.

Part of the job of everyone in Washington, whether you belonged to the big five, the Alliance for Managed Care, the Health Insurance Association of America or little CAHI, as we call it, was to prevent overregulation by the federal government. In fact, many of us felt that the NAIC was doing just fine as far as monitoring and regulating long-term care. We don't need to create a regulatory battle between the U.S. Congress and the NAIC. I don't think anybody wanted to witness that, and hopefully we have averted that. I think, with the emphasis being placed on affordability in long-term care, this Congress is ready to put in place a system where we can purchase long-term care in any of the 50 states and not have to worry about federal regulation in a broad sense.

HR 1215 has passed in the House. This is the bill that is languishing in the Senate as we speak. There are a number of things in this bill I want to call to your attention; however, I probably do not have the time to do it in the best possible manner. You will notice that it has six ADLs. I was told by the people who wrote this bill that the provision would be two of five of the six. However as you read it, it is two of the six. These are the kinds of things that lobbyists love to take home. This is why I think lobbyists and actuaries are closely related. I love to take stuff like this home and read it and write all over it and make little notes on it. I notice a lot of you do the same thing, so I feel very comfortable in your environment. However, there are what I would call some questionable regulations. As I understand it, a very prominent Congresswoman from Connecticut, who we expect to become a big-time regulator of long-term care on the federal level, told me that she felt that the NAIC in the states was proceeding quite nicely. She believes there is no need to regulate long-term care on the federal levels any further than what is done in HR 1215. Ironically, I heard the exact same thing about an hour later from one of the top Senate Finance Committee staff members, who is in charge of writing whatever Senator Dole and Senator Packwood will be countering in the next two weeks.

There is a current provision that puts a cap on the daily expenses of $200, or $73,000 a year. We fought very hard to get that number in there. It was going to be much lower than that. Now we do know that both, and particularly Senator Packwood, did not want to go any higher than $150. This means that any benefits received over $73,000 would become part of gross income and taxes would be paid on that excess. We're a little bit concerned that it might become yet another federal deterrent or disincentive to purchasing this kind of insurance, so we continue to work with the powers that be to make this less onerous. It could be said that people would be penalized because of their disabilities.

We do like the way HR 1215 addresses deductibility of the purchase of premiums. We find it to be quite fair. There is quite a difference with the Archer approach under a medical savings account, because he actually takes a long-term care insurance premium and declares that it is a qualified medical expense, but only as it relates to medical savings accounts. I can see that this is going to have to be expanded to some degree beyond medical savings accounts to make it politically palatable to 535 members of Congress, it is due to the heavy lobbying that will naturally pursue that approach.

That is what I am preparing for in the next six weeks as we see where the deductibility is going to fall out. We want 100% deductibility. We want it on the front page of the tax form. There are currently, I believe, 16 things that you can deduct from your gross income, such as mortgage interest and moving expenses. We want to add the purchase of long-term care insurance. Employers, as you know, can deduct their insurance premiums. However, they will not be able to deduct long-term care premiums if they offer cafeteria

plans. That's another lobbyist group that's not going to like this. This is a very timely presentation, and what I'm afraid of is that by tomorrow somebody will have a change of heart.

You have to keep on top of this. Please offer your services. I know it's pro bono, but if possible, begin developing a relationship with your Congressman, Senator or member of Parliament. You are all held in very high esteem and your expertise is sorely needed in Washington. They do not understand and this is new to them. They only spend about ten minutes on something and then they move away. You all are going to have to deal with the mistakes they are going to make on this legislation, and it is inevitable that mistakes are going to be made. I hope you know who your Congressman is. I'm sure you know who your Senators are. Call up their staff, tell them who you are, tell them what you do for a living and make yourself available. I know of very few Congressmen who have a good working relationship with an actuary. I know that is the last thing in the world that you would want to do. However, you're going to end up dealing with the results of their mistakes. Help us nip them in the bud and create a working relationship, not only with your Congressman and Senator, but with state legislators as well. That will go a long way in getting them to understand what they are about to do. Many of them do not know. They have to depend on somebody like me, and I think they and you would much rather have them depend on someone like yourself.

