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CURRENT DIRECTIONS IN LONG-TERM CARE

Moderator: BARTLEY L. MUNSON
Panelists: MICHAEL J. ALOISIO
VINCENT L. BODNAR
Recorder: BARTLEY L. MUNSON

This panel will review the current status of the long-term-care marketplace with respect to nonforfeiture requirements and product design issues.

MR. BARTLEY L. MUNSON: The program said that you would hopefully come away with a better understanding of products and current issues affecting long-term care. The panel is going to look at product design, company attitudes and changes, and some innovative product ideas, especially relationships with some other products.

I am from Coopers & Lybrand L.L.P. and will moderate this panel. We also have two panelists. First, Vince Bodnar, from Peat Marwick, works in this area and is a member of the AAA's Long-Term-Care Committee, which I chair. Next is Michael Aloisio from John Hancock. The Hancock is a major writer of long-term-care insurance, both on the group and, as they like to call it, the retail side.

MR. VINCENT L. BODNAR: In my portion of the presentation, I will focus on some of the benchmarks and trends that we've seen emerge in the last year in long-term care.

The first part of my presentation will focus on results based on our analysis of long-term-care experience exhibits. Since 1991 we've gathered, from approximately 100 companies, the long-term-care experience exhibits that they filed with insurance departments. From this information, we're able to get information about market volumes, market growth, and who dominates the market share. We're also able to look at loss-ratio experience and persistency and reserve results. The second part of my presentation is based on data we obtained from a carrier survey; there I'll focus on policyholder demographics, expenses, and commissions.

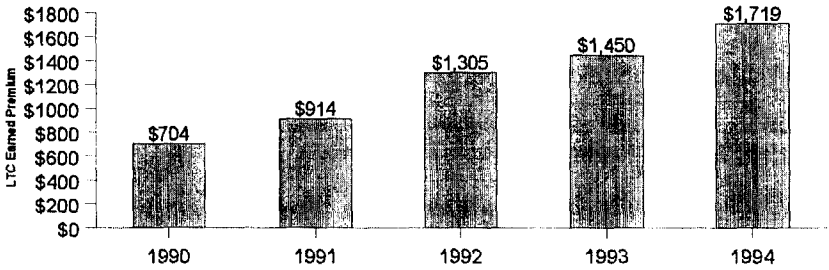
In Chart 1, we see the premium volume of the long-term-care market since 1990. The bars represent earned premium by calendar year, and you can see there has been some significant growth in this market since 1990. You do see the slowdown in growth in 1993. Since 1990, we've averaged about 25% growth in the market. In 1993 we saw it grow by 11%, and in 1994 it has rebounded up to about 19%.

In Chart 2, we have the same information split between the group and individual markets. We see the same "speed bumps" in the growth in 1993, and we saw an approximately 30% growth in the group markets in 1994. As a percentage of the total market, group represents about a quarter of the market.

In Chart 3, we see the total number of policies in force at the end of each calendar year in 1990–93. The 1994 experience exhibits are filed in April 1996. Again, this reflects the slowdown in the growth in 1993. In Chart 4, we see the same data split between group and individual. The group portion of the total policies is much larger than if we're measuring premium, because the group average annual premium is much smaller than for individual policies.

CHART 1

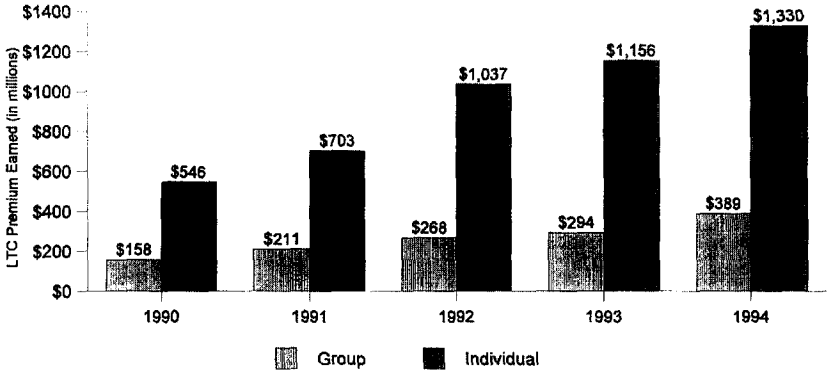
PREMIUM VOLUME OF THE LTC MARKET (IN MILLIONS)



Source: Long Term Care Experience Exhibits filed with regulators

CHART 2

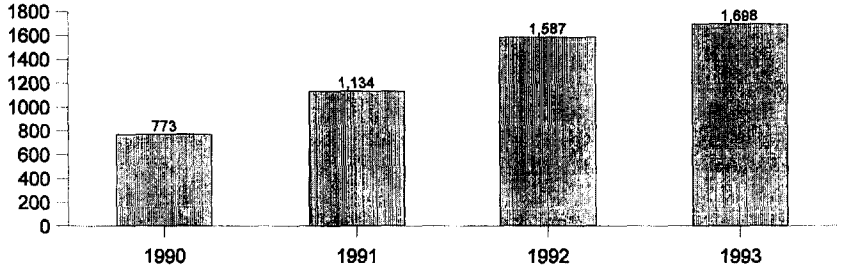
PREMIUM VOLUME BY TYPE OF MARKET



Source: Long-Term-Care Experience Exhibits filed with regulators

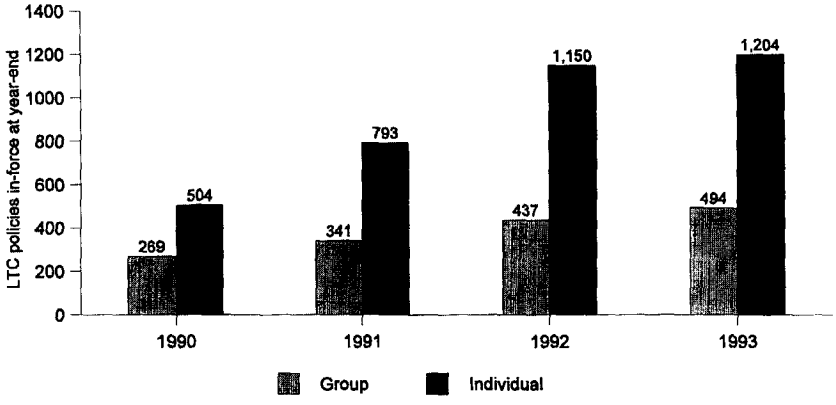
CHART 3

TOTAL NUMBER OF LTC POLICIES IN-FORCE AT YEAR-END (IN THOUSANDS)



Source: Long-Term-Care Experience Exhibits filed with regulators

CHART 4
NUMBER OF POLICIES BY TYPE OF MARKET (IN THOUSANDS)



Source: Long-Term-Care Experience Exhibits filed with regulators

Table 1 represents market share in 1993 and 1994. It's based on earned premiums in each year. This represents the top nine long-term care carriers in both the individual and group markets combined. In 1994, these nine carriers represented about three quarters of the total market. AMEX is the leader and is as big as the next two competitors. We see these nine carriers grabbing a larger portion of the market from 1993–94.

TABLE 1
TOP NINE LTC CARRIERS
MARKET SHARE BASED ON PREMIUM VOLUME—INDIVIDUAL AND GROUP

Company	1993 Market Share	1994 Market Share
AMEX/IDS	22%	21%
Travelers/Transport	11	11
CNA	9	8
Bankers Life	7	7
John Hancock	6	7
AEGON	5	6
Prudential	5	5
American Travellers/J.C. Penney	7	5
Penn Treaty/Network America	4	4
Total of top nine	71%	74%
All other	29%	26%
Grand Total	100%	100%

In Table 2, we focus on just the individual market. Here AMEX is the leader, and again, is almost as big as the next three competitors. These are the top ten carriers, representing about nine-tenths of the total individual long-term care market.

TABLE 2
TOP TEN INDIVIDUAL LTC CARRIERS
MARKET SHARE BASED ON PREMIUM VOLUME

Company	1993 Market Share	1994 Market Share
AMEX/IDS	28%	28%
Travelers/Transport	11	11
CNA	11	10
Bankers Life	9	9
AEGON	5	7
American Travellers/J.C. Penney	8	7
John Hancock	4	5
Penn Treaty/Network America	5	5
Mutual Protective/Medico Life	4	3
Mutual of Omaha	2	3
Total of top nine	87%	88%
All other	15%	12%
Grand Total	100%	100%

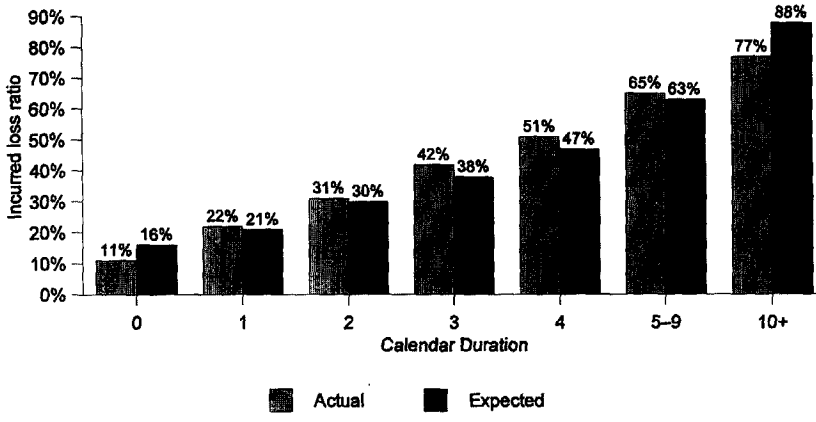
Table 3 shows the top six group carriers. Here Prudential clearly dominates with its American Association of Retired Pensions (AARP) program.

TABLE 3
TOP SIX GROUP LTC CARRIERS
MARKET SHARE BASED ON PREMIUM VOLUME

Company	1993 Market Share	1994 Market Share
Prudential	25%	23%
John Hancock	13	14
Aetna	10	13
Metropolitan Life	13	12
Travelers/Transport	10	11
Pioneer Life	10	10
Total of top six	81%	83%
All other	19%	17%
Grand Total	100%	100%

In Chart 5 we see loss ratios by calendar duration. The lighter bars represent actual loss ratios; the darker bars represent expected loss ratios. Two things jump out: first we see the steep loss-ratio pattern in this product, which does not surprise anybody. You also see how close actual experience has been to expected. This tells me that either we've done a good job at pricing, in spite of the lack of data that we have to price with, or we're very creative when we file these exhibits.

CHART 5
ACTUAL V. EXPECTED POLICY YEAR LOSS RATIOS
INDIVIDUAL AND GROUP BUSINESS
(INCEPTION-TO-DATE)



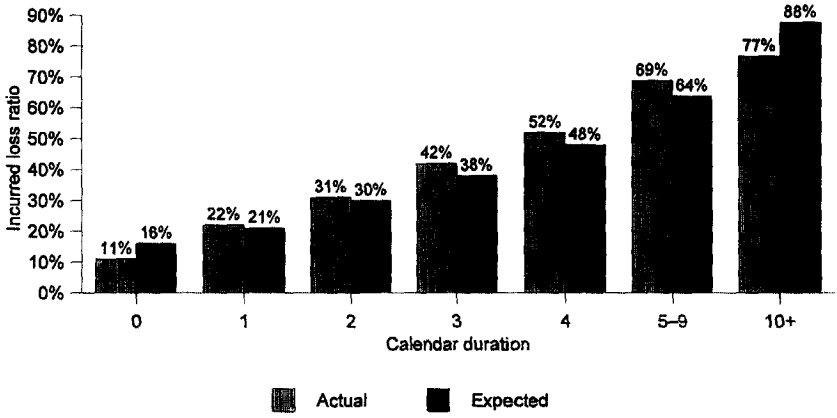
Source: Long-Term-Care Experience Exhibits filed with regulators

In Chart 6 we see just the individual portion, and this graph looks very similar to the prior one. Actual experience has been slightly worse than expected in just about every year except the first and last duration. In Chart 7 we see the same information for group business. It's just about the same story.

I've taken the inception-to-date loss ratios and sliced them up by calendar year, so in Table 4 each column represents a calendar year's experience, and each row is the duration. Now let's just look at the total calendar-year experience since 1990. You can see an increasing pattern up through 1994, where loss ratios actually declined from 33% for the calendar year to 24%; this is also true by duration. You see a decrease in loss ratios by duration in just about every year except duration number one. You also will see that the 6% for the zero duration in 1994 will probably increase to something between 10% and 15% next year, as 1994 results will be filed using retrospective claim reserves.

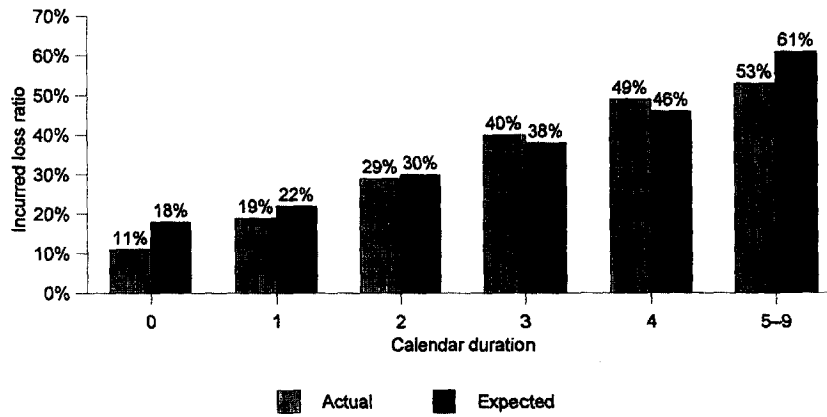
Chart 8 has data from Table 4 depicted graphically for 1992, 1993, and 1994. Here you can see that at least for duration 0 through 4, experience by duration has been relatively stable. However, when you look at years 5 through 9 and 10+, you see a decreasing trend.

CHART 6
ACTUAL V. EXPECTED POLICY-YEAR LOSS RATIOS INDIVIDUAL BUSINESS
(INCEPTION-TO-DATE)



Source: Long-Term-Care Experience Exhibits filed with regulators

CHART 7
ACTUAL V. EXPECTED POLICY-YEAR LOSS RATIOS
GROUP BUSINESS

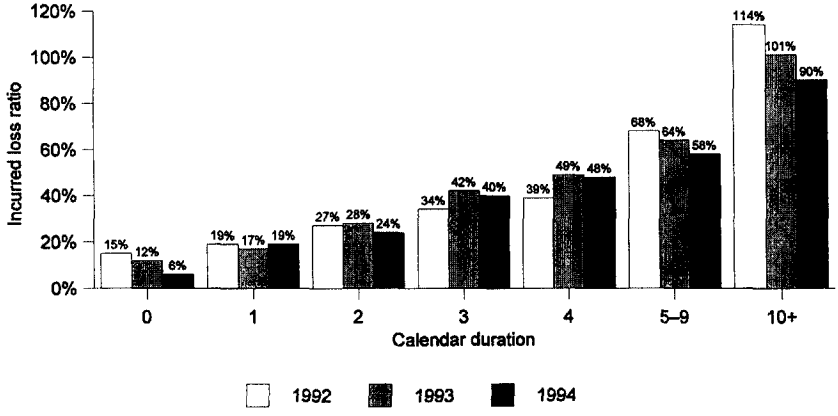


Source: Long-Term-Care Experience Exhibits filed with regulators

TABLE 4
CALENDAR-YEAR LOSS RATIOS
TOTAL LTC INDUSTRY LOSS RATIOS
INDIVIDUAL AND GROUP BUSINESS

Duration	1990	1991	1992	1993	1994
0	11%	12%	15%	12%	6%
1	18	20	19	17	19
2	25	27	27	28	24
3	42	31	34	42	40
4	79	37	39	49	48
5–9	78	72	68	64	58
10+	154	103	114	101	90
Total	15%	27%	30%	33%	24%

CHART 8
CALENDAR-YEAR LOSS RATIOS BY DURATION
INDIVIDUAL AND GROUP BUSINESS

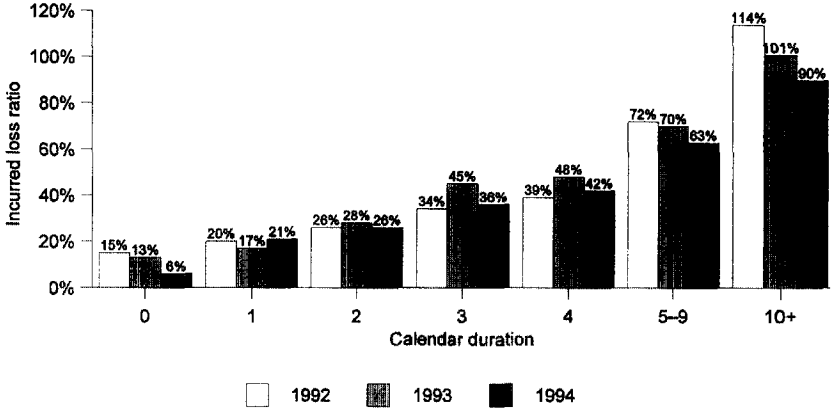


Source: Long-Term-Care Experience Exhibits filed with regulators

Chart 9 is the individual slice of that. It's basically the same story. Chart 10 is group. Here we have a little more volatility, most likely because this is a much smaller market. From the experience exhibits we were able to look at changes in policy reserve by duration. In Table 5 the top portion is companies that use the one-year preliminary term method. We see their change in policy reserves for 1992–93 by duration. In the bottom half, we see the same set of numbers for companies that use the two-year preliminary term method. As you can see, these changes are quite large. Basically, whatever method you choose to use, eventually you have to begin to fund large policy reserves. I think this just underscores the importance of communicating these new policy reserves to

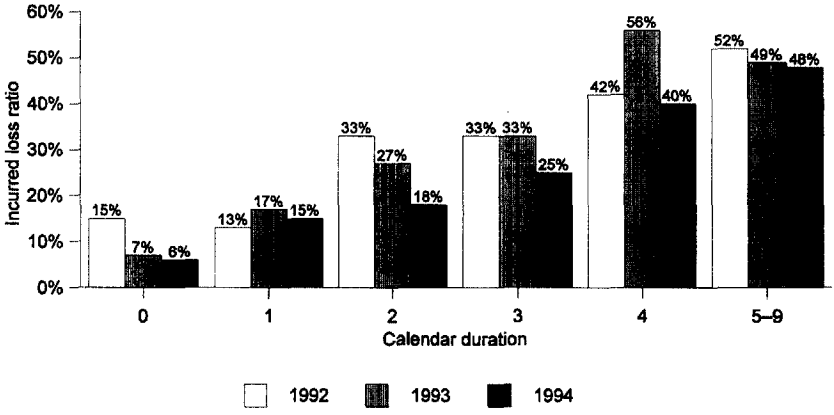
management when you price these products. You may be making a great deal of money on the cash basis or strictly underwriting basis, but on the statutory basis, as we all know, we've probably seen much different results.

CHART 9
CALENDAR-YEAR LOSS RATIOS BY DURATION
INDIVIDUAL BUSINESS



Source: Long-Term-Care Experience Exhibits filed with regulators

CHART 10
CALENDAR-YEAR LOSS RATIOS BY DURATION
GROUP BUSINESS



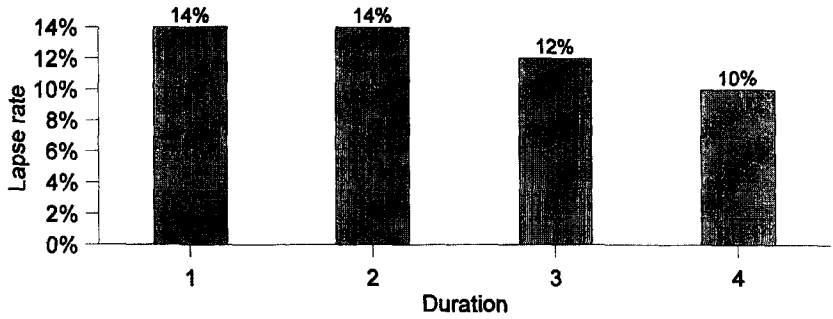
Source: Long-Term-Care Experience Exhibits filed with regulators

Also from the experience exhibits we are able to look at lapse rates. Chart 11 represents 1993 lapse rates of the individual market in total. You can see they're about 14% in the first year; this is based on policies in force by duration from calendar year 1992 to 1993.

