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Long-Term-Care Compliance Issues

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Summary: The passage of the Health Insurance Portability and Accountability Act of 1996 left long-term-care insurers with many unanswered questions, regarding such issues as: tax status of non-qualified plans, what constitutes a material change in a policy, whether waiver of premium and other incidental benefits are qualified long-term-care services, etc. Panelists present the latest information on these topics.

Mr. Andrew M. Perkins: Dick Garner is a senior vice-president in CNA's long-term-care operation. Dick is responsible for both corporate account sales for the long-term-care program there but also for industry affairs related to long-term-care. He's been with CNA since 1971 in a variety of actuarial and product development roles within the company and has been involved heavily both in the individual and group long-term-care product development efforts. He's the current chairperson of the Long-Term-Care Committee of the ACLI and he's also a member and past chairperson of the Health Insurance Association of America (HIAA) Long-Term-Care Committee. He's a member of the Brookings Institute Advisory Panel on Long-Term-Care Financing. Dick has also spoken before Congress on issues related to long-term-care and health care reform.

Loida is the general director of product development and systems for the retail, or individual, long-term-care operation at John Hancock. She is responsible for the designing, pricing, state filing work, compliance activities, and systems management

for their individual long-term-care operation. She has been working on long-term-care for 12 years. She's spoken at many industry meetings. Loida is a member of the Actuarial Standards Board's Long-Term-Care Task Force. She's also a member of the Society's Long-Term-Care Valuation Methods Task Force.

One last plug I'd like to put in before we get into the actual topics. I'm on the Academy's Actuarial Standards Board's Long-Term-Care Committee, as is Loida. We have a new draft long-term-care standard out, and we would encourage everyone to take a look at that, if you haven't already, and provide any feedback that you might have, positive or negative, on that new standard.

We're going to start off with a discussion that Dick will lead. He's going to make a few comments about the Health Insurance Portability and Accountability Act (HIPAA). That's certainly had a major impact on this line of business.

Mr. Richard W. Garner: What I'd like to do first of all is just set the stage a little bit by talking about HIPAA and defining some of the terms there so that we can communicate a little bit more easily. The Health Insurance Portability and Accountability Act passed in August 1996, and was signed into law at that time, generally with an effective date of January 1997, and what I've tried to do here is list some of the documents that have come out that have helped interpret that law since that time. The first thing that came out was a conference report that described the intent of the legislation in prose and less legalistic language. We may refer to that conference report on occasion. Then in December 1996 the Joint Committee on Tax for the Congress released their blue book interpretation of that law. Some of the things that we talked about may have come from that blue book. Then the Treasury Department in May 1997 released what they called interim guidance that was meant to answer some of the more critical questions that the insurance industry had asked for interpretation. Most recently, in December 1997, we received draft regulations from the Treasury Department in their attempt to develop formal regulations that would interpret HIPAA. Those are some of the different sources of information that we talked about.

Again by way of setting the stage here, I'd just like to give a quick synopsis of some of the events that happened in that first year after HIPAA was passed. Near the end of 1996 we saw this fire sale as a lot of people rushed to purchase long-term-care products before the end of 1996 that would be grandfathered to have favorable tax treatment without having to go through the new filings and the specific requirements for new, tax-qualified, long-term-care policies. During 1997, companies were responding to the need to have these new products out there. There was a wave of filings in all the states with all the companies who were active in the long-term-care business. That took place during 1997 with almost all of the

states getting approved by that time. Of course, California's been a notable exception.

Another thing that we saw during that first year was a fairly cautious approach to new product development. Companies felt compelled to introduce products that they were sure would be tax-qualified. There was a tendency to use the exact definitions that were in the law and have fairly vanilla products during that one-year period. There were a lot of concerns about material changes in 1997. Some of those concerns have been addressed by the Treasury Department since then. In 1997 there was also a lot of debate over qualified versus non-qualified products. What were the differences in those products? How would it really affect consumers? Was one better than another?

Comments that I get from my colleagues at other companies show that qualified products pretty much dominate new sales so far in 1998. We did a little survey of the top ten writers of individual long-term-care policies. Nine of those ten companies reported that in states where they have both qualified and non-qualified products available 80–100% of sales were on qualified products. That was true of nine of the ten companies. There was one company, a substantial writer of long-term-care, that did not have that data and that I believe would have had a much higher proportion of non-qualified sales, but for most of the companies the qualified policies seem to be dominating the market.

Also, I think we're seeing now the filing of second generation qualified products, in which there will be a little bit more experimentation. Companies will be pushing the envelope a little bit further to try to find out just what types of benefit packages truly can be considered tax-qualified. I think we're going to see, as a result of that, some return to more innovation in qualified products, at least until we get the next round of Treasury regulations.

Mr. Dennis V. McKeown: The Treasury has come back and has clarified what constitutes a material change and what hasn't. Could you indicate what things do constitute a material change and what things are still outstanding that we're still trying to get resolution from the Treasury?

Mr. Garner: The main thing that the Treasury Department has told us is that they have a fairly broad definition of what is a material change. If you read the legislation and the interim guidance that they provided, any change in the policy that affects either the benefits or the premiums is, in their mind, a material change. That's a very onerous requirement because there are a lot of fairly innocuous changes that would then be considered material and that, therefore, would destroy the grandfathered status of policies written prior to January 1, 1997. When they

came out with the draft regulations in December 1996 they gave some specific exceptions that the industry had petitioned them about. They made it clear the exercise of any benefits in the policy that were there at the time of issue of that policy would not be considered material changes, even if they changed the benefit or premium amount. For example, if you had an inflation protection rider that was attached at the time of issuance of the policy that escalated your daily benefit by 5% a year each duration that the policy was in force, then the movement of those daily benefits over that time period by that 5% a year, even though it changes the benefits under the policy, would not be considered a material change.

There are also some other provisions of the policy where you may have had the ability to purchase additional amounts of coverage. Let's say every second or third year you could buy another 20% of the initial amount. Again, if that was a provision of the policy at the time that the policy was issued, the mere exercise of that right under the policy would not be considered a material change, even though it did change the benefits available under the policy.

Another type of change that they gave us relief on was mode changes. For example, if someone purchases a policy by paying the first quarter's premium and then later they switch to an annual mode because it's less expensive, a strict reading of the law would have said that is a material change that would destroy the grandfathered status. The Treasury made it clear that that type of change would not be considered material for this purpose in the policy. There were other instances as well where premiums could be affected. A lot of companies have provisions where they will give a spousal discount; if both husband and wife purchase coverage, then each of them might get a 10–15% discount on their premium. What can happen in some situations is that you may initially charge the full price to one spouse because the second spouse may not even qualify for coverage at that time. It's not until a year or two later, after the person might complete some underwriting waiting period, that the second spouse could obtain coverage. In those situations many companies will then go back at the next anniversary and reduce the rate of the first-sold individual now that both spouses have coverage. That type of post-issue application of a spousal discount was something that they also gave us specific relief on so that that does not destroy grandfathering.

From the Floor: What about a premium reduction?

Mr. Garner: Premium changes by class, either up or down, would not be considered a material change. That's a very important one, of course, and I think what we did on that one is we made the case that that is really a right under the policy anyway. These policies are guaranteed renewable. It's understood that under certain circumstances, if experience warrants, the prices, by state form, might

move up or down based on that experience and that there are established procedures in place with the states and under those contracts that govern how those changes are made. The IRS accepted that argument. Where we had to come up with standards of practice types of arguments was when we got into making changes for individuals like the post-issue application of a spousal discount and things like that.

There's one other related thing, and that is the post-issue application of affinity group discounts. Some of you may have noticed that was not specifically granted as an exception to material change in the guidelines that they released in December 1997. We met with the Treasury Department in early June 1998 to make it clear to them that there are certain situations where you may have post-issue applications of an employer group discount or affinity group discount just as you would with a spousal discount, and we would want them to make it clear that that also would not destroy grandfathering under a policy sold prior to January 1, 1997.

From the Floor: Didn't it also allow people to reduce their benefits pro rata?

Mr. Garner: Right. There's also another provision that says that if an individual decides to reduce his/her benefits and to make a pro rata reduction in their premium as a result of that, that too would not be considered a material change. We're even arguing with them, and this may be something of a stretch, that certain increases in benefits such as the increase in the daily amount, for example, should also be not be considered a material change for this purpose. That's a little bit different type of argument, and we haven't been successful with it at this point.

Mr. McKeown: The Treasury had ruled that qualified policies receive favorable tax treatment. Have they ruled on the tax treatment of non-qualified policies?

Mr. Garner: The answer to that still is it's not known, and let me elaborate on that a little bit. The Treasury Department says it's the job of Congress to say how they want to handle the tax treatment on these policies, and Congress has spoken about the qualified products, but they haven't said anything about non-qualified. The IRS feels somewhat stuck in the middle because they don't have clear direction on how those policies should be treated. You continue to have this ambiguous situation. Some people would say, well, you just look to what the law was prior to when HIPAA was passed; the problem is that the law wasn't clear at that time at all. If something is clearly a medical expense and you can make an argument that it is very much medical in nature, then you may have some established law to fall back on. The problem is, much of long-term-care today, including the personal services aspect of it, is not something that was thought of as being medical care in the past.

The second factor that the Treasury Department will tell you is that the simple fact that HIPAA has now been passed does add some new input to the whole discussion about how non-qualified policies should be taxed. There's a strong implication there that even if you have qualified policies, certain benefits under a qualified policy are now very clearly taxable income. For example, consider per diem policies that exceed the maximum per day benefit, which was $175 in 1997 and is now $180 in 1998. Benefits paid under a policy that would otherwise be tax-qualified except for the fact that it's a per diem policy–those benefits now are very clearly taxable benefits. Someone could say that's a strong argument why non-qualified policies definitely ought to be taxable benefits. You get arguments on both sides, and the only thing that the Treasury Department will tell us for sure is that if you want certainty of favorable tax treatment, you must have a qualified policy, and there is no firm answer to the taxability of non-qualified.

They also don't have a schedule by which they expect to give an answer. In our session in early June 1998 they said it would probably be 60–90 days before they even distribute the final regulations from the proposed regulations that they gave out in December 1997. They held a hearing in May 1998, to get further input on those December 1997, regulations, and they had some questions about a couple of weeks ago. They're still thinking even about that aspect of it. There's a long way to go before they would want to speak on non-qualified benefits.

From the Floor: Do you think it would still be safe to say that your reserve would be deductible for non-qualified plans if you have a two-year preliminary term? That's the way it was before. They were considered health reserves.

Mr. Garner: In terms of the treatment of the reserves, I would think that there would be no change in what was accepted practice prior to that for those policies, that's right, but the more favorable treatment of reserves applies only to tax-qualified policies and only those policies sold January 1, 1998 or later. There was a one-year delay in terms of the favorable treatment of those reserves that was really more of just a revenue issue than anything else.

Mr. Robert W. Darnell: You mentioned that the $175 daily limitation had gone up to $180 in 1998. What does the limitation on premiums get posted to?

Mr. Garner: We should check to see whether there's a citation. I can't do all the numbers by memory. I think the $200 went up to $210, the $2,000 to $2,050. While Loida is speaking later I'll see if I can come up with those numbers.

From the Floor: What about the other issue that has cropped up a little bit in the industry right now where companies are saying you can sell a person a

non-qualified plan, and then at the time of claim you can convert to a tax-qualified plan? You're going to run into some issues regarding when that claim was incurred. Was it incurred on the non-qualified policy? Can all the dollars after the conversion date be treated as if tax-qualified? Are we safe from the questionable tax-qualifying status of the benefits on the non-qualified plan?

Mr. Garner: The question refers to the practice that a lot of companies have of being able to switch back and forth between a non-qualified plan and a qualified plan or vice versa. The question really has the biggest impact when someone has a claim. Our company's attitude on that is that whatever contract that person had at the time the claim was incurred is what would govern whether or not that claim occurred under a qualified or non-qualified contract. The other aspect of that, though, that I guess is most relevant is that whether someone incurred benefits under a qualified or non-qualified contract is really something between that individual and the IRS. The insurance company doesn't necