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Managing Long-Term-Care Risks

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Summary: Speakers comment on the value they place on ensuring proper management of risk, contract preparation, underwriting, and claim handling.

Mr. Andrew M. Perkins: Long-term care is certainly a product line that involves a large number of risks. As we prepared for this session, we had to recognize that we're not going to be able to cover all the different types of risks which you, as actuaries, have to deal with. We're not going to be dealing, for example, with investment risk or with the impact of persistency. But there's still a great deal of material for us to cover. We have an aggressive agenda. We're going to try to cover issues related to product design, underwriting, claim management, and regulatory issues, and we may dabble in one or two other topics.

Long-term care has been in place now for a while. We still think of ourselves as a young industry, but there are a number of companies that have been in this business for a period of years and have had enough business to have a meaningful track record. It's good to see that many of those companies are doing quite well, with experience results that are quite close to what they expected and financial results that are close to what they were aiming for. Some companies have done

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better than what they had initially priced for in terms of loss ratios and other elements of their profit-and-loss statement.

On the other hand, there are also companies that have had real problems with their long-term-care economics. Some have had claim costs in excess of what they priced for, and that includes some fairly large carriers, though it hasn't always been a claim issue. They were companies that had been in the business for a while and had quite a bit of resources devoted to long-term care. I mention this just as evidence that it's not an easy product to manage. Long-term care has many different elements. As we all know, it's a very long-tailed business, so if you have problems, they may not show up for a number of years.

We're also all faced with a considerable competitive pressure in the marketplace. There are over 100 organizations that are offering some form of long-term-care benefits, and at any one time a number of those organizations are trying to do something better than the others, such as offering enhancements in benefit features or pricing, changes in underwriting method, or stretching a little further in compensation. All of that competitive activity just puts more of a premium on the people in your jobs making a good assessment about what all these things are worth, what the relationships are, and how to manage the product line.

Our first speaker will be Margaret Hottinger. Margaret is the vice president of the Long Term Care Group, which is an organization that focuses on the design, development, marketing, and administration of managed care programs in long-term care. The Long Term Care Group currently has programs covering over 50,000 people, and it continues to grow on a steady basis. Prior to joining the Long Term Care Group in 1992, Margaret was director of the managed care for the aged division at United Health Care Corporation, and in prior positions she did HMO research and served as the chief financial officer at Interstudy.

Ron Hagen, our second speaker, is someone who many of you probably already know. He has been very active in our industry. Ron is currently general manager of senior services, national businesses, and specialty products for Wellpoint Health Networks in California. In that role he oversees all aspects of Wellpoint's senior services programs, including sales, product development, and operations. Prior to joining Wellpoint, Ron was the vice president of product development and government relations at Amex, and I think everybody is aware of the leadership position Amex has held in the long-term-care field for a number of years. Before that, Ron was the director of insurance services at the American Association of Retired Persons where long-term care was one of its products. He has been very active in regulatory and legislative discussions affecting the long-term-care industry.

Ms. Margaret Hottinger: One of the goals in my presentation is to give you more background and understanding of some of the key factors that truly influence managing the risks of a long-term-care product.

Ron will talk in greater detail about product design and development and many of the issues that you face prior to launching a product. I will talk about two of the things that are more operational in nature and have a tremendous impact on managing your risk. Those two things are: (1) making sure that you have the right approach to select the correct risks to take into the risk pool, which we call underwriting, and (2) at the time people are requesting benefits, managing the benefit payment process, including applying managed care techniques.

Some of this is going to be fairly basic for people who have been working in this industry for a while, but we weren't sure exactly what type of audience to expect. We do know that there's a lot of new and renewed interest in looking at long-term care. We wanted to make sure we covered the whole gamut of the things people would be interested in. Let's discuss the basic premise of insurance. The concept of insurance is to spread loss over an entire group. Because the data that are used in pricing programs are the community kind of data, the group accepted in underwriting theoretically needs to mirror the community. There is an understanding, however, that, unlike group health programs, in group long-term care or even individual long-term care there is a person who has raised his or her hand and said, "I want this kind of coverage." There is a risk of adverse selection. One of the key goals and criteria of underwriting is to make certain that you don't get adverse selection and that your pool, as a whole, is basically mirroring your community.

Underwriting is also what keeps your rates affordable and the product attractive. Obviously, you can't allow everyone in who's going to go quickly into benefit, or the program as a whole and the product as a whole would have to be priced way beyond the reach of most people. In underwriting we try to look for and screen out people who are now experiencing the insured event and people who are at high risk in the near future of having an event. The Long Term Care Group's preference is that you do your work up at the front-end. You underwrite correctly so that you don't need pre-existing condition clauses at the back-end. Part of that is based on industry experience. When you are looking at a product that's based on a loss of functionality or cognitive impairment, writing pre-existing clauses and holding to them is fairly difficult at the back-end.

Philosophically, you have to look at what your product is based on, and your underwriting has to be geared to match the benefit triggers. We look closely at the functional and cognitive ability rather than focusing exclusively on medical conditions that people have, although the medical is still important to look at. You also

have to view the applicant as a whole and look at how the applicant is functioning and what his or her living conditions are like. It's important because you're basing your pricing and your product on industry experience and the experience that is in the data model. So it's important to use protocols that work with that experience in the field.

The biggest challenge for a long-term-care underwriter is trying to balance the need to get people into the risk pool and to keep the underwriting costs within the budget that is part of your pricing structure and still be doing an adequate job of creating a viable risk pool. That process can often be a challenge and works directly with some of the market forces that are at play. That's one of the greatest challenges that an underwriter has to face when he or she is looking at long-term care.

Again, the criteria that you use in approaching underwriting a long-term care applicant need to reflect the triggers for benefits and to be customized because there are different kinds of triggers in play and different kinds of products. Even though activities of daily living (ADL) and cognitive impairment tend to be the standard triggers, there are some programs that have medical necessity triggers or other types of triggers. Again, we evaluate the functional and the cognitive status, we look at the case as a whole, and we try to look for the potential of future loss in functionality or potential of future cognitive impairment; however, it is difficult to predict four to five years out into the future. And part of your pricing exercise will be to look at what kind of an underwriting effect you expect the program to have—how big will the impact be, and how far out will the underwriting impact the experience.

Our belief at the Long Term Care Group is that the more information you are able to gather on the front-end about that person and about their particular state of functionality and their particular medical conditions, the more people you're able to accept in your program. For example, sometimes it's not enough to understand that someone has had cancer. You need to understand the stage of it and the particular prognosis and particular treatments. In addition to that, you need to know how the person is functioning after that incident.

Obviously age has an important impact in looking at underwriting long-term care. People at older ages tend to have more frequent and multiple medical conditions. Much of that is known to the applicant's family and to the applicant, and you get much of that reported in the application process. The biggest issue that I think is facing long-term-care underwriting is the potential of a long and costly claim from a cognitive impairment, and sometimes detecting early cognitive impairment is not as simple as understanding the applicant's medical condition.

I'll just give you a few examples of some of the types of multiple conditions or co-morbidity factors that we see in underwriting an older population. For example, you often see hypertension with a history of a CVA and hip fractures. Then there are other types of conditions that have such a high potential future probability of resulting in functional disability that they become, for most companies, automatic decline conditions. In some states, and in some instances, you may actually decline some of these people with these types of conditions right from the application, and in other areas I don't believe you're always allowed to do that. Some states require specific ADL impairment, but the ADLs used in the Long Term Care Group are bathing, dressing, toileting, transferring, continence, and feeding. Also important in looking at the functionality of a long-term-care applicant is how he or she does in performing what's called the individual activities of daily living (IADL). We typically ask that question on our applications because the industry experience is that people who are losing the ability to be independent in those IADLs are usually likely to start losing the actual function of ADL. So it's an important thing to look at when you're trying to determine the functional abilities of an applicant.

As I mentioned before, cognitive impairment is one of the biggest risks in underwriting an older population for a long-term-care product. Table 1 provides some data on the industry as a whole and the role of cognitive impairment in both the nursing home population and the home care population. As you can see, almost two-thirds of everyone in a nursing home has cognitive impairment as a problem. On the home care side, it's not quite as strong, but then again the data in the home care programs are not as prevalent as some of the information we are able to get on the nursing home population. You can see that if you can find a means of detecting and analyzing an applicant for the risk of cognitive impairment, it's a important aspect to keeping your risk pool viable.

TABLE 1
ROLE OF COGNITIVE IMPAIRMENT

	Percentage of LTC Population with Cognitive Impairment
Nursing Home Population	62.6%
Home Care Population	37.0%–Severe
Qualifying for LTC Assistance*	16.0%–Moderate
	53.0%–Total

* Connecticut PAS/CBS Program

In assessing cognitive impairment, one of the issues is that it's not often picked up in a traditional medical underwriting approach. It sometimes will show up in medical records as references—the wife is reporting, for example, her husband's

having a few memory losses. But physicians, as a whole, are not attuned to, or as good about noting these facts, or doing much screening during office visits. Therefore, the industry has developed some techniques for earlier detection of cognitive impairment that involve actual assessment. The best of those, the gold standard, is really an in-person assessment.

We use a number of different tools as an industry for detecting early cognitive impairment. Obviously, at some point cognitive impairment will show up in medical records, and in those cases it will be easy to detect. The big challenges are the ones where it's really just starting to manifest itself, and that's where we've done a number of things. Obviously, we have our underwriting guidelines and our manuals designed to look at the cognitive impairment potential, to look at how to detect it and to make it clear that functionality is an important component of understanding a medical condition. We use a detailed application form. We ask a great deal of questions about how people are performing on their IADLs and their ADLs as well, and we ask questions geared at their activities and the amount of and kinds of things that they're doing. What is their lifestyle? In some states, again, there are different restrictions about what you can ask, but generally much of the industry will ask questions related to those types of issues, trying to get at how this individual is functioning, and whether there is any evidence of a diminished functional capability either through cognitive impairment or for other potential reasons.

Let's discuss other sources that the industry uses. There are quite a few telephone interviews being used, and different insurance companies and different underwriters each have their protocols about when to do telephone assessment versus in-person assessment. Some of it is based on age. Some of it is based on underwriter discretion. Some of it is based on how the applicant answers certain questions on the application. It varies across the industry.

Medical records are also a tool that underwriters use in assessing long-term care. Again, that depends on different organizations and what their particular approaches are. The Long Term Care Group prefers to have three years' worth of medical records on everyone that's 65 and older. We have sometimes discovered evidence of cognitive impairment in the medical records that doesn't exist in other risk management sources. The problem with medical records is that you are pushed to make a quick decision, and sometimes ordering medical records takes some time; however, it's well worth that extra time. Again, there's also a balance of how much money you want to spend on underwriting versus other things. So it's always a decision that the internal organization needs to make about assessing its risk.

These are some well-known cognitive screening tests that the industry uses. I have asterisked the ones that I believe are most common, and I believe some research that was done by Cologne Life Reinsurance Company will bear out that these are commonly used by a number of long-term-care carriers. There's the Short Portable Mental Status Questionnaire,* the Mini-Mental State,* the Short Test of Mental Status, and AVLT.

One of the tests that we like to use at the Long Term Care Group in looking for early cognitive impairment claims is the delayed word recall. Actually, that showed up as one of the most popularly used techniques in the industry in Cologne's research. In terms of a telephone interview, we use underwriter discretion on the spot in phone interviews when using the Telephone Interview of Cognitive Status, which is a Folstein test. We found that to be effective when you're on a phone history interview where your protocol doesn't call for a face-to-face assessment for that particular person. If the underwriter suspects something is amiss, he or she can use these questions to make an on-the-spot cognitive assessment. For the most part, these questions are fairly standard types of things, and all of these tests have come out of different experiences and different types of research environments and settings. I don't think that there is any one right way to do it. I think that, for the most part, the industry and each of the underwriting departments within organizations have developed their own approaches and have developed what works best for them. We certainly have a belief in a particular approach, but I think that's discretionary.

That gives you a flavor of how we approach long-term-care underwriting. It is different in a number of ways from underwriting other products because of the functional approach and looking for early detection of cognitive impairment, which I think are the two key things that really differentiate long-term-care underwriting.

The other component of managing long-term-care risk that I wanted to discuss is a managed care approach to long-term-care claims. We define the managed care approach for long-term care as a blending and managing of both the informal and the formal long-term-care delivery systems that will maximize the system efficiencies and the plan benefits, to provide an enhanced quality of life for the person who's in claim. Second, it will maximize the value of the benefit dollars because most policies in the industry right now are not unlimited lifetime policies. It's important when you're working with someone who's going into claim to look at the issues of how much dollar coverage he or she has and where the caps and limits are, and try to make sure that those dollars are used most effectively because that person may be facing a long and lengthy type of situation. That's part of the goal of actually managing long-term-care claims.

Then third is the containment of costs. It is important from the perspective of the insurance company to do that, but there are other elements to trying to deliver a full component of managed long-term care that are beyond just trying to keep the costs lower, and I think that translates into trying to achieve a higher quality of life for the person.

The first step in doing any managed long-term care is really the same step as doing claims payment for any product, and that is determining that the person meets the benefit eligibility requirements of the program. Typically, that would be functional and cognitive impairment triggers, and some programs also have medical necessity requirements as well. In doing that, your assessment tools and your ability to look at functional deficits need to mirror the contract. To the extent that your contract specifically defines an ADL deficit, you need to have all your tools and everything designed to mirror the contract language. In addition to doing in-person assessments, we also will frequently access, to the extent possible, the provider medical records, sometimes even police reports or other types of tools that allow us to look at the full situation and the information that we need in order to make a fair and impartial eligibility determination.

There are some things we look at in assessing benefit eligibility, which are, to some degree, the same things we've talked about in underwriting on the front-end. The IADLs are cooking, handling money, shopping, cleaning, taking medicine, and getting around.

Some of the steps of assessing benefit eligibility are needed whether you have a managed care product or not, and others are only needed if you have a managed care component to your long-term-care program. Obviously, even without managed care, you need to have an eligibility assessment to make sure that somebody has met the criteria in the contract for receiving benefits.

If you have a managed care approach to long-term care you would also collect information that will help in the care planning process. I want to make an important distinction between getting information and having your assessor actually discuss potential care plans on the spot. You need to be extremely cautious in what role you give your care advisor in this whole process. You do not want the care advisor implying that the insured is eligible for benefits. You don't want them in the position of making that determination while they're in a person's home. It can be a tremendous conflict of interest for that on-site advisor. It's much better to have that decision come from a secondary source who reviews the information that the site advisor is collecting.

Once the person is determined to be eligible by that secondary source, then the actual development of the care plan can be completed, including looking at the different provider options and potentially even adding in, if you have one, a preferred provider organization long-term-care network.

Then you can also add in the possibility of having the whole provider selection part of that network, or just working with the family. The care planning process is actually a very interactive process that involves a lot of give-and-take because an important part of any care plan, other than the straightforward case where someone is completely institutionalized, involves a balancing of informal and formal care giving in a way that best allows someone to remain as independent as possible for as long as possible.

Clearly, you have to work with the family and basically negotiate a care plan that works for everyone, including the insurance company's interests. Then, the next step is the ongoing claims adjudication which includes looking at the claims that come in to be paid and adjudicating them against the care plan. Obviously, there's benefit tracking, and you have to monitor all the caps and the benefit levels.

Then you need to set up a schedule for ongoing reassessment and eligibility determination. We would recommend an ongoing care advisor role in the program if people have that as part of their product features. As the condition may change, as incidents may happen, you may need a modification of your care plan. There can be a number of changes happening, particularly in the earlier stages of a claim, as people are either potentially rehabbing into other situations, or sometimes they have a downhill course. The latter situation is particularly likely if it's a terminal type of illness.

This is an actual case that we've worked on. In the programs that we administer we encourage early calls when you believe you're going to have a claim situation. In this particular situation, Mrs. O was hospitalized for a stroke and her family called to let us know. She was in a rehab facility for about three weeks, and we chose to let her go through the rehab situation prior to sending the care advisor to do a full care-plan assessment. There was some belief that she might rehab into a higher level of competence and that her care plan might be modified over that period. As it turned out, that didn't happen.