TABLE 5
CHANGE IN POLICY RESERVES
AS A PERCENTAGE OF EARNED PREMIUM

Duration	1992 change in policy reserves	1993 change in policy reserves
Companies using one-year preliminary term method		
0	0%	0%
1	20	25
2	46	42
3	41	49
4	40	39
5–9	42	32
Total	28%	31%
Companies using a two-year preliminary term method		
0	0%	0%
1	0	0
2	16	36
3	39	39
4	43	44
5–9	28	42
Total	17%	24%

CHART 11
LAPSE RATES OF INDIVIDUAL POLICIES



Source: Long-Term-Care Experience Exhibits filed with regulators

Then they decline to 10% by year four. Lapse rates vary greatly by carrier. We had some carriers whose lapse rates were in excess of 35% in the first year. We had other carriers at 8% or below in the first year. In aggregate this represents the total individual market.

The rest of the charts are based on information we obtained from a carrier survey. We sent out a supplemental survey to every long-term-care carrier, which was in excess of 100 carriers. We received about 25 responses.

One set of questions focused on expenses. Table 6 is excess first-year expenses as a percentage of first-year premium. I split the results in Table 6 between brokerage and career agency carriers, for obvious reasons. Table 7 represents policy maintenance expenses. Excess first-year expenses represent just those expenses you incur in the first year, whereas policy-maintenance expenses represent ongoing maintenance expenses. Total first-year expenses would equal what you see in Table 6 plus what you see in Table 7. You see that brokerage systems are much lower than career agency systems in the first year.

TABLE 6
EXCESS FIRST-YEAR EXPENSES
AS A PERCENTAGE OF FIRST-YEAR PREMIUM

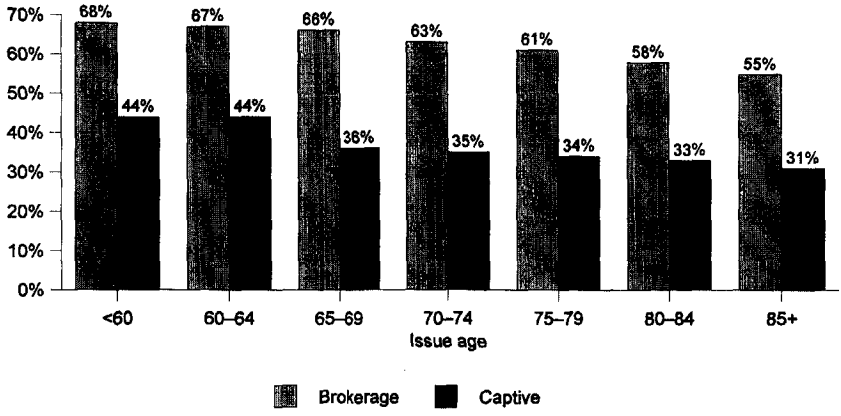
Expense	Brokerage Distribution System	Career Agency Distribution System
Underwriting	6.0%	13.3%
Policy issue	3.0	3.0
Marketing (except commissions)	10.5	56.9
Other	1.3	14.6
Total	20.8%	87.8%

TABLE 7
POLICY-MAINTENANCE EXPENSES
AS A PERCENTAGE OF ANNUAL PREMIUM

Expense	Percentage of premium
Billing and policy service	1.8%
Claims administration	2.1
Overhead and other	5.8
Total	9.7%

Chart 12 shows that commissions are much different. The biggest portion of expenses in the first year are obviously marketing expenses. Career agency systems also tend to have higher underwriting expenses. It also represents average first-year commissions as a percentage of premium by issue age since many carriers are now varying their commission rates by age. The lighter bar represents the brokerage system and the darker represents the captive agency system. We supplemented the information from our survey with an additional brokerage survey. This represents the average commission being paid by the carriers to their large volume producers. It includes overrides in the case of brokerage systems.

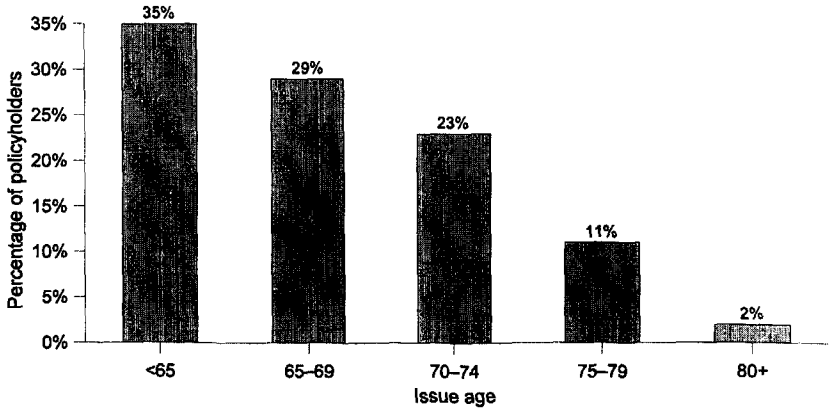
CHART 12
COMMISSIONS AS PERCENTAGE OF PREMIUM



Source: KPMG Long-Term-Care Broker Survey and KPMG Long-Term-Care Survey, Supplemental Questionnaire

Chart 13 represents the distribution of new policies issued in 1994 by issue age; this is just the individual market. The average issue age is 68, which is close to what I expected. You'll see that 35% of all individual policies are issued to persons under the age of 65. When you add in the group market, which is issued predominantly under the age of 65 (the group market is approximately 30% of the total long-term-care industry), you'll observe that a little more than half of all policies have been issued to people under the age of 65. This was a little bit surprising to me; so much for this being a seniors-only product!

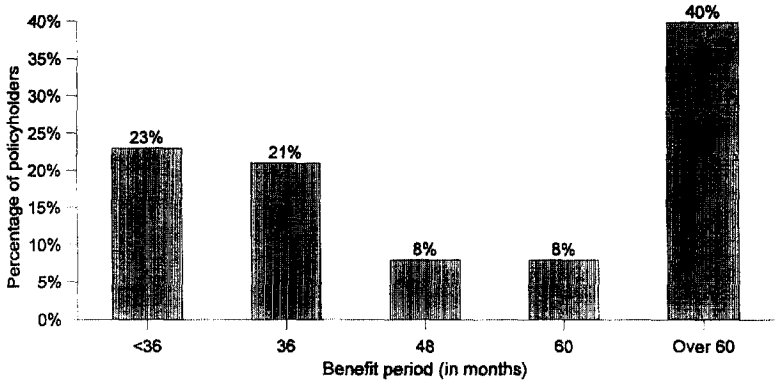
CHART 13
LONG-TERM-CARE MIX BY ISSUE AGE
AVERAGE ISSUE = AGE 68



Source: Long-Term-Care Experience Exhibits filed with regulators

Chart 14 shows the distribution by benefit period, elected at the time of sale. Again, this is the individual market in 1994. You see many in the over-60-month benefit period; for the most part they are lifetime benefit options. On average, in 1994, we had a 50-month-benefit period sold to policyholders.

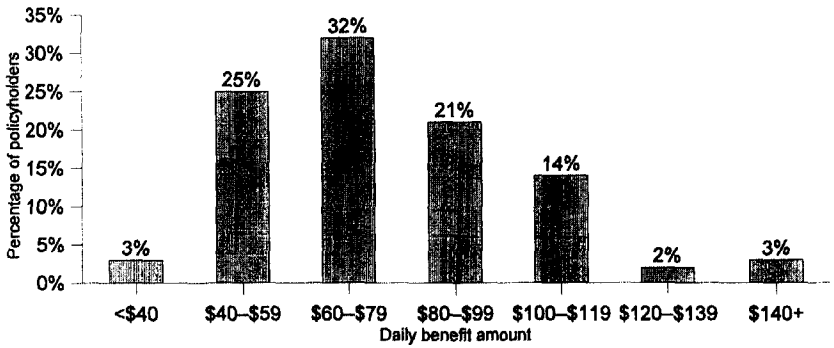
CHART 14
LONG-TERM-CARE POLICYHOLDER MIX BY BENEFIT PERIOD
AVERAGE BENEFIT PERIOD = 50 MONTHS



Source: KPMG Long-Term-Care Survey, Supplemental Questionnaire

Chart 15 shows the distribution of the average daily benefit elected at the time of sale. There's a distinctive bell curve around the average which is about $70 per day. This is well below the average daily nursing home charge of about $100 nationwide. In fact, only 19% of all policyholders elect a daily benefit that is greater than $100; this indicates a willingness to share in the cost of long-term care.

CHART 15
LONG-TERM-CARE DAILY BENEFIT DISTRIBUTION
AVERAGE DAILY BENEFIT = $70 PER DAY



Source: KPMG Long-Term-Care Survey, Supplemental Questionnaire

Regarding the percentage of policyholders who elect an inflation benefit, about three-fourths of all policyholders decline this option. Also, in 1994 about 90% of all policyholders did not elect a nonforfeiture benefit.

FROM THE FLOOR: What does the NAIC say about nonforfeiture and return of premium, and low participation of policyholders taking those benefits? Is there any feedback from them yet? They've been pushing it quite hard.

MR. BODNAR: This is the first time that information has been publicly shown. I would be interested to see the reaction to that. Most policyholders are not interested in the option. Most carriers and most marketers don't see it as a high demand option; it's just too expensive. In a lot of cases it can increase the premium by 50%, and for that reason a lot of marketers and carriers don't see it as a high-demand benefit.

MR. MUNSON: To not make nonforfeiture mandatory, because not many would voluntarily take it, was not an argument the NAIC was at all persuaded by. That is, a consumer who goes through a tough sale and two or three visits at the proverbial kitchen table with maybe two generations of "buyers" typically will not then volunteer to pay 30% more because they think they might drop it. You don't think that way at the time of purchase. We have had some debates about whether it is a convincing argument that few opt to pay for the benefit. It was not going to convince the regulators and it didn't. Therefore, they made it mandatory. Of course, making the model one way doesn't mean that it happens in the states; it hasn't happened anywhere. It's dead in the water.

MR. BODNAR: Three key states, Florida, Pennsylvania, and California, do not plan to pass a mandatory nonforfeiture benefit. And that would be a large portion of the market. Florida does have a mandatory offer.

MR. E. PAUL BARNHART: One of your graphs showed commissions paid; I gather those were first year?

MR. BODNAR: Yes.

MR. BARNHART: Brokerage numbers were up around 60%. Was there anything in there showing renewals?

MR. BODNAR: No, I didn't get into renewals. The information that we received showed renewals averaging 15%.

FROM THE FLOOR: I was wondering about the participation of home health care coverage.

MR. BODNAR: I'm seeing more of a trend of the home health care benefit being included with the base policy, usually in a pot of money approach or an ultimate care approach. It's to get away from the nursing home only and the home care rider.

MR. MICHAEL J. ALOISIO: Please note that my development experience has been with incurred products for the individual marketplace. I say this so it might excuse unintentional product biases that slip into my discussion. There are nuances to group

products and individual indemnity products that I leave for a more qualified individual to address.

Direction may be thought of in a more universal sense. For long-term-care insurance, the direction I wish to take is truly universal in nature. In fact, it's one and the same with the current direction of the universe, that is, expansion. From this point of origin, from where I'm standing right now, no matter the heading, no matter the topics, the long-term-care universe is expanding.

I'd like to focus on five topics that, to me, cover the breadth of this expansion. These topics are: people, presentation, producers, providers, and product. The first two, people and presentation, set the initial conditions for the expansion.

When I refer to people expansion, I'm referring to the growth in the number of customers at key purchasing ages and their expanding awareness of long-term-care issues. Demographers have predicted large growth rates for the elderly population for many years. Statements like, "in 40 years, there will be twice as many people over 65 as there are today," are found in the literature. Two comments might be made about these predictions. First, they are, in fact, coming to pass. Second, these growth rates represent growth in the number of real people with real lives and experiences. Some are experiencing, first hand, the need for long-term-care services. More are seeing their friends and relatives need these services. This is increasing the incentives to purchase.

Of course, no commentary about contemporary population trends would be complete without a reference to the baby boom generation. The leading age of this group is still a few years away from entering the primary market. They are, however, being sensitized to long-term-care issues, through the care of their parents and elder relatives. Information about long-term care is also easier to find. The press has found long-term care a fertile field for stories of interest and who else, except for retirees, has much time these days to read the papers?

A recent literature search turned up over 100 articles under the long-term-care heading. Information about long-term care is also available in new venues. An Internet search under long-term care turned up four references, each leading to additional cites. While certain seniors will likely never become comfortable with computers, others are embracing them and the networking they provide. Long-term-care issues are frequently discussed in senior chat groups and bulletin boards. These information networks are expanding for providers, researchers and developers, too.

By going online service, I was able to call up a recent *Consumer Reports* article on nursing homes and visit a medical support bulletin board with topics such as Alzheimer's and care- giving. The following sample of government agencies have World Wide Web home pages on the Internet: the Department of Census, the Center for Disease Control (CDC), the National Center for Health Statistics (NCHS) and Health Care Finance Administration (HCFA). I've noticed over the past few months that the quantity and quality of government offerings has increased.

Finally, the government has done a magnificent job in the last two years of expanding customer awareness. Last year's Health Reform Act and its demise has come up as an explanation for the growth of long-term-care sales in 1995. The government is

continuing to keep these issues alive with the current Medicare debate. The current climate only enforces the notion that long-term care will be a private responsibility.

Now, the opportunities to present long-term care to customers is also increasing. This presentation expansion means long-term-care issues are being addressed in more types of financial planning sessions. As these presentations become more refined, they are likely to lead to differentiated products.

Long-term-care insurance has often been sold on a stand-alone basis. It is a product that promotes independence in the face of increasing frailty, debilitating accidents, or health events. It is sold on a stand-alone basis when individuals already have retirement programs and estate planning programs in place.

It is increasingly emerging as an element of the retirement planning process itself. As individuals close in on their postretirement income, they may feel it appropriate to allocate a portion of that income to protect against the financial strain of long-term-care events. Long-term-care insurance is also finding a place in the estate planning sessions. Even wealthy individuals may wish to protect the assets of their estate plan, and not see them expended on health care needs. This situation may call for a product that offers fairly large deductibles but longer benefit periods.

This is a slightly speculative idea at the moment—an intergenerational planning process may emerge. The likelihood of this increases if social policy changes to encourage or demand support from children for their parents' care. There may be design features that encourage the purchase of long-term care by children for their parents.

With regard to producer expansion, the types and numbers of producers who are knowledgeable about long-term care and its potential are increasing. Senior specialists have been in the market for awhile. They've dedicated themselves to the elder marketplace. Long-term-care marketing is an important component of their services. These specialists are a source of brokerage business.

While the number of life agents selling long-term care has increased, there's more to learn here. It has been tough for successful life agents to become equally knowledgeable and successful with long-term care. This may change as integrated training programs evolve. Producer counts and volume have been expanding from new agents specifically trained on long-term care.

Finally, producer expansion may come from the ranks of the health service providers themselves. Funeral homes have often been active marketers of burial policies. They have, after all, a vested interest in establishing future sources of demands with a capacity to pay. Similar situations may evolve with long-term care. For example, if marketing activity is sited in the nursing home, we would first hope that the new entrant is not the prospect. However, it is a time for the entrant's support group, whether it includes a spouse, siblings, or children, to be receptive to their own planning.

Production activity may become a service of care management organizations. As is often the case today, that when care management is provided, it is provided by the home health agency itself. This situation is ripe for a conflict of interest. Organizations specializing in providing information and support as opposed to providing the services themselves

may evolve. There are both health and financial aspects to care and case management. Financial advisory services developed for the post-claim period may be expanded to the preclaim period. This would allow the organization to market itself to potential customers before a crisis situation emerges. And sales would provide an additional source of revenue. It is debatable whether organizations of this type could be directly linked to the insurance carrier. It would have a similar conflict of interest appearance as care management through the health agency itself.

Let me now touch on examples of provider expansion. This expansion covers the expanding nature of delivery site, services, and concepts. First is the growth and the number of assisted care living facilities. Broadly defined, they are not quite nursing homes. At the moment, these living facilities have great appeal to developers. Fortunately, state licensing efforts appear to be increasing and there appears to be a movement towards the emergence of trade associations. The facilities saw great diversity in the lifestyle offered, the anticipated care levels, fees, and service packages. There's great appeal for the frail elderly to be able to maintain a large, if no longer complete, degree of social independence in these facilities.

Second, growth in care-management agencies is expected. There continues to be a need for unbiased advice at the onset of a claim. This is particularly true when the informal care giver begins to doubt the adequacy of the care they provide or their ability to continue to maintain it. Where can they turn to? There are national organizations that offer assessment and care plan development services. But these are often in support of an insurer client. The organizations may be able to begin to market their services directly to the elder population.

Third, in provider expansion is the expansion of medical HMOs into providers with long-term-care services. From a service perspective, this is a natural expansion. Administrators who have already learned to network with hospitals and physicians may consider adding the providers with long-term-care services to their network. All the infrastructure necessary to do this is not yet in place, but the notion of how to get it in place is very much a current topic. For example, diagnostic codes and protocols for long-term-care services are not yet in place. But there are pilot programs running that may develop this information structure. Questions will remain regarding the financial funding arrangements and ultimately whether the public will be receptive to managed care.

The fourth expansion area, product, is really expanding. Designs, benefits, and features are dynamically responding to the needs of the public, producers, and providers. I'd like to refine the topic of product expansion into three areas: expanding coverages, expanding combinations, and expanding covertures.

There are three examples of coverage challenges to be met by current contracts. First, there is the care or case management challenge. The insurance contract is becoming a source of payment for care advisory services. A question is whether this advice will promote a more stable and efficient use of services covered by the insurance. If case management features are included, how aggressive should they be? Will the policy owner be receptive if sticks are included, or responsive if carrots are used?

Second, the assisted-care living facility challenge must be met. The living facility is a home; but, unlike other home healthcare, all services are not clearly provided by an

independent agency on a separate-fee basis. Unlike a nursing home, there are usually no rigorous building codes regarding the physical requirements of the facility. How then should or could the contractor avoid paying for the bricks and mortar of the assisted-care living facility? Decisions to tightly control benefits here can easily lead to higher administrative costs at the time of a claim.

Third, contracts are expanding in the manner they address informal care giving. There's increased recognition of the desirability of informal caregivers, as long as the quality of care is not compromised. For expense-incurred policies, pricing recognizes a proportion of benefit-eligible individuals who do not seek formal paid services. With suitable quality of care controls, efforts are increasing to enhance in-home informal care. The coverage of training for informal care givers is but one example.

The product concept of expanding combinations means the linking of long-term-care coverage with life, annuity, or disability income coverages. These combinations come in three flavors. First, there is the notion of transformational insurance. This means that the contract is issued with a certain combination of life, annuity, or disability insurance (DI) coverages, and then later transforms into a second set of coverages with long-term care included. Long-term care may be the only transformed coverage. Often the nature of the transformation considered by a company is heavily influenced by the products already offered by the company. Thus, a DI writer may design a DI policy with specific conversion privileges to long-term care. Such contracts currently exist. Also, annuities may transform in whole or in part to long-term-care insurance. When done on a partial basis, the income stream appears to be augmented during long-term-care events.

A second flavor of combined products is the bundled product. Here a central policyholder account is created from which periodic deductions for insurance coverages and guarantees are made. Within certain time frames and limits, the insured is free to revise coverages without evidence. These designs always seem to present concerns when the tax code is finally considered.