MS. HELWIG: In the HR 1215 language, do they keep the HR 8 provision which includes the long-term care premium in with medical expenses if deductions are itemized?

MR. STRAYER: When Dawn introduced me, she mentioned that I used to work for David Stockman. He is the guy who raised the qualifying level for a medical expense deduction from 3% to 7.5%. I am here to atone for what he has done. Only about 4% of the population uses this. This means that if your qualified medical expenses exceed 7.5% of your income, you can deduct them from your gross income, but you have to itemize. In other words, you have to be very sick and very rich in order to take advantage of that 7.5% trigger. It is the deductibility language that is going to come into conflict with the 100% deductibility language that is appearing in other legislation. This is a great concern to Senators Dole and Packwood because they do not know where they are going to get all the money to fund all the cuts and everything else that the House Republicans have put forward. There are many billions and billions of dollars involved. In fact, $6.5 billion over five years is needed for HR 1215 alone. That is just for long-term care. This is a very expensive undertaking; I think that in the present legislation that passed the House, the deductibility is there but it is tied to that 7.5% floor or trigger. I have a feeling it will stay in there if the Senate takes it up.

We are still not sure what the Senate is going to do with the medical savings account bill once it passes the House and goes over to the Senate. I don't know if the long-term care title in HR 1818 would be stripped or not. Part of my job is to make sure that it is not. But we just don't see how you can make something marketable by having something as onerous as a 7.5% trigger. It should either be lowered or done away with. The problem is if you think about it, this kind of reform will pay for itself in a few years. If we can get as many Americans as we can to purchase long-term care, the relief that it will give Medicaid will just simply pay for itself. States spend more on Medicaid, as you know, than they do on education. These are the kinds of political forces that are driving this kind of reform.

MR. CHRISTIAN B. BUTTERFIELD: You mentioned that in HR 1818 that long-term care premiums will be deductible or they could be paid out of a medical spending account. Is there some talk out there about having a long-term care product come under the nonforfeiture laws? In other words, a cash value would be built; I wonder what Congress would think about people deducting premiums that could be thought of as a savings vehicle.

MR. STRAYER: I think what you've asked is probably the question that was asked at the hearing because it is a very good question. I think what they really have to do is get down in the minutiae of nonforfeiture and where it's going to apply. I think that once they start doing that it's going to create problems in the market. Obviously it is going to create problems for companies to have all these different products which may or may not meet the nonforfeiture criteria. I do not think that is going to be allowed. I do not know what was discussed at the recent NAIC meeting regarding medical savings accounts and as far as nonforfeiture and long-term care goes because no one anticipated it. It's a question that we have not addressed because we did not anticipate it being included in this bill.

I am sure there's talk behind closed doors somewhere in the Senate about how they're going to address HR 1215. HR 1215 has passed and gone over to the Senate. HR 1818 is going to pass and go over to the Senate. That's when they're going to have to sit down and determine which long-term care regulations are going to apply to which aspects of legislation and, frankly, I can see some problems with a plan purchased by a medical savings account.

MR. KARL D. ANDERSON: I think HR 1215 had some sort of requirement in the standards that would disallow cash value growth or something like that, so that's something that I think you'd want to look at in HR 1215. I am wondering if there are any standards in HR 1818 or if it's silent at this point for long-term care standards like ADLs or whatever?

MR. STRAYER: It is silent. Actually the only reference made to long-term care is in the definition of qualified medical expense. I think they're counting on the NAIC or someone else to make that determination. It's a very small bill. Bill Archer does not have a penchant toward regulation, and I am sure he did that on purpose. That would not be something that he would have to deal with in his initial bill.

MR. ANDERSON: My second question concerns HR 1215 and that's a concern about grandfathering. I believe that plans in force before 1986 would be grandfathered in. Is that correct?

MR. STRAYER: That is correct.

MR. ANDERSON: Do the legislators understand the importance of that?

MR. STRAYER: Yes.

MR. ANDERSON: We're real concerned about something going wrong and that we'd end up having policies rolling over.

MR. STRAYER: Their constituents have these policies, and they have paid a lot of money into these policies. There's no way a Representative or Senator can politically pull that rug out from under that person.

MS. LOIDA RODIS ABRAHAM: Two comments. One is that you mentioned the $150 indemnity cap. My understanding of that is that there are actually two types of products being considered. One for the indemnity where there is no cap, and the other for the per diem where there is a $160 cap.

MR. STRAYER: Yes, and there's a third one, as I understand it, on services.

MS. ABRAHAM: The services are linked to the actual indemnity where there is no cap. You talked about the three out of six and two out of six ADLs. Bear in mind that what actually passed in some of the state bills under benefit eligibility criteria, for instance, in California and Texas, is actually two out of seven. That is a concern when you are looking at tax-qualified plans as well.

MR. STRAYER: The way the federal regulation sets the floor and the fact that states can go above that floor makes it more difficult. They're not going to penalize states or they're not going to disallow states from making those ADLs even more strict. That won't be addressed, but my concern is that there is a huge difference between two of six and two of five of six. That is the question that the Senate is going to be dealing with and it's not in this bill. Right now, it's two of six for a federal standard. California could have six of six.

MS. ABRAHAM: What I meant was that if California currently has two out of seven, in order to meet the California regulation, you would basically have to develop a plan that would not be tax qualified if the tax qualification is two out of six. All of the California plans could not be tax qualified.

MS. HELWIG: My understanding is that they are setting the two of six as a minimum standard. Tax law wants the least liberal so two of seven would not qualify.

MS. KIM H. TILLMANN: We all know that regulations are a necessary part of our business, and if you're a long-term-care actuary or product manager, keeping up with the latest changes in state variations is a major part of your job. As my part of the presentation, I'm going to briefly go through some of the more significant developments in the NAIC model and fill you in on a couple of states that have unique requirements.

Standards for benefit triggers are really hot off the presses. They've just come out of the working group of the task force and they are expected to be adopted into the model regulation in September of 1995. The NAIC is not expected to make any changes to what has come out of the working group.

The next thing is the nonforfeiture benefit requirement. It was just adopted last March. As far as I've been able to find out, no states have enacted it yet.

The next is premium rate restrictions. You might know of it as rate stabilization. It was adopted into the model about a year ago. I called the NAIC and was told that there are

several states that have some sort of rate increase restrictions, but no one has passed this particular version yet.

Next is the suitability, also just adapted last March, so no action has been taken yet. The next two things, reporting requirements and compensation, are things that I happen to have been looking into and doing some work on at my company, so I thought I would throw them in and fill you in on what I know about that. Last, Texas, California, Kansas, and Maryland are doing differently from the model.

The first topic is the standards for benefits triggers. The new minimum is three of six ADLs or cognitive impairment. You can go more liberal than that if you like, but you need to use these same six ADLs. I personally think this is OK because it seems to me there's a tendency to put a lot of emphasis on the first number and ignore the second number. I have seen a trend in the industry that has gone from using the three of six to two of five. Those of us who have worked in the product line know that three of six is pretty much the same as two of five if the ADL that you have deleted is bathing, since that is usually the first one to go. However, the marketing people will tell you that two of five sounds a lot better because you only have to qualify for two deficiencies to get benefits. Then there are companies out there that are trying to offer a more liberal trigger by using two of six, but they don't really sound too much better because it's still two deficiencies and they have to charge more for it. It becomes difficult for them to justify that extra cost in a competitive situation. If this is widely passed, everyone will have to start with the same six ADLs, and it will be much easier for people to get a real idea of what the trigger is among all companies.

