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Underwriting for the Senior Life Market

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Summary: Considerable sales opportunities exist in the senior marketplace for life products. However, insurance companies must change the traditional underwriting paradigm, which is largely based on the risk profiles of younger buyers. In this session, issues critical to successful underwriting of the senior life market are examined.

Mr. David Nolin Cook: John Yanko is vice president and chief actuary of The Forethought Group. David Rains is director of development and consulting with Security Life Reinsurance. Peter Komsthoeft is assistant vice president with ERC Reinsurance Life Corp. Peter is an underwriter. My name is David Cook. I am a consulting actuary with Milliman & Robertson. Our goal is to make you more familiar with the products and underwriting approaches used in the senior life market. We will describe product pricing assumptions and underwriting criteria for senior life products and provide information about the potential protective value of underwriting procedures used in this market. Where appropriate, our panelists will contrast senior life market practices with general market practices.

In the first part of the session, we will describe some of the important life insurance products currently written in the senior market. John will discuss the final expense

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and pre-need markets and the associated products. David will discuss estate planning products along with the needs and practices associated with that market. Peter will discuss several subjects, including extension of general market products into the senior age range, as well as the role and perspective of reinsurers.

In the second part of the session, we will describe underwriting approaches, underwriting criteria, product assumptions, and reinsurance in the senior life market. In the last part of the session, Peter will discuss the protective values of underwriting tests as they relate to the senior market.

Before we get started, let me describe the population we will be talking about. The senior life market is commonly thought of as individuals age 50 and over. That definition is too broad for today's market. The products we will discuss as senior life products are targeted at individuals age 65–70 and higher.

Demographers call individuals over the age of 65 the elderly. They subdivide the group into three different cohorts. These cohorts have interesting names. Sixty-five to 74 is called the young-old. Seventy-five to 84 is called the aged. And 85 and older is called the oldest old.

The population over 50 currently consists of about 70 million individuals and is the fastest growing segment of the population. If there is anything that truly defines this group it is its diversity. For example, look at the broad range of ages involved. Whether you define the senior market as age 50 and above, or age 70 and above, the range of ages is very broad. Employment status is another example. There are significant populations of full-time, part-time, volunteer, and non-working individuals in this group.

Although wealth is unevenly distributed, this population is relatively secure with the poverty rate generally declining. Geographic distribution is also quite variable. States have very different elderly populations. About 20% of Florida's population is over age 65, while in a number of states the percentage of the population over 65 is in the single digits.

There are also a wide range of health statuses in this population, with significant numbers of the very healthy, as well as the ill and frail. Heart disease is the number one killer. Seven out of ten elderly die of some sort of heart disease. Gender distribution is very important for this part of the population. The current sex ratio for males and females age 65 and over is about 39 males for every hundred females. At younger senior ages, the ratio is higher. For the oldest old, the ratio is substantially lower.

The senior population is also undergoing a great deal of social change, including extended life expectancies, lower overall mortality rates, and more individuals living alone or without a family caregiver. The incidence and prevalence of disease is also changing. This population is very interested in the results of research and application of research into diseases, particularly those of the elderly. Most of these trends point toward a more significant and more viable senior market in the future.

So how are life insurance companies adapting? Our panelists will tell us. The first presentation will address products in the final expense and pre-need market.

Mr. John B. Yanko: One of the larger expenses for senior citizens is the cost of a funeral. Many people pay cash at need or at the time of death. Others work out installment payments if they can. The main ways of funding the cost of a funeral are by trust, by life insurance, or by annuities. I am going to be talking about pre-need insurance, but there are other ways of funding.

In a funeral trust, an individual will go to a funeral home, prearrange their funeral, and remit the current price of perhaps $4,000 to the funeral home. The funeral director will then deposit the funds in a bank. Another approach is to divide the current price by 60 and pay in monthly installments over five years. The funeral director will deposit those installments in a local bank earning perhaps 2.5% interest. He may deposit the installments in a certificate of deposit (CD) of one, three, or five years. He can also pool deposits in CDs or mutual funds.

The reason I mention trusts will become apparent later. Of the amounts deposited annually to fund funerals, 50% goes into trusts. The market today is approximately $10 billion. Life insurance and annuities make up the balance of the market. Several phrases are used to describe these products: burial insurance, pre-need insurance, and final expense insurance. They are used synonymously by most people. I am going to try to make a distinction.