The third flavor considered is an offshoot of virtual reality. For the moment, I'll call it the "virtual combined product." Here, traditional single coverage contracts are combined administratively and presented as a unified design to the insured. While greatly complicating the system implementer's role, this approach has the advantage that the life contract is a life contract, an annuity is an annuity, and long-term care is long-term care.

Finally, in the general area of product expansion, is the possibility of expanding coventures. These would include products that go beyond traditional contracts. They may be coordinated ventures between providers, services and insurance companies. This might include provider networks offering discounts or joint ventures between insurance companies and expanded HMOs with a genuine mutual respect for the financial and health expertise provided by each partner.

I hope you agree that there is a great deal of expansion going on in the long-term-care universe. However, I shouldn't end without commenting on one more expansion. That is simply the expanding complexity that results from a larger interactive universe. Complexity, however, may encourage beneficial simplifications and product design. Instead of separate dollar pools for separate benefits, a more integrated structure will evolve. It should be noted that the group to which these products are sold often tightly control the

allowable level of complexity. One should also keep in mind the effort of explaining contractual features to claimants at time of claim.

The complexity issue, given its expansion, raises a key question. Can the long-term-care universe expand forever? If not, what forces will limit its growth? This is a fundamental, cosmological question, perhaps, but it's also appropriate to long-term care. It may be, perhaps, beyond the focus of this panel. This is, after all, a discussion about current direction.

Permit me to introduce a second mixed scientific metaphor, by introducing the government gorilla in all its forms. Perhaps the consistent metaphor is to recognize the government as an irresistible force that can affect any expansion to any degree. Let me review some governmental levels and provide an example or two of how their actions affect long-term care products.

First, the federal legislative branch has the ability to change the basic rules. The Medicare revisions currently under discussion will directly impact the public's perception of managed care. If the perception is good, then managed care features may become more viable in long-term-care designs. If there is a backlash, then contracts promoting provider choice shall succeed. The legislation also has power over the tax code. In addition to indirectly affecting product design, such as limiting the growth of bundled products, current proposed tax legislation will affect design directly. The degree to which customers will demand federally qualified long-term-care policies is unknown.

The federal executive branch has the ability to interpret congressional acts and formulate regulations. Companies are responding to the recent HCFA interpretation that long-term-care policies may not coordinate benefits with Medicare. A valid debate is that this may not have been Congress's intent. Nevertheless, the HCFA interpretation is currently in effect.

At the state level, we have the state-sponsored NAIC model law and regulation structure. This regulatory structure can be beneficial to future long-term-care development when it achieves consensus on common standards. These standards can enhance the appeal and security of the public of owning a long-term-care policy. The current benefit trigger initiative is a case in point, even though it potentially means a new round of filing.

However, NAIC initiatives require a follow-through on a state-by-state basis. When a consensus and a common standard is not reached, the implementation on a state-by-state basis may not be consistent. The NAIC has mandated that nonforfeiture benefits be a part of every long-term-care policy. This is likely to meet resistance in some state where a different balance between benefit and premium is perceived. Some states are likely to adhere to the model as is; others may make it a mandated offer. The current Massachusetts proposal has it as a mandated offer, but only at ages 55 and above; below age 55, it must be included. The result of diversity at the state level is higher cost and greater complexity to develop, file, communicate and administer long-term-care products.

In closing, I don't mean to suggest that the government is the only force that can limit long-term-care expansion. As in any product, there's always a question of its continued viability as a product itself. If the insurance pooling mechanism can remain intact, if regulatory compliance and operational administrative costs can be kept reasonable, and if

we can continue to react in a timely manner to marketplace development, then the current direction of long-term-care should continue to be an expansive one. Clearly, the opportunities and challenges are both present. It's an interesting time to choose a heading and set a course to the adventures ahead.

MR. JAMES M. GLICKMAN: Around the pool of money approach, which has also been known as the bucket of benefits, is the concept where a comprehensive long-term-care plan with home health care is put into effect. You have a certain number of dollars to spend over your lifetime, and any dollars you don't use one day are still left in that bucket for future use. Much of the pricing that has been done on that type of product has been oriented towards the fact that you coordinate with Medicare and therefore have some substantial savings on the home health care side of the product. In particular, the new HCFA regulation that came out on August 11, which specified that long-term care cannot coordinate with Medicare anymore, at least until such time as that whole ruling is reversed, has left the pricing issue in somewhat of a disarray, especially for companies that have been using that procedure for quite some time, since the regulation was retroactive. Now the question I have is, what type of exposure do you think that companies have who are continuing to sell the pool of money approach, without changing their premium structures? And second, what type of approach or risk is there to the client who buys policies now that this warning system is out? If some day, for example, the government decides that Medicare should be a secondary payer, as it is in the medical marketplace, what will happen to all of those policyholders who bought a product that was priced on a coordination method that may become outdated at such a future date when they need their benefits?

MR. ALOISIO: I want to start off by saying that our contacts within HCFA indicate that there will be a correction, amending this interpretation. They did not mean for it to apply to long-term care, although corrections do take some time to happen. In that same ruling, they deferred enforcement of this issue to the state level. When you poll all the states, especially the key states like Pennsylvania, which does not allow duplication of Medicare benefits, you find that they're letting companies go ahead as usual. I think, we have the same story in Florida, where you have to at least not duplicate Medicare benefits and then offer a rider of some sort to increase your premium if you want to pay in addition to Medicare.

It is a big deal. Medicare expenditures on home health care are increasing. They've quadrupled in the last five years. Medicare carve out is certainly an important provision when pricing the products.

MR. BODNAR: I concur with that. We realize that pricing now into the current environment is on one set of rules and we have to be prepared for that. The products that are in force, have taken our own interpretation of how to bring them into compliance with the HCFA regulation. Other companies may take a wait-and-see attitude, yet the regulation is there and it's current. I would not want to look towards the general guaranteed renewable premium provision concept to elicit a fundamental change in the nature of the insurance contract. I wouldn't want to rely on that, though that is there in guaranteed renewable contracts.

MR. LINGDE HONG: Is it common for group long-term-care products to have a premium rate guarantee of a few years? And if it is the case, doesn't that mean that we

are taking some kind of a risk in this guarantee, specifically an investment risk? That's assuming that if you guarantee the premium rate, you're implicitly guaranteeing your investment return rate.

MR. BODNAR: We do have great stabilization requirements on the individual side also, and the investment assumption is critical to the pricing of your product.

MR. ALOISIO: I could say on the individual side that a rate guarantee, at least for three years, is becoming more popular, and most companies are not really concerned about this. Typically if you do need a rate increase, it's more than three years down the road and it's usually a small enough rate increase that you don't have to be too concerned with it. We saw all the results in which actual experience has been very close to expected, somehow. There is a trend towards rate guarantees on the individual side, and I generally don't recommend any increase in rates to provide for that extra risk.