There are other aspects in the model that unify the benefit trigger. They define deficiency, which means requiring hands-on experience or assistance to perform the ADL. A cognitive impairment exists if supervision or verbal cuing is needed to protect yourself or others. My opinion on this for the cognitive definition is that this is a little more lenient than the one our company uses or that I've seen elsewhere of requiring that continual supervision be necessary. There are people who only need supervision, for example, when they're away from their own homes or maybe they only need supervision when cooking so they don't leave the stove on or things like that. If our definitions do change as a result of this regulation, I think we have to think about the pricing implications of this.

The model goes on to outline things about assessment languages; you need a description of your grievance procedures. It may happen that someone will say, I just can't dress myself without assistance. Your claims person might reply, "You could dress yourself without assistance if you stopped wearing blouses that buttoned up the back." I think there will be many other less obvious instances where there may need to be a discussion on how much adaptation the person is expected to make before they are considered deficient.

I listed out the required ADLs. I always thought it was kind of funny that incontinence was an ADL, but the definition was broadened to include personal hygiene if someone is incontinent, or caring for the catheter or colostomy bag, which makes more sense.

STANDARDS FOR BENEFIT TRIGGERS (SEPTEMBER 1995)

1. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

2. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

3. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

4. "Continence" means the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

5. "Toileting" means getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

6. "Transferring" means moving into or out of a bed, chair or wheelchair.

"Cognitive Impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. The next item is the nonforfeiture requirement. I feel like I have been waiting for this requirement to come out for years so we could figure out what to do, but it has changed direction at the last minute. I think what they ended up with was very interesting. We have known for a long time that the model was going to say that nonforfeiture must be included in every policy. It is not an offer that the insured can select or not select. It is a shortened benefit period using a benefit bank approach. They define something called a nonforfeiture credit, which is the sum of all the premiums paid. The nonforfeiture credit needs to accrue no later than the end of the third policy year.

The maximum lifetime benefit is really a safeguard for insurers because there will be someone out there who's going to try to figure out how to get more money out of the policy by lapsing it than he would have by premium paying, so we are allowed to put some sort of language that says that can't happen. You can't get more money out of this contract if you lapse than if you kept on paying premiums. They've also given us some time. I don't know of any companies that have developed this type of thing. The effective date of the provision is 12 months after the adoption, so we have time to come up with something once that first major state adopts it.

Here are a couple of examples. Suppose you had a contract with a five-year benefit, an $80-a-day nursing home plan and the annual premium was $1,200—a number I just pulled out of the air. Suppose it lapses after six years and there had been no claims. The nonforfeiture credit is all the premiums paid—six years times the $1,200, which would allow for about 90 days of nursing home care to be paid. That's the $7,200 divided by the $80 a day. Everything in the contract stays the same except the number of days that you are going to pay.

Another example brings up a question as to what happens with waiver of premium. Suppose they had collected some claims and had one premium waived. I would think if it

is waived, it is not paid and you would not count that in your nonforfeiture credit. It would be $6,000, which would pay for 75 days of nursing home care. Let us make the maximum check. The total possible benefit in this contract, now that it has lapsed, is $14,400, which is the 180 days already paid, plus the $6,000 in the nonforfeiture credit. If it would have remained in premium-paying status, the maximum amount would have been $146,000, so you can see that this cap is not going to come into play very often, but it is there for those extreme cases.

The next item is premium rate restrictions. These restrictions essentially add another dimension to the premium classification. The other dimension is the attained age of the insured or duration. These are the limitations. Age 80 is in both of those categories and I would imagine that when this is passed in insurance departments, you would be held, for those 80-year-olds, to the more restrictive definition.

It is very important for us all to get involved in commenting on these drafts. I know you can get on a mailing list to comment on drafts. I think it is very important that we send in our comments so that the regulations can best meet the needs of both the insurance companies and the insureds.