A little history. In the middle ages, there were societies, guilds, and craft organizations that provided a funeral benefit or service for their members. During the 1800s, burial clubs were formed; by 1850, there were over 200 such organizations in London. These differ from the first group I mentioned. These involved basically working-class people. They collected a levy or a premium, which might be differentiated by age, and it was collected weekly. This was much like debit insurance sometime later in the U.S.

During the same period, ministers in the U.S. got together and organized a fund they called death insurance. Some of these funds provided what we now know as

life insurance, although today's life insurance is much more sophisticated and refined than just providing death benefits.

After World War I, in the southeastern part of the U.S., burial insurance came into existence. Mutual benefit associations, funeral certificate plans, funeral debentures, and funeral trusts sound fairly antiquated, but a great deal of this business is still in place in the U.S. mainly in the southeast and southern parts of the country. The death benefit or life insurance payable under these arrangements was not cash, it was funeral goods and services. If a member stopped paying premiums, he would lose everything. There were no nonforfeiture values as such. New members are accepted, but no new associations can be developed or founded.

Another format is small face amount final expense policies. These whole life policies may be paid on a single-premium basis, but are usually monthly limited pay. The intent is to fund or defray funeral expenses. These products have a level death benefit, and there is no associated prearrangement contract. They are strictly a contract between the consumer and the life insurance company.

The preceding benefit funding arrangements and final expense policies provide a contrast to pre-need life insurance. First, in pre-need, there is an associated prearrangement contract. This is a contract between the consumer and the funeral home or the funeral director. The Federal Trade Commission regulates these contracts. The Funeral Rule, effective in 1984, applies to the contract between the consumer and the funeral home. The consumer can stop paying on the prearrangement, but in most cases the money goes on to prefund the funeral. In prefunding, single premium or three-, five- or ten-pay life insurance may be used. The limited-pay policies are usually paid on a monthly basis. The significant thing here is that the contract includes an increasing death benefit. That is a difference from final-expense policies.

Originally, many of these policies had a death benefit determined by a government index, such as the Consumer Price Index or the Gross National Product deflator. Others had a 3% increasing or 5% increasing simple or compounding interest rate. But most companies have moved away from such increase mechanisms and now provide increases on a discretionary basis to avoid excess reserves. Each buyer assigns the insurance policy to the funeral home. The funeral director then guarantees the price of the funeral so that it will be paid for by the insurance policy whenever death occurs.

Pre-need insurance is typically limited-pay whole life. Single-premium coverages typically have issue ages of 0–99. Five-pay coverages typically have issue ages 0–85. Ten-pay typically have issue ages 0–80. Single-pay premiums of $995 per

thousand are normal. The sum of the premiums on a limited-pay policy for $1,000 of coverage (if a person survives the limited-pay period) will typically be $20,000 or $15,000. Keep in mind there is an increasing death benefit.

If you sell these products, there are some things you should be aware of or work with very carefully. Make sure the policy is a life insurance contract and that it complies with Internal Revenue Code (IRC) Section 7702. If you have an index guaranteed in the product, conform with the National Association of Insurance Commissioners (NAIC) Actuarial Guideline XXV. Again, most companies have gone to discretionary crediting because of the additional reserves.

One other item you may want to take into serious consideration is the proxy deferred acquisition cost (DAC) tax. Most premium periods are single, three years, or five years. Death rates are fairly high in this business, and since proxy DAC tax is amortized over a ten-year period for a fairly large amount of this business, the company may still be amortizing when the insured is no longer living.

Returning to the trust held by the local bank, this gives leverage to the funeral home or the funeral director. The large pools of dollars in the bank provide the funeral home or director advantageous rates for other things such as financing a home, buying a boat, or other financing. However, banks are finding that this is very costly and expensive, and they are getting out of the business of handling trusts for funeral purposes.

I mentioned state associations, or I should have. In the U.S., funeral directors have organized within each state. A fair number of state organizations have their own trust members use for funding. Again, trusts can use CDs, mutual funds, or various other investments. California, Michigan, and New Jersey are among these states.

We have a sister company named Forethought National Trust Bank. It is a national bank in Batesville, Indiana. They received their charter this year from the Office of Controller of the Currency, and we are now funding and experimenting to see just what can we do with a trust. We have life insurance, annuities, mutual funds, and CDs inside this trust or national bank.

Pre-need contracts are irrevocably assigned to the funeral home to make a loop in the whole business structure. But there are some states that have a freedom-of-choice law where the owner and the beneficiary have the right to move funds whenever they wish. That being the case, it would be a conflict to have a contract irrevocably assigned when the state laws provide and allow freedom of choice. Companies must be careful how they do this.

We have a fair amount of business from public assistance programs, supplemented security income (SSI) and Medicaid, where insureds are spending down their monies. In those cases, you want your insurance contracts assigned. In Indiana, they changed the laws recently such that any pre-need contract must be irrevocably assigned to a trust. Once it is in a trust, it can be funded in many different ways.

If the death benefit of a pre-need policy is in excess of the at-need price (the then-current price of the funeral), the difference is refunded or paid to the beneficiary. If the death benefit of the policy is less than the cost of the at-need price, the funeral director has a shortfall or a reduced margin.

There is a lot of premium reporting required by various states, which is a carryover from the trust laws of many years ago. The prearranged funeral agreement is required and is under the control of the FTC.

The next part gets a little complicated. In most states, if you prearrange a funeral, it must be done by a licensed funeral director. In some states, a licensed funeral director cannot receive commissions. In other states, he or she can. There are licensing requirements on the part of the funeral director. In Canada, if you prearrange, you must use a licensed funeral director. And, in Canada, you must be a full-time agent to have a life insurance license. This is a conflict. Some of our competitors have found a way around this.

On the state level we deal with the Department of Insurance. We also have a fair amount of dealings with the attorney generals' offices for clarification of statutes or due to the different entities we deal with inside the state. We also deal with banking departments. In Texas they control what is happening in pre-need to the point that when a person dies we must have the banking commission approve every check before we can pay it. They do an internal audit; they look at the prearrangement; they want to see the contract at death or at need. They want a listing of in-force business, sales, and death claims. They come in annually and go into a great deal of detail. We also deal with the state board of funeral directors and morticians, which typically wants to approve funeral planning and agreements.

We have had the opportunity to deal with the American Association of Retired Persons and the NAIC because pre-need insurance deals with both senior citizens and the funeral industry.

To summarize, burial insurance pays in goods and services. Final-expense contracts are between the consumer and an insurance company and provide a level death benefit. In pre-need, there is a contract between the consumer and the funeral

director, between the consumer and an insurance company, and an irrevocable assignment with a guaranteed funeral price.

Mr. David A. Rains: I am going to talk about some products that we use in estate planning. I believe there is one major product in use, and the others have relatively minor roles. So we will focus on last-to-die insurance. I assume that everybody knows what last-to-die life insurance contracts are.

One of the primary reasons that last-to-die is useful for transferring or for covering estate taxes is that it takes advantage of a full, special deduction for taxes. When one spouse dies, his estate can transfer to the other without any tax or liability. At the death of the second spouse, the entire estate is taxed. The way this is normally done with a last-to-die policy is that the base amount is the projected tax liability, and the premium for that generally costs quite a bit less than the tax you eventually pay.

An irrevocable trust is normally used. Without a trust, the benefits would be taxable themselves. You would have to have a much larger base amount, a much larger premium, to accomplish what you were trying to do. It would still help, but it is not nearly as powerful as putting it into a trust.

If the beneficiaries of the trust do not have a right to the money at the time you put it in the trust, it is a gift for use at a later time and is not excludable from the gift tax. So there's something called the Crummey Rule, which helps. If the beneficiaries have the right to demand out of that trust a fair portion, for example, 50% of the premium paid into this trust, then you do not incur any gift-tax consequences. This is a much more attractive way to fund those policies.

I mentioned that joint second-to-die policies are an effective tool to replace wealth in conjunction with a charitable remainder unitrust. There is an income technique whereby one can donate assets to a charitable trust. It is a remainder trust, and what that means is that when you die, what is left in that trust will pass to the charity. You get a deduction because you are giving something to charity. It earns interest in the trust and that interest is paid back to you. However, the asset is gone. So, you can use part of the income that the trust is generating to purchase a last-survivor policy premium to replace the asset. This is becoming more and more popular.

There are other varieties of trusts. There is an annuity trust with a fixed payout, and a pooled-interest trust, where several people have put assets in the same pool and proceeds are paid as earned ratably over the donors' lives.

Individual life products may also be used. These are plain, ordinary life insurance products. However, someone worried about their estate may have a pre-deceased spouse or may have never had a spouse, and they have to fund estate taxes with a single-life product. Mortality charges for these products are quite a bit higher than for last-to-die, so they can be expensive.

The special riders for estate planning are not normally available with individual life policies. An example of a rider that would be available with last-to-die is an estate reservation rider. It amounts to a four-year term policy. I mentioned that the effective way to use a last-to-die policy is to put it into an irrevocable life insurance trust. If that is done within three years of death, it is pulled back into your estate so you do not get any of the benefit you anticipated. A four-year term insurance covers the contingency that you die early and you need additional protection.

Last-to-die is the primary tool that is used. There are a couple of things that are a little more esoteric and useful in more specialized circumstances. Group life insurance is potentially very effective for the employee-owners of the closely held business, especially with smaller amounts of insurance. The idea is the insurance is owned by the beneficiary of the insured, but the premium payer is the corporation or the closely held company. The premiums will be deductible, and a portion of those premiums will not be taxable to the employee, depending on the size of the policy. You do have to assign the rights of the policy absolutely, and you still have the three-year fall back into your estate to worry about.

The last and somewhat esoteric thing I want to talk about is a split-dollar plan. In the case of a major stockholder of a corporation, the beneficiary of that stockholder can buy an insurance policy, enter into a split-dollar arrangement with the corporation and obtain favorable tax treatment at the time of death. The entire proceeds are passed to the beneficiary outside of probate and estate taxes.

Mr. Peter Komsthoeft: Wonderful design, but it must get by the underwriter, right? We are the bad guys. The drivers and the need for coverage at older age have existed for some time and, for no particular reason, senior products did not take off until the last ten years. The reason is joint, second-to-die policies, and David alluded to that.

For a very rational reason, the underwriting community has felt uncomfortable with issuing coverage on people 75 and 80 years old. I don't know why, but along comes joint second-to-die, a nicely designed product, and we say, "Wow, this is great. Two people have to die before we pay out. This is clearly much safer than just one person." Never mind that the company is not collecting very much of a

mortality charge. We never talked to an actuary, so we did not know about that, and we started issuing policies.

I am being facetious only in part because there was a mental block against writing policies on seniors. They have experienced some mortality improvements in the last ten years without question, but not to the degree that it would justify the swing in what we are doing in the marketplace now in our treatment of old-age applicants compared to ten years ago.

The other point I want to make is that the motivation for joint second-to-die policies is the movement of money, wealth transfer, commissions to the agent, and all of that. The protective element is less important. It only comes to play in the anti-selective factors that we have to deal with. It is interesting to note that the only compilation of true data that we have is probably the Manual Life advanced age mortality studies.

On reinsured lives term products have the better mortality. I have a personal theory about that. On term we underwrite more aggressively because we are more acutely aware of the possible antiselection, whereas for cash-value accumulation products, we assume the motivation for coverage is intergenerational movement of money and we get lax.

There is really nothing magical about products for the senior market. They have the same behaviors. Everything gets a little bit compressed. However, there are some issues we must deal with specifically. I think we have to address them in conjunction with actuarial, underwriting, and marketing, together. We cannot do this blindfolded and locked in a room, not talking to each other.

One of the issues we are talking about is estate transfer. The purpose of a second-to-die policy is to transfer wealth. There is often no incentive to have the policy mature at a certain point. If it does, the person may still be alive, and we just complicate the estate problem. They wanted to get rid of the money and have it available at the time of death to pay the estate tax. As a consequence, the most successful designs do not mature or mature at a time that is more reasonable—110 or 115.

Retention management is very important. Companies have had reduced retention levels at old ages for a long period of time. Not until recently have many had to deal with determining their true comfort level.

My advice to anybody who may be working or consulting for a company that is looking to get into this marketplace is you must talk to the chief executive officer

and make it clear he or she must be prepared to support and pay early death claims, retained death claims. Real money will be going out within three to six months. Look very carefully at your retention. Also, look at commission structures. It is not uncommon to find commission structures that approach 100% or more in the first year. At old ages, such rates are difficult to maintain. The time period during which policies must perform and be profitable is greatly reduced. The agent should be prepared to participate in the process if he wants a viable product.

Underwriters must get comfortable with table ratings and extra mortality. Is our traditional way of approaching them a reasonable one? I will talk about that a little more when we get into the underwriting issues and the protective values.

Companies must consider what is a preferred risk at certain ages. As David indicated in his opening remarks, there are many subgroups in this old-age group. Clearly, there is one subgroup that is much better off. These people have a much higher likelihood of living a long period of time—20 or 25 years from the time we issue the policy. Companies need to find the tools to recognize those individuals and give them the best rates. Market pressure may force us to do that whether we want to or not.

Smoking statistics are interesting. Smoking does not lose its predictive values as applicants get older, but it gets somewhat blunted. I still have a great deal of suspicion. The 75-year-old person, upon the advice of his doctor, stops smoking and two years later should a company issue that person a nonsmoker policy? It does not seem to make a lot of sense. It happens, however, every day.

The gender distribution was alluded to. This is predominantly a female market, and it is a female-rich market.

Do not believe that you can underwrite post-mortem. Our societal values will not allow you to do that. If a company issues coverage on the basis of whatever evidence is available at advanced ages, there is no judge or jury in the country that will let the company get away two years later with saying it did not mean to issue. That means underwriting up front, which means cost to the company. That is one of the things you need to look at and be very much concerned about if you are designing or modifying a product.

It is my experience that, at a certain age, even with the current societal disdain for smokers, people do not stop smoking unless they are symptomatic. If somebody at age 70 suddenly stops smoking, it is not because they have read a *Time* magazine article about the hazards of smoking. It is because he or she cannot walk up the stairs anymore, or the doctor has frightened the person into it.

Fortunately, the industry is moving away from smoking questions and going to tobacco-use questions. In the real world, it is a pain trying to make a distinction between the two. There is no cigarette test. All that we have is a nicotine test. There are many products that will cause that test to be positive. Yes, occasionally, we punish somebody who truly only smokes six cigars a year and has no adverse effects. That's it for products.

Mr. Cook: We are now going to talk about underwriting senior life market products.

Mr. Yanko: We generally guarantee issue pre-need life insurance. We do not perform much underwriting. Seventy percent of our sales are guaranteed issue single premium. The remaining 30% is limited pay. About 30% of the limited pay is guaranteed issue. Guaranteed-issue policies have a graded death benefit. They are graded in the first and/or second year, perhaps 50% of the ultimate death benefit in the first year and 100% thereafter. Other designs include return of premiums in the first year or the first two years or return of premiums with interest.

The balance of limited pay is field underwritten. We ask two questions. It is very much like group insurance. Qualifiers are provided full first-day coverage. The consumer pays the same premium regardless of health status. If coverage is guaranteed issue or they fail to underwrite, they get a reduced death benefit.

The funeral director is our agent. Funeral directors are not particularly after commissions. They do a fair amount of selection on our behalf or with us. In the process, when they see imminent deaths, they will typically fund by way of a trust. The family or beneficiaries will then pay the difference between the funeral price and the trust balance when the funeral occurs.

To summarize, our underwriting is our premium structure. We appear to have a very high cost per thousand. We have benefitted from it.

Just to give you a quick profile of who and what we insure:

- Two-thirds are female
- Average issue age is 71 (74 in 1995)
- Average size is $4,000
- One-third of policies are Medicaid spend-down
- Seventy percent are single pay (our primary market)

That is the profile of people we insure today. We are trying to move down into younger ages with limited pay.

Mr. Rains: For estate-planning products we do a little bit more underwriting. I hope so anyway. At age 35, about 90% of applicants qualify as standard. At age 60-65, 60–75% qualify as standard. The percentage begins to drop. A company must decide how it wants to define that 70-plus age group.

The market is changing in these age groups, and standard does not mean anything specific to many companies having five, six, seven, or eight underwriting classes. The difference in the classification standard is a way of applying rates in many instances. There must be interaction between underwriting and actuarial before a product is fielded. Often there is not.

How a company defines the standard class is related to how it feels morbidity is affected by advanced age. Now, I say morbidity. Just how sick do people get? That is what you pick up from underwriting at advanced ages.

There are three theories. One says morbidity is compressed into the last few years of life. If someone lives to 70, or lives to 90, then all but the last four or five years will be healthy. Everything happens at the end.

The second theory says that the older you are, the longer you live, the more diseases you pick up, and the sicker you will be overall.

The first theory says that longer-living people are generally more healthy. The second theory says that longer-living people are generally not as healthy.

The third theory may be more reasonable and says that the longer-lived folks are exposed to more chronic diseases, but that old-age morbidity problems are cognitive problems, etc.