She was released from the rehab facility and went home, and this is still her current status. She has deficits in all of her six ADLs, and her care plan currently provides for a 24-hour caregiver and relief caregivers on the weekends. What's interesting about this case is that this particular person has a comprehensive policy that pays higher amounts for nursing home care than home care, but she still chooses to keep

herself in her home, even though it is costing her over $1,800 a month out of pocket. If she were to go into a facility, she would be completely covered. You can't remove the individual and their family preferences from the whole picture of long-term care.

The other thing that's interesting about this case is that the caregivers were put in place through independent providers rather than through an agency, which is not technically part of the contract that we're administering in this program. So it falls under what we call an alternative benefit. The alternative benefit is an out-of-contract arrangement among the insurer and the individual and their family that we will do something that is alternative to the actual contract as long as it meets the needs of all of those parties and is totally agreeable. In this situation she needs to have ongoing oversight by the care advisor because of the presence of an unli-censed provider in the home. It's an interesting situation because it points out the ways in which client preferences play into the actual care management of a long-term-care program, and it is also one example of saving the plan money overall.

I hope this at least gives you a flavor for some of the basic issues in managing risk both on the front-end of underwriting a long-term-care program and also on the back-end of actually paying long-term-care claims.

Mr. Ronald D. Hagen: I'm going to talk about a couple of issues surrounding some of the topics that Margaret has already talked about, specifically some of the product design issues and risks with long-term-care products and some underwriting risks and claim risks. I'll talk briefly about some distribution and sales issues that impinge upon developing, designing, pricing, and selling these products. I'll talk a little bit about the regulatory and legislative piece and what's going on in that whole arena as well.

Most of this information is from my experience, until three months ago, with Amex Life, which is the largest long-term-care insurer. Some of the issues that had been developing there, I believe strongly from conversations with others, are issues that the industry as a whole is facing or will be facing. First, we have this thing called dread-event mentality, which early in the development and pricing of what typically were facility-only products was a warm blanket at night for most long-term-care insurers. Specifically, the public as a whole, including the people who purchased these products, would move heaven and earth to stay out of a facility, given the general nature of nursing facilities. Their unattractive nature, their smell, and everything about being in one was negative. They were not a place live, but a place to go to die.

I think many people in this room would admit that some of that has changed in a fairly significant way. That there is something called antiselection, and I think we've certainly started to see it develop around unlimited or lifetime benefit plans on the institutional side. The simple fact is that nursing homes, skilled nursing homes, assisted living facilities, board-and-care homes, or any range of other less-intensive types of facilities where custodial long-term-care benefits are provided have become more attractive facilities. They have become places with the availability of unlimited or lifetime benefits that don't run out necessarily. There has been a great deal of that type of product sold over the last several years, both for institutional and home and community care benefits. They're easier places to put mom or dad.

Families seem to be finding it easier to make that decision in an environment where there are relatively much better and comprehensive products, where the institutional definition has been broadened significantly, and appropriately so, given the fact that custodial long-term-care benefits are starting to be significantly provided in places other than nursing homes and skilled nursing homes. Skilled nursing homes are increasingly starting to fill the gaps on the subacute care side, taking care of patients who otherwise would have been in hospitals. Similarly, board-and-care homes, assisted living facilities, alternate care facilities, and a whole range of other institutional providers are starting to pick up that more chronic, long-term, custodial need.

Let's briefly discuss the other benefits in these products. We talked about home care. Specifically we are talking about skilled home and community care benefits, physical therapy, occupational therapy, and skilled nursing visits in the home as opposed to homemaker and chore services or personal care services. This is really the custodial care component, and when you talk about personal care, this means hands-on care. This doesn't mean homemaker services in the personal care context of housekeeping or chores around the home—the IADLs that Margaret was talking about. I think there are some real issues that we can talk about at some other time, like whether on a long-term basis the legislative mandates in California make much sense, given the long-term care and hands-on care that's being promised in these policies and in some of the mandates. What they have done there regarding adult day care, medical and social models, and respite care is interesting.

I believe, and I think there are probably others who share this belief, that there is and continues to be a significant risk in selling stand-alone, home healthcare policies. Those policies cover a range of skilled, intermediate, custodial, and personal care services, and that risk comes from a simple fact. Certainly there has been some significant marketing appeal with these policies, and there have been

some pricing problems. Many of the companies that offer stand-alone home care continue to have some price stability issues surrounding those products.

What's more important than anything else is the typical way the products have been sold. It has not been unusual for somebody who's purchasing this policy, whether the agent says it or not, to think this product will guarantee or at least help them stay out of a facility and not have to go into a nursing home or into some kind of institutional setting. In fact, in most cases these products, even given the comprehensive benefits that are available, are only delaying individuals from being institutionalized, especially those who are at significant ADL or cognitive deficiency levels. There is a truth-in-advertising, sales and distribution risk issue there. I suggest that many of those people selling those products will ultimately, in courts of law, perhaps be liable for paying the institutional benefits, even though they're not part of the policy, because of the way the product was sold or because of how the person understood the product when he or she bought it.

There has been a great deal of discussion over the last several years about the Medicare program and what impact it has on long-term-care policy design, risk management, and rating. On the facility side, to the extent most companies now are coordinating benefits with Medicare, the impact has been relatively limited, although there is some benefit on the pricing side. The impact, as far as assumed risk and needed premium, has been huge on the home and community care side and will continue as long as we continue to pay out, as we did last year, some $16–20 billion a year in home care benefits under Medicare. It will also continue as long as those spending patterns continue to grow at 40–45% annual rates, and until there's some kind of Medicare reform that takes a look at the types of benefits that are being provided under the Medicare program, and whether they are, in fact, part-time, intermittent, skilled types of services. The biggest growth component of the Medicare home care benefit is in the homemaker/chore type services, the custodial, personal care stuff—the nonskilled area. That's where we're seeing the greatest growth pattern as far as visits per beneficiary and dollar amounts as well. That has a significant impact. I'm sure there are many in this room who know better than I do precisely what the impact is, but, in the absence of being able to coordinate, if you will, or shift some of these home/community care costs onto the Medicare program, you could have to reexamine the adequacy of the rates.