The next section is suitability. This regulation really insures that insurance companies are not selling air conditioners to polar bears or things like that. We want to be sure that the insurance we're selling is what the person needs. These are all things that I think we should be doing anyway. Now we have regulations so we have to wrap a lot of red tape around it and report every move to ensure that everyone is doing these kind of things. It is all very common sense stuff. We need to develop standards to evaluate suitability. We need to train our agents in that and then have that copy of the standards ready should any regulatory bodies ask us for it.

How do you decide what's suitable? You should think about the person's ability to pay and his financial situation. His personal goals and needs and any other existing insurance he might have should also be considered.

Here are the details of the red tape type things that we have to include. There is required text in the model for a brochure called, "Things You Should Know Before You Buy Long-term-Care Insurance." There is a long-term care insurance personal worksheet. The worksheet emphasizes that rates may increase unless it's paid up or noncancellable and then it asks a person where the money is going to come from to pay the premiums. It then asks them to categorize themselves as to income and asset levels. Those are the things that we are supposed to use to decide whether we think this insurance is suitable or not.

If they don't meet the standards that you set, you can say, "Tough luck, you can't buy this insurance." However, we usually do want to sell it to people if they want it, so they have a suggested text of something called "a suitability letter." It just goes over the information they have given or declined to give in the document which says, really think about this and if you still want the insurance, you can check this box that says "Yes, still consider me" and send it in. Then we can still consider them. Now we need to keep track of how many applicants we've had, how many didn't want to provide this financial information or how many did not meet our standards, and then of those, how many still wanted to be considered for the insurance. There's going to be a lot of counting and recordkeeping

once this gets going in the states. I think this may be more widely passed than some of the others we've talked about.

I won't go through the four reporting requirements such as lapses and replacements by agent and by state. I have 13 states on my list that I send this to. A couple of them have a form that I fill out and send but to the others I just send a letter and I just list the name of the agent. They haven't asked for anything else, so that's what we've been doing.

The last thing I have been working on recently is compensation, primarily on replacement sales. As far as I know, there are four states that tell how we need to pay our compensation. Only one of them follows the model and that is Indiana. The requirement there is that your first-year commission can be no more than double your renewal commission, and renewals after the second year need to be the same as the second year. Delaware looks at total compensation as opposed to commissions and says that, in any year, it can be no more than 25% of the premium. That makes for a much more level scale also.

Wisconsin is similar to the model, only they have said no more than 400% of the renewal rate instead of the two. And Michigan requires level commissions for the first three years and then whatever the company wants after that.

The thing that we have recently been working on, that has been tricky to set up administratively, is restrictions on replacement compensation. This includes both internal and external replacements, although I would think you would probably see more external replacements. Pennsylvania and Wisconsin have followed the model and require renewal rates of compensation to be paid only if the business is replacement.

Sometimes it is good to replace a policy. There are some old ones out there with fairly heavy benefit triggers, such as the prior hospitalization requirements or the requirements for skilled care before custodial care. Some states have recognized that and are making allowances for replacements in most situations. North Carolina, Indiana and Alabama have said that first-year commissions can be paid if the benefits are clearly and substantially greater than the benefits of the old policy that is being replaced. Those things that I mentioned may be some things that would provide a clear and substantial improvement. The problem we ran into with this was—how do we know? The people who administer our compensation do not know anything about the policy that is being lapsed. Our Marketing Department suggested that we just ask the agent and have him tell us. I didn't think that was a very good idea. What we're having them do is take out the last page of the long-term care shoppers guide where there is a comparison they can fill in. We are asking them to fill that out—policy number 1 is the replacement policy, and policy number 2 is the new one that they are replacing. We are going to look at that and decide for ourselves whether we think it is better or not. If they choose not to send it in, we have told them they are going to get renewal compensation.

We are using the same idea in California where the first-year commission is paid but only on the increase in premium over the old policy. I suspect this is their way of getting at an improvement, although the increase in premium could just come from someone getting older. There is a premium line in that comparison that we've asked them to fill in. Kentucky has a new twist and they have taken the 200% renewal or first year no more than double the renewal and said—we will apply that to replacements.

I'll move on to a few details of some states that I know about that are marching to the beat of a different drummer. I talked with someone at a consulting firm who said some of these states are very proud to be going off on their own using their own ideas. It makes it a little trickier for us to have different things in our contracts for different states.

There are three states that have done something with ADL. It was mentioned that Texas and California required two of seven ADLs. The same six plus mobility are in the new NAIC model. Kansas is behind the times and I'm hoping they'll catch up soon. It doesn't allow ADLs for nursing home benefits on individual policies. It has allowed it on group, because it is experimenting. It is going to try it on group first and if it likes it, it will expand it to individual. I'm hoping that since it is now in the NAIC model, it will feel that it's widely accepted enough, and will change its policy.

California is a biggie. We've just recently filed a new home care policy there. The number of the regulation is CA SB1943. You can probably get a copy by knowing that number. The differences are mostly where we want to say we cover home care or community-based care. If you say that, there are certain benefits that you have to provide and there are six categories. Home health care and adult day care are probably what you think they are and what most products cover already. Most of our policies would cover personal care, and assistance with ADLs. Also included in our policies is assistance with instrumental activities of daily living (IADLs). Those included using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry and light housekeeping. Now I read that and I thought, how can I get this? I would love to have someone come in and do my housekeeping or help me prepare meals because, although I do not have any ADL deficiencies, I do have trouble with those things. That is what concerns me about providing this coverage. There are services that people would like to get anyway, and if they can get their insurance policy to pay for it, so much the better.

Under personal care, when we go on to homemaker services, the language is—assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence. I take that to mean anything anyone can come up with that didn't fit under one of those IADLs that was under personal care. One thing that I can think of is lawn care. Then they also have hospice services. Someone from our other company was worried because the hospice services include family support. It is not just services for the claimant. Then the respite care must be a separate benefit, but I know many companies have that already.

I think the biggest thing that companies tried to do to control this risk is to require that these services come from a licensed agency. They can be provided by a skilled or unskilled person, but these services must be coordinated under a plan of care that's put together by a physician or a team of people managing the care.

My opinion on this is that you could not possibly price enough to cover all these aspects and then, on top of it, have the more lenient benefit trigger of the two of seven ADLs. Our claims person said, "I guess whenever we get a claim from California we'll just pay it; I hope that we'll be OK with that."

The last state that has done something different with their nonforfeiture design is Maryland. This came out before the NAIC model, and I asked someone if they thought

they were going to change now that there is a model language to follow. I was told that they are one of the states that are very proud about coming up with something on their own, and she didn't think they were going to be changing. This is a true shortened benefit period where you actually use your cash value to purchase insurance rather than just hold it in a bank account, so to speak, as the model regulation says. You can offer other options, but one of the choices has to be the shortened benefit period. They set a nonforfeiture value which is very similar to the nonforfeiture credit. You use that value as a single premium to purchase paid-up insurance. The thing that's going to be tricky here is that you must provide a personalized schedule for each individual person of what they would get if they lapsed at each different age. You can change this if you ever raise or lower your rates. Then you can change the schedule.

MS. HELWIG: I just want to add one other thing which is NAIC related. In case you are not aware of it, the NAIC, in the *Federal Register* of a couple of weeks ago published the duplication notices for long-term care. This was something that was included with the HR 5252, which was the technical corrections to the *Medicare Act*. Technically, as of August 11, 1995, you are going to have to start attaching those duplication notices to every long-term-care policy you sell. There is a mistake in the technical corrections that will need another technical correction to fix. It says you cannot have a policy that has a Medicare exclusion in it. There are policies in the market right now with Medicare exclusions, but as of August 11, it will be considered out of compliance, and there are some pretty substantial fines for that. My understanding, from talking to Jack, is that they are going to try to get that fixed before August 11, so that companies aren't going to be scrambling at the last minute to either change their policies or be fined if they're going to risk being out of compliance. Evidently they're going to start a "corrections day" in the Senate and the House each month where they are going to try to clear up little problems like this.