MR. MUNSON: I recall that a couple of years ago the regulators debated long and hard with a number of people about rate stabilization. It was observed that maybe it isn't that bad to guarantee rates for a short time (whatever short is). That is, if one doesn't low-ball premiums, or do guarantee rates unprofessionally, or with lack of information, they ought to be fine for a little while. Another comment heard a lot was that maybe the regulators should permit increases in rates for morbidity changes, but not for interest, maybe even lapse, or expenses, because, after all, actuaries price many other products with those assumptions quite fixed and guaranteed. After they went through a lot of debate about that, they didn't absolve those assumptions from possible future changes. Vince, you commented on the wide range of lapse rates that companies have. Have you experienced or been involved in any companies where lapse rates are greatly reduced and they are refiling and are regulators taking a dim view of that? In some states, I think regulators have been troubled by lapse rates that have a sudden drop (maybe by half) from an initial filing. The regulators have had some trouble with some companies who wanted to change rates for that reason.

MR. BODNAR: There have been relatively few rate increases in the market, and it's usually because they tend to be the high-lapse companies that are suffering from antiselection, or it's an earlier product, where the product is simply underpriced. The gatekeeper wasn't worth what they thought it was worth.

MR. ALOISIO: I haven't come across any filings or seen any filings where low lapse rates have resulted in the company asking for a rate increase. I haven't really seen that. The low lapse rates tend to be observed by the bigger companies like AMEX and CNA. CNA did file a rate increase, I believe it was last year, and it was because it was an older product with a prior hospital requirement. So it was just an example of an older product.

MR. MUNSON: I'd like to ask Michael a question about integrating long-term care with other products and blending risks and charges, and getting there some day in this expanding universe. How do we get there? We've all been trained as actuaries, and regulators follow laws that are written as if we have health insurance, long-term care insurance, DI, and life insurance. They're all different and they're all separate. It's very difficult to blend those risks as we see the demographics and other things you mentioned. Do you have some hope that we'll be able to price, file, get approval on market, and be taxed on products in a more blended fashion some day?

MR. ALOISIO: The short answer to that is, no because of the current tax code, the current political structure, and the momentum and force it would take to get the kind of issues that prevent us from marketing this cleanly to customers, let alone the mathematics of the risk. I'm fairly confident that with the creativity of the actuaries involved, the risk management portion can be accomplished. But when you bring in the questions that relate to the individual purchasers, and especially tax situations, everybody is just stumbling over a section of the tax code. Until that gets fundamentally rewritten, or a champion comes along that can show somehow that these products will mean cleaner revenues to the government's coffers in some manner, I really don't see much of a future for our ability to bundle coverages within a single account. That's why I wanted to mention the virtual combined product that I think has a chance of succeeding. Actually, we're already in a state where the long-term-care regulation precludes, for example, increasing the premium for long-term-care coverage. That's very valid when the person is paying for the level-premium-type policies, but you can hypothecate an increasing premium sort of plan, just as you would have for life insurance rates. But we can't even start to go down that road due to the level-premium requirements.

MR. BODNAR: I see bundled products as not really taking off because the senior market traditionally does not like complicated products; the more you complicate it, the harder it is to explain. I just never see it taking over as the meat and potatoes of the long-term-care market.

FROM THE FLOOR: I'd like to elicit a comment on what I think are two perceived competitors to financing long-term care. The first would be at the upper end of the market, where many individuals consider continuing care retirement community (CCRCs). Many of these have associated limited-care-nursing facilities. My understanding is that these services are usually included in the basic fee. I'm wondering if this is a substantial barrier to sales in the upper income market. On the other side of the market, of course, there is this idea of self-impoverishment to qualify for Medicaid. I wonder if the billions of dollars we're considering cutting from Medicaid are likely to have a potential impact here. Will, in fact, the standard of care we provide to those who become impoverished markedly decrease as a result of the proposed federal cuts?

FROM THE FLOOR: Addressing your CCRC comment, I'm seeing many CCRCs and long-term-care providers banding together and looking to do managed care contracting. They're really trying to attack the private-pay market. Right now, a great deal of the revenues are coming in through Medicaid and Medicare, and they're looking to HMOs to get involved with joint ventures with Medicare-risk contracting. Many nursing homes own home health agencies, and CCRCs have doctors in home health agencies on staff. They look at themselves as being capable of providing the full spectrum of care for the elderly within their system. They're saying, why don't we just go after these Medicare risk contracts and get the $10,000 per capita from HCFA? I see the CCRCs doing this and I see providers banding together and doing that as well. I see it as potentially damaging to the individual long-term-care industry. As far as Medicaid goes, we're seeing a lot of social HMO experiments where an HMO will get the Medicare capita payment, as if it were a Medicare risk contract, plus a per capita payment from Medicaid once the person becomes eligible for long-term care. I see that doing a great deal of damage on the lower end. I do agree with you; it's very possible to see a big change in the industry from those two angles.

FROM THE FLOOR: I have one short follow-up comment. The panelist commented on the appeal of simplicity to many elderly buyers. One thing that was formerly much more prevalent, I believe, especially in the field of fraternal organizations, was the idea of simply, in return for an assignment of virtually all of one's assets, the promise of a lifetime of care. I wonder if a market is eventually going to develop where the insurance industry might be involved in, for instance, writing substandard annuities to fund this type of arrangement?

MR. MUNSON: The examination syllabus book on CCRCs for our profession has many interesting references to the early history of care homes, back when the cost of care wasn't as high as it is these days and the people didn't live as long. The CCRC market is interesting and challenging for our profession, and for a limited segment of the population who can afford it. There's often not complete coverage, but it may be a solution. A paper is coming out on how to evaluate a CCRC. Those with interest in that subject will want to take a look at the advance printing of that.

The NAIC has said we may have piece-mealed the long-term-care regulation too much, and it has caused some of the regulators to think twice about its nonforfeiture, rate stability, and benefit triggers provisions. Someone said publicly, let's step back and take a look at the future of long-term care 10, 20, or 30 years from now. Glen Pomeroy, Insurance Commissioner of North Dakota who chairs the Long-Term Care Senior Issues Task Force, said that. The NAIC members intend to have a discussion of that issue in San Antonio in December. Some of us hope that they will have that discussion, but we do not expect any miraculous answers because who knows what the long-term care industry or the CCRC's financing mechanisms will look like in 20 or 30 years? I suspect, Michael, that your comments would be of interest to them. You could at least put some thinking of the expanding universes on the table. I suspect you wouldn't mind if they looked at or you provided a copy of your remarks.

MR. ALOISIO: How can I say no? That's fine. I will put a plea forward for regulators to just realize that the world is dynamic. Any time there's an opportunity to reassess what made sense in the past, I'll be very happy to comment on how I perceive things currently.