Even President Clinton has proposed, as part of his Medicare reform proposal, that we move the Medicare home care benefit to Part B (which is generally 75% financed by the general taxpayers) from Part A, because it would have such a significant impact on the solvency of the Part A trust funds and allow those funds to last somewhat longer than they would otherwise last.

The issues around ADLs may be repetitive. One of the issues that Margaret touched upon that we probably should talk about briefly is this whole issue of medical necessity and injury and sickness triggers, sometimes also euphemistically referred to as complex yet stable or complex and unstable. There is a certain core of people who do not have the requisite (typically two) ADL deficiencies, however those are defined and however the cut points are established. They are not significantly cognitively impaired, yet they need to be in a facility because of some underlying medical condition. Initially, there was a fairly broad trigger here, the third of three triggers, but that has been tightened up by most companies lately. There were very real possibilities for the individuals' physician to play games, and to use that trigger as a way to get people benefits who otherwise would not be sufficiently disabled to get benefits. Do those people need to be in facilities? Yes, probably so. There are probably anywhere from 5–20% who have no underlying significant cognitive or ADL deficiency yet need to be in a facility. What we've seen here is a fairly significant tightening up of that trigger as we've tried as an industry to get control of this whole benefit eligibility process and still allow the individual's doctor a voice, but not necessarily the final say.

I've already mentioned antiselection. Whether that's the appropriate way to phrase it or not, it certainly relates to this whole dread-event mentality. In many companies, over half of the individuals who had purchased nursing home products or even comprehensive products have purchased lifetime or unlimited benefit plans. There certainly is an emerging issue to consider with that, and it relates, I strongly believe, to the general view of families and individuals who make decisions about placements in those facilities and how they are becoming nicer, more acceptable places. I always remember there were a number of assisted living facility publications and continuing care retirement community (CCRC) publications that would come across my desk, and I wanted to make sure our actuaries never saw those publications. They portrayed these facilities, and accurately so, as quite different from what we thought about nursing homes 10, 15, or 20 years ago (or even more recently than that). They're not that bad anymore.

Another factor is certain geographic areas where there's high nursing home bed ratios relative to the population of seniors 65 and older. There are certainly some states where I think the industry as a whole has experienced some loss ratio problems, to the extent that there's adequate experience out there to look at. These are states where we see high bed ratios and high provider availability. There is also probably an issue with states where high daily benefit amounts and maximum benefit amounts are purchased. I think that's something we need to be watching over time as well.

Quickly I'll touch on some of the underwriting issues. Certainly there has been a progressive development of doing face-to-face assessments, in large part, I think, because of the need to screen cognitive risks better. It's an expensive part of the underwriting process. Nevertheless, we've seen a constant downward trend in the ages at which applicants are screened face-to-face. The delayed word recall and some other tools that have been developed seem quite effective in screening for early senile dementia or Alzheimer's claims, which as you're probably aware can be for significantly higher dollar amounts than other ADLs or physically impaired-driven claims can be. Actually at Amex, when we started using that tool, it had a fairly significant impact on some of the quick claims for Alzheimer's and senile dementia that we were seeing. Typically, I think we also need to be getting medical records even though it does take, as Margaret said, a significant amount of time.

It's interesting how many companies are using many similar underwriting techniques. Underwriting in this business, I believe, is an art, not a science. It's funny how declination rates by company can vary significantly depending on how much input they're getting from their field force. I'm not always convinced that all of this is as precise as we would like to believe or the state-of-the-art here is developed as fully as we would like it to have developed. There are a large number of borderline cases here that can be decided one way or another. In many cases, getting more information can help you make a positive decision that many underwriters perhaps would not make in the absence of that information. The face-to-face assessment helps not only on the cognitive side, but it certainly also helps on the ADL piece. If you talk to a person, if you see that person mowing his or her lawn when you walk off the street to the house, we think that's fairly important, even though it is a costly piece of the underwriting process.

Just a couple of other brief items. There are starting to be some data developed that would indicate ready, willing, and able spouses or significant others in the home can help. Spousal discounts can be justified, other than merely writing two policies at the same time and have some expense savings associated with them. We're going to have to see how that develops. I think spousal discounts have been used as a fairly effective marketing tool by several companies.

Housing type is a significant issue. Certainly you want to know if the person is in an independent living or a supported living environment. Whether there are homemaker/chore aides, home health aides, other kinds of supportive individuals able and ready to help in a retirement housing, CCRC, or other kind of supported living environment is something that most companies ask on the application, and can be a significant issue.

Let's move into claim issues. I think there's a real question when we talk about care management and managed care in the long-term-care environment, whether there really are any true managed care products within the context we typically think about on the acute care side. Certainly there are comprehensive, integrated, long-term-care plans that require plans of care, and that integrate informal and formal caregivers. I think that's important. I don't think we've really gotten to the point yet, as an industry, where we've tried to link that up with network development, provider relationships, and contracts. As the industry develops its care management approach, some of the quality assurance issues need to be addressed as well.