Many of the things we find wrong with older lives will not kill them. How accurate are these as predictors for a future life span? Just a minor point. People applying for insurance at these ages are possibly more select than people who are too sick to get out of the house to go apply for insurance, or sign the insurance applications, or understand what the insurance is.

What do we do if applicants are not standard, that is, standard for older lives? How are we going to rate them? If we divided the substandard into three groups, what would we have? We could have mildly substandard, moderately substandard, and people who we simply cannot take. The market that companies continue to write is the mildly substandard market—a few tables.

So how substandard a person can a company take? One thing I have seen is a requirement for minimum expectation of life. If a company does not want to underwrite anybody that, according to standard tables, is not expected to live more than five years, then it limits the number of tables it will take. If a company is willing to accept only people with an average expected life span of more than three years, it can be more aggressive and pick more tables. In this market, companies have some deaths in the first year, some in the second year, and some in the third year. Nobody did anything wrong in underwriting; they are just going to be there. You need to have the stomach for that and price for it.

Mr. Komsthoeft: It is very much a measure of how well you get along with your CEO. How are you going to feel when you have to pay those early claims?

Mr. Rains: The "good thing" about the market is that mortality characteristics become clear very quickly. It is common to have an uninsurable life on joint, second-to-die policies. In these cases, companies apply more strict underwriting to the healthy life that the uninsurable life is paired with.

Mr. Komsthoeft: Once people get into their 80s and one life is severely impaired, to the point of dying within a couple of years, the lives are not independent anymore. Absolutely not. That must be priced for.

Mr. Rains: Companies are really using traditional underwriting techniques for the older life market. But they have begun to add some nontraditional factors as well. Some of the traditional factors change their importance somewhat. Peter mentioned smoking earlier. It is still a valid predictor, but less so than at younger ages. The same with alcoholism. Alcoholism is somewhat blunted at older ages.

Mr. Komsthoeft: It is very elusive. There are statistics that indicate that a large number of male hospitalizations are actually due to alcoholism. They may not be labeled as such.

Mr. Rains: The things I consider very important include coronary risk factors and diabetes. A large percentage of diabetes cases occur in the elderly. Less important are underwriting for human immunodeficiency virus (HIV), amphetamines, and cocaine. Family history is still very valid. Deaths of both parents before age 60 or parents living past 70 is still valid.

Mr. Komsthoeft: We run on DNA. That is the one thing we cannot change. The good thing is it is valid in both directions. If both parents live well into their 90s, I would most definitely give credit for that, and I feel very good about that. Some things are more important at older ages—prostate specific antigen, for example.

Mr. Rains: In the elderly, cholesterol results that are very low are sometimes predictors of occult tumors that nobody knows about; the same is true with coronary factors. Results on a coronary factor may indicate the presence of something else.

Mr. Komsthoeft: Cardiovascular can be underwritten very well. There is little difference by age. The parameter changes, the incidence of disease changes and, as such, the findings change, but the principles remain the same. The one thing that underwriters are struggling with and have not really found a good test for yet is malignancies. It is the cancers that are responsible for most of the fluctuation in mortality rates. I hate to say it but we really have not found a good test yet.

Mr. Rains: What are some of the nontraditional things you need to look at with older lives? Functional ability. There are three levels of activities that are used in classification of daily living. Cognitive impairment, which is something that can be a predictor of mortality due to physical reasons. Another is a highly increased risk of accidental death at older ages. Also, mobility, depression, and psychiatric issues must be considered. You actually have significant suicide risk at older ages.

Some of those go together. The level of functionality and activities of daily living and mobility are indicators of the kind of disabilities the older market has. This is very interesting at older ages, because at younger ages, disability translates through morbidity cost; a lot of health bills, spending money on therapy, etc. In older lives, it relates to mortality directly. This can be a very good indicator of whether someone is healthy or not.

For activities of daily living (ADL), there are different levels. Some are very basic. Can a man bathe and dress himself and feed himself? The instrumental activities become more advanced. Can he use the phone, go shopping, and take his own medication? Can he cook his own food? And then there are the advanced activities. Is he still working or going to entertaining events, playing games, recreation, golf, board games, or driving a car? If the person can do several things on that list, they are a much better risk. Then the question is, what kind of evidence do you take? Your attending physician's statement (APS) should have some special questions.

Mr. Komsthoeft: You can try to gather this information from a number of different places. You can utilize the traditional application form and fill in the blanks or you can collect the information directly from the applicant. That is much the preferred way. Also, more physicians that speak primarily to geriatrics will be prepared to give you that information.

Telephone interviews, personal interviews, and multiple sources of information covering the same subject matter are extremely important. You try to verify the data collected. Then it's validity is not based simply on the absence or presence of a yes or no answer on any particular question.

There are seven basic ADLs listed in the comprehensive span. If you answer four as negative, meaning you do not do them or you need some assistance with them, the chance during the next year of being committed to a nursing home is better than 50%. That is quantifiable. And the mortality rates, once you are committed to an assisted living setting, go up steeply. Companies find it difficult to write these risks unless they have a product specifically designed for that purpose.

You can get a lot of this information from the APS. The thing is, older people have more than one physician. You may have three, four, five APSs at an average cost of $50–60 apiece, depending on how you get them. But again, the average premium is also much higher. Also, a commission may be charged to help offset these costs.

Mr. Rains: APSs, inspection reports, and customer interviews are things that are very helpful to assess functionality. So are special questions on the questionnaire. Ask the neighbors. Do you see him up and around? Is he getting his own mail? Is he confined to the house most of the time? Maybe you will get a correct answer. You can ask a couple of different people.

Lab screening. You can argue that it is more productive and more cost effective at the older ages because you will get more true positives. It is still very expensive because of the number of tests you get.

Mr. Komsthoeft: Whereas, in the younger age groups, you look at thresholds, i.e., is that test high? If it is high, the applicant immediately goes into a certain risk class. In the older age group the underwriter is looking for trends. The lab value may be normal, but what you are looking for is the trend line. Where is it going? I do not care if it is at the threshold. I know he has the disease. I just want to know where it is going. It is a different approach to the same type of data.

Mr. Rains: Understanding the financial motivation is particularly important for last-to-die. As we said earlier, if it is just a bet on whether you are going to live or die, it is not a very good bet for us because we never know as much as the potential insured.

There is no traditional economic loss here. There is no future income stream replaced for the family and for sending kids to school. Even so, seniors still have needs, such as estate planning and final expenses.

The financial plan should be reviewed to see if it makes sense. It should fit into an understood role, such as paying estate taxes. The insured should be able to pay for the policy and be self-supporting economically. You do not want it to lapse because they cannot pay for it.

Life insurance should not stick out in his overall financial planning. It should be integrated with other investments and provide a fair return. How do you determine what is a reasonable amount of coverage? You can project the estate and apply an estimated tax liability. You should be fairly conservative. People at advanced ages have a very conservative investment philosophy and are probably investing very short term.

Mr. Komsthoeft: The agent really needs to make two sales. He needs to make one sale to the applicant and owner and the other sale to the insurance company. They often utilize the same information.

Stockbrokers are different in a lot of ways because they often do not understand that need. Agents have the same talent and the same analysis, and they understand we need to make the sale twice. It is coming around. It's working.

We will now discuss predictive value tests. Cardiovascular disease and cancer are the leading causes of death at older ages and together account for 60% of such deaths. Older ages, for our purposes, are 70 and up. You can underwrite for cardiovascular. The thing we have yet to learn is cancer. There is an antiselective element associated with cancer because cancer in the early stages tends to make an individual feel different in a way that they cannot quantify. Cerebral vascular is on the same basis. Cardiovascular has a little bit different distribution as to its severity, and it is not as easily accessible to surgical means. Pulmonary is important. Smoking comes with that.

For males, the leading cancer is lung cancer. For females, the leading cause of death due to cancer is now breast cancer. Lung cancer will be moving up, unfortunately, as women increase their rate of smoking, while lung cancer rates for men are decreasing. Accidents and suicides are very important causes of death. It is hard to get good data because death certificates are often not specific enough.

When talking about chronic conditions, standard risk does not necessarily mean absence of disease. There are many conditions not traditionally associated with mortality, but with morbidity. However, there is a definite connection between mortality and morbidity, and they arise from similar conditions in the elderly.

We talked earlier about the ADLs. Those folks that are underwriting and writing long-term care are ahead of the life side. They have very nice questionnaires that address the ADLs.

The next level is the instrumental ADLs, as well as the advanced levels of daily living. The life side ought to think about using these tools. There are inspection companies out there that can solicit this information. They may add a few tests to an exam, such as, can the applicant get out of a chair without using his or her arms? Can the applicant pick something up off the floor? See how the person approached the test . Can he or she actually bend down. This sounds odd, but it is tremendously predictive.

The absence of major organ disease is the single biggest predictor of mortality in the age group over 70. Think about that for a while. You can have all these little ailments that just aggravate you, but if they do not impair you to the point that you cannot lead your life in the way you would like to, you are relatively healthy. The very moment conditions start to affect normal daily living is when they start to impact morbidity and mortality very strongly.

Applications are important. You can do a lot with the design of the application and the questions you ask. You design your product and then phrase your application to get to the mortality you need to produce. You have a need for clarity. Many of us cannot understand what our applications ask today. An 80-year-old may not be interested in trying to understand. A simple thing is large print. Include inquiries in the application about the instrumental ADLs. You will want to confirm them later with independent data.

Exams involve a cost issue. Forget about the paramedical. It does not have enough value. What can we get in addition to the height, weight, and blood pressure? Nothing. I think the charges are too high. Save your money when you can and use medical exams with specific instructions for the examiner stating that you want an ADL assessment.

The standard blood tests are used in underwriting the elderly. There is often some kind of connotation that certain findings are OK in old age. Anemia is one of those being thrown out. It is not OK to be anemic when you are 85. There is a reason. Now, if that reason is demonstrably of a benign nature, that is OK. I can live with it. If it is not demonstrably benign you are talking mortality. It is very important that the underwriters and physicians who interpret elderly blood tests know what they are dealing with.

An electrocardiogram (EKG) is one of the favorite screening tools of the insurance industry because they are so easy to administer, noninvasive, and relatively cheap. Resting EKGs as screening tools do not mean much. You are ultimately going to get one from your APS. Exercise tests are very good. You will get a lot of tests that show you coronary heart disease and ischemic heart disease. For what? You are talking about an age group where 50% are expected to have coronary diseases. What you are looking for is exercise ability without symptoms. An 80-year-old can have a positive stress test, but as long as he can plug away eight or nine minutes without symptoms, he is a standard risk. That is not just my opinion.

Chest X-rays are seldom used in most age ranges because of people's concern about radiation exposure. We do not like to order them, so we have let them fall by the wayside. I am concerned about smoking. It does not have to be an insurance X-ray. It can be one from the physician.

The other thing is that we are increasingly dealing with ethnic groups that were not necessarily born in this country. In that age group, we are talking about the children and heirs applying for the coverage. You are dealing with somebody you did not start out on the base line. I see that in the ethnic marketplaces. An X-ray may be something to think about—that perhaps it should be a routine requirement.

If there is anything we should add routinely it is a pulmonary function test. It is absolutely the best test. I do not know whether you are familiar with the mechanism. You breath into a tube that measures the amount of the air flow and force during breathing. It measures your lung ability. It measures your cardiovascular ability. It measures your mental ability to take instruction. It measures muscle status, your muscular skeletal status. The presence of a normal pulmonary function in that age group is of tremendous value. It is relatively easy to administer. It's not particularly expensive.

APSs are a no-brainer. There is a very different relationship in geriatrics between physicians and patients. You get so much information out of the APS. It is foolish to waive APSs in that age group. The cost is absolutely justifiable. Even if you are only confirming the absence of something you thought might be there, you will be able to prove that person is standard, and you will solidify the mortality experience. But waiver happens a lot. The APSs take a long time to get, the agents are screaming they want the policies issued, and the clients especially in that age group, get cold.

Inspection reports and telephone interviews are probably a good thing to do. The ability to relay a story to you over the telephone without you sitting in front of them is a positive. Unfortunately, we do not allocate enough money to inspection

reports, so they may not be very valid. The financials need to be redesigned. Even at much lower face amounts, it is absolutely key to understand the financial structure and the motivation behind the sale; otherwise, you cannot make a proper underwriting decision. The current tools are not well designed to do that. But that can be changed.

Motor vehicle reports (MVRs) can be very important. They are cheap to get. They are easy to get. It has been proven that once you either voluntarily or involuntarily surrender your license, there is a mortality implication. It translates into the ADLs and Instrumental ADLs very clearly.

The elderly have more accidents than teenagers and people in their early 20s. There are a lot of people over the age of 75. They tend to have low-speed impacts. But the mortality impact is still there because, at these ages, even the injuries sustained by a low-speed impact may ultimately cause death. While death may not occur right there on the spot, the hospitalization and convalescence period opens up a whole bag of things that can happen.