There's also the issue of whether the care management benefit really is a benefit or a claim adjustment expense. In most states it can be considered a benefit and subject to the loss ratio issues and requirements of the state. Certainly it makes a lot of sense to structure something here that's a win-win for the customer, that saves otherwise limited benefit bank dollars, that gets the person to the most appropriate lowest level of care, and that the company benefits from as well as the customer.

It's important to get people into your care management system, to have your assessors and care managers doing plans of care, to talk to people early, and to manage all of the different care sources (informal and formal). But I think there are regulatory issues here that will surface at some time, if they aren't already surfacing, as to what this care management benefit is. Who really benefits, what kind of limits should it be subject to, and what kind of definitions and standards need to be in place?

Early assessment and involvement in the care management process and intervention to manage the claim risk are important. A number of companies are looking to get a care manager in the hospital talking to them before discharge. Getting early information to people so they know what the claim expectations are and can manage those expectations is helpful. This is often done through an information and referral benefit, a social worker, or medical social worker who can help work through some of these issues with the family, get an assessment done if that's necessary, and help get the family information on a variety of public and private services and programs in a given community.

Another issue is about whether home and community care benefits actually serve to substitute for more costly institutional benefits. I think you're going to continue to see very comprehensive home and community care benefits in these policies with fairly reasonable pricing as long as Medicare keeps its pocketbook open. But I think we're going to see some restrictions being placed there. We do have a disclosure issue with these policies that are offering fairly broad and comprehensive home and community care benefits. Especially when Medicare's paying a big share of those

through coordination of benefit provisions. There is an issue about what the policy actually is paying for and where the risk premium is actually going. Many people in this marketplace continue to buy these comprehensive, integrated products primarily for the home and community care benefits, not the institutional benefits where their risk really is.

Medicare nonduplication is a regulatory and legislative issue that the federal government has been attempting to address for a number of years now. In essence, most long-term-care insurers have historically been in violation of the letter, if not the spirit, of federal law by selling policies that coordinate with Medicare. There was some poorly worded legislation that was passed about three years ago, and although repeated congressional attempts have been made to correct that, there is still an issue there. To the extent that our federal government decides to take a look at the policies that are being sold and those that coordinate with Medicare, in particular, there is a potential impact on benefits and on the overall rate of the policy. This is an issue that needs to be addressed as quickly as possible. But given the fairly strong back-and-forth that will occur politically, I doubt we're going to see any quick movement on it.

I mentioned there are some distribution risks. There are two primary ways of selling the product. People are more often looking at career or captive distribution systems—people who are totally expert in and involved in selling only long-term-care insurance. It's a product that is sold, not a product that's bought. It's a difficult product to sell. There's a great deal of denial and risk aversion. People still don't understand the need for the product. I think that there's a lot of pressure that's typically put on those captive agents to come out of a household with an application. They don't have other products to sell that individual, and it's a costly process that takes quite a period of time. Three or four hours is not unusual for someone to talk to an individual applicant. Going back a second or third time is not unusual.

When you look at independent agents, they tend to be more casual producers and there's often a knowledge of risk. They may not be as knowledgeable about how Medicare and Medicaid interface, what the products actually pay for, or how the long-term-care-provider system works, and other issues.

Replacement activity is a fact of life. There is a general feeling that any product that was sold more than three or four years ago probably is not a good product and deserves to be replaced. There are a number of problems with that. Not all companies provide credits and discounts to facilitate that process. Therefore, a person buying a new integrated, comprehensive product probably is going to pay a significantly higher rate because they're older and probably because the benefits are more comprehensive. Another factor to be aware of is that there are a many states

now that have rules in place that provide a strong disincentive for an agent to go out and replace a policy, given the commission that can be paid on a replacement.

I've been away from the regulatory front for a couple of months now, but I don't think the issues really have changed all that much. What we typically want to be talking about regarding long-term-care products is the value of those products in the marketplace. From the perspective of a regulator what's the benefit, and how do insureds obtain it?

Unfortunately, we've been caught up over the last several years talking about mandatory nonforfeiture benefits, rate caps, and premature movement of the product to noncancellable policy forms. We've been caught up with issues about group versus individual, disclosure issues, and marketing and sales issues. We've been caught up in risk-based capital, to some degree. Again, we need to look at how those products are designed to have some standardization of things like ADL definitions, policy exclusions, and limitations, and allow companies to compete and continually evolve and design better products. We're not at the end point in the product evolution process.

I think, unfortunately, many of the regulators and the NAIC have been caught up in the issue of whether there has been some gaming going on in the pricing of the products. They asked themselves, "What can we do to solve that problem?" Their answer was to just put rate caps on the product. Let's not look at the underlying assumptions that companies use when they file a product and rates. Let's not develop grids or other approaches that can facilitate the review and approval of those products. We're too concerned about older people getting products where they're going to see the rates go up fairly soon thereafter. It's kind of a broad brush, meat ax approach, and there are certainly some concerns about this on the part of companies that are in the business, or may want to get in the business in a bigger way. That, along with mandatory nonforfeiture benefits, are two things put in the NAIC model several years ago that continue to be resisted by this Congress and others, and hopefully they will not end up included in any kind of standards and tax-incentive or clarification package. There has been off-and-on discussion about changing those two items in the NAIC model. I doubt that will happen any time soon, but there's always a chance that the NAIC model gets incorporated in federal legislation, which would be an obvious, significant issue.

Where are we as a whole? First, you have an incredibly untapped market here. You only have about 3% of folks over 65 who currently have a policy. There are probably a little less than two million in-force policies, although many more have been sold. We have seen repeated efforts by Congress to pass tax clarification incentive legislation, such as the Kennedy-Kasselbaum bill. It probably doesn't

have the best chance to pass. That means we'll probably be back at it again next year with a new Congress, trying to do this all over again.

I think we're likely to see continued good growth rates in the individual as well as the employer group business. Certainly the edification effect of tax incentives or clarification legislation passing would be very helpful. Certainly state and federal governments committing to communicating with the Medicare population, as well as the preretiree group, about the limits of government programs would be helpful. How likely we are to see that remains questionable. But I think this business, which is most often individually bought by those over 80 years old, at this point, probably will continue that way for the foreseeable future, while growth rates on the group side will continue.

There continue to be very strong "consumer advocate forces," who continue to believe that this is a product that the private sector has failed at and will continue to fail at. They believe that a government solution in whole or in large part still is the only answer and will continue to create significant roadblocks at the state and federal level as we attempt to evolve these products and make them more in tune with the needs of an ever growing, aging population.

Mr. Roger J. Gagne: I work in the group long-term-care area. My question is about insured choice. Both Margaret and Ron talked a lot about managed care in the context of long-term care, and in my background in medical managed care this meant utilization review and limitations on what you'd get for benefits. In my experience so far, in the group area at least, our insureds have very much wanted the choice of where they go, and as Margaret had said, insureds will move heaven and earth to stay out of institutions. It's usually a cost effective win-win situation. Do either of you, Ron or Margaret, see an evolution towards a true utilization review approach for long-term care? I'm not familiar with the individual side, but on the group side, it's not happening now. Perhaps when employers start contributing that might be of interest.

Ms. Hottinger: I think the fundamental issue is whether the managed care component of the product is voluntary or mandatory. Is a plan of care required, and do you have to adhere to it, or is it a voluntary benefit? We have programs that go both ways, and we even have a program that has one plan that's mandatory and another plan that's voluntary. Our experience, interestingly enough, has been that the voluntary benefit in most cases is accepted, and people want it. I don't think the industry as a whole is at a point where it can really mandate it and be viable in the marketplace, particularly with an individual product. I think some groups can get away with that.

Mr. Hagen: I agree.

Mr. William P. Bigelow: I have a question about the case study that you described. My understanding is that the person was getting their maximum benefit from home care. The question has to do with how you required them to have a case manager because of the providers that they were using. My question is how is that case management paid for? Was that paid for by the insured?

Ms. Hottinger: It's a benefit. It doesn't go against their daily maximums or their caps.

Mr. Thomas C. Foley: Before last October I was with the Florida Insurance Department. I've been very actively involved in the NAIC. Ron and I have gone around and around. I would like to second the challenge that he threw out. I've tried for the last several years to get industry to come to the table and talk about alternatives to loss ratios, to talk about ways that would allow this industry to open up, and I can't get people to come to the table. I have a couple of questions also.

I've been intrigued for a long time about the concept of the changing attitude that people have as they get older. I continue to think of examples of Person A and Person B who have the same physical and mental things wrong with them. "A" copes very well with life independently; "B" doesn't. My question is, have we made any inroads at all, either in the underwriting process or education process, both with the insured or with their helpers, in trying to measure this difference in attitude? Some people clearly are going to work independently, and others aren't.

Second, I agree with Ron, and I have screamed as loudly as I can about stand-alone home healthcare policies in Florida. I've recently heard about a capitated home healthcare product that has been approved in Florida. If anyone else has heard about this, you might have a discussion or at least you might think about that concept.

Mr. Hagen: I haven't actually heard about that, Tom, but certainly your comments about attitude are significant and important. As we attempt to coordinate informal and formal care and support services, the family typically plays a very significant role. Different people have different coping capabilities, too, and that's why I think it's critical that in the process of assessing an individual and making an ongoing reassessment of the individual's needs that you ensure you have people who are capable of doing that. You can't just have anybody. The unfortunate part about that is it costs when you have very capable people doing it. They need to have experience and know the long-term-care system and really be able to tailor packages to meet people's needs. But I think you're right. I think we need to think

about attitude a lot more. A positive attitude has a great deal to do with what those needs are and how they evolve over time.

Ms. Hottinger: I agree with Ron and with you as well. One other additional comment I would make is that I agree with Ron when he said that long-term-care underwriting is still more of an art than a science. I think that goes back to the point of how you can look at two applicants for insurance at the front-end, both who have the same conditions, the same ages, and yet you can see tremendous variation in their functional capabilities and how they deal with those situations on a day-to-day basis. That's the point. Information gathering is an important part of the front-end. You must look at that individual situation. Actually that's one of the reasons why all of us believe very strongly in using people with experience. All of our underwriters are nurses and have experience dealing with the long-term-care population. The approach is very different for a 75-year-old than a 60-year-old applying for something.

Mr. Hagen: In addition, I know there have been some experiments or pilots, if you will, going on among companies that are dealing with younger individuals, in this case those that are 55–65 years old. They may have a multitude of other products available and are looking for the asset protection piece with long-term care. Yet they're troubled by having that person wait 45–60 days to go through an underwriting process that involves getting medical records and other information like that. They may even do a face-to-face assessment, but they're not going through the process necessarily of getting medical records on every applicant. They are seeing if they can't work that through for the younger folks without doing that. It's more of a customer service issue. I'm not sure how that's all going to play out. I guess it gets back to how important you feel it is at those younger ages that complete medical record copies are available.

Mr. Perkins: Tom, regarding your question about a capitated home healthcare product, we have a client that's filed such a product in Florida. My impression is it doesn't have final approval yet. I'm not sure if it's the same situation you're talking about, but given that it's a client, and also it doesn't have products available to sell yet, I don't think it's something we can talk about. My impression is that, as Ron was saying earlier, there are some geographic problem spots for the industry and for some companies. Home healthcare in Florida has been one of those problem spots. My understanding is that both the company in question and the department have been constructively trying to find a better way to do it.

I had one other question I wanted to pose to the panelists on the subject of ADLs. I've heard the opinion expressed by some of the people in our profession that it may not matter that much how many ADLs you use. The thinking behind that opinion, I

believe, is some combination of the fact that there's some judgment in the assessment process, and second, that the people doing the assessments are often people who have been trained as caregivers. It's not in their mentality to look for a way to deprive the person of benefits. Third, the insurance companies or organizations providing the coverage tend to have a reluctance to challenge a claim if it's a close call. I'd like to ask both of you for your reactions as to how strong a difference you think the number of ADLs makes.

Ms. Hottinger: I would like to believe that it will hold water and that you have to establish your cutpoints and definitions. You have to train and use standardized tools and methodologies, otherwise you will be subject to many appeals. If you don't have fair and impartial collection of the information and establish standards for judging people equally, I think that you can run a huge risk in the future. That's my own personal belief. I think it is possible to establish protocols for gray-area types of claims and recognize that the world is imperfect. I also think it's very important that the person who's doing the collection of the information and the assessment is not making a benefit eligibility determination. I think there's a huge conflict of interest situation if you have a care advisor in the home collecting the information, who is also making a recommendation. None of our care advisors in our programs do that, and they're able to say that to the person when they're asked. They only collect the information, and the home office staff who understands how to interpret the information using the standardized tools that those people have been trained to use make the determination.

Mr. Hagen: I agree with everything that Margaret just said. There certainly have been some games played with the use of ADLs. Certainly the bathing and dressing is an issue. I think there's starting to be some movement. Believe it or not, this came up during the congressional consideration of the issue because they were trying to figure out what the right set of ADLs was. What's maybe an even more important question is how you set the cutpoints and how you determine disability or impairment levels relative to the need for ongoing human assistance. I think that all will be relatively standardized, at some point. It has to be because companies shouldn't be competing on the basis of who uses bathing as an ADL. Therefore, it maybe has a little different pricing approach, and who doesn't?

There are six standard Katz ADLs that I think many people in this industry or in the provider community have recognized for a while. That's what we should be using. And we probably should set some upper bounds or limits on how disabled you have to be. Total and complete disability probably isn't what we should be talking about here. Similarly, the other end of the spectrum probably doesn't make much sense either relative to the continued affordability and availability of the product.

Ms. Kim H. Tillmann: I have a follow-up question for Margaret. You've said a couple times how important it is to have the person who is assessing be separate from the person who determines eligibility. I'm wondering how it's set up so that the person doing the assessment is prevented from getting knowledge in how the eligibility is determined. If they know how the things they write determine eligibility, how can they avoid being involved?

Ms. Hottinger: You don't give them the cutpoint information. You give them enough skill and training to collect the information in the way that you need to have it in order to interpret it and you apply the cutpoints against it.

Ms. Tillmann: So are they from a separate company?

Ms. Hottinger: In our programs, at least, they're a separate vendor organization. I don't know that there's anyone at this point with enough long-term-care business to have the ability to have their own network of employed people in all the communities where you might have a long-term-care applicant. I suppose it's possible. I haven't heard of it yet, but we do use vendors.

Mr. Hagen: Certainly there needs to be protections put in place, not only for agencies who do the underwriting assessment, but also for the ultimate claim assessment. They can't also be a provider of service. It's like having a home care agency do a care plan. Surprise, they're ordering a lot of home care. Those kinds of protections need to be in place and, frankly, it is difficult in some rural areas. I know the network we used at Amex is a good broad network, but it's not available in every town in North Dakota.

Ms. Hottinger: I don't want to imply either that every single case requires an in-home assessment. That's not always the case. Often you have enough evidence to know the person is eligible without having an in-home assessment.

Mr. Hagen: Right. It's a costly process to go through if you don't have to.

Mr. David P. Mamuscia: What's happening with group sponsorship? Do you see much group sponsorship with long-term-care plans, and, if so, do they result in less expensive premiums or anything like that?

Ms. Hottinger: We administer, to my knowledge, the only two self-funded, group long-term care programs in the country; and there's some tremendous advantages I believe to a sponsor to use a self-funding vehicle rather than a fully-insured vehicle. I see a great deal of future potential and excitement around the concept of group sponsors looking at self-funding as a viable option for creating a long-term-care

program for their populations. I think the evidence in the industry is the group market is still strong. Some other people could speak to that in this room. I know several of the people who came to the microphone are big players in that marketplace, but I think the interest is there, and I think that the excitement about long-term care has been growing in the last year. If proposed legislation can help get it in the forefront, I think it will help the whole market.

Mr. Hagen: I think Margaret's right. I'd like to make one last suggestion that we need to be thinking about concerning the products that we're currently making available in this marketplace. Are our products as appropriate for somebody 40 years old buying a product that will be used 40 years from now as they are for someone 65 to 75 years old buying them to use 5 to 10 years from now? I'd suggest to you the provider community is going to change radically in the next several years, even more so over the next 40 years. There's a real question about whether we have the right idea about what the most appropriate and flexible product is for that younger population. I don't think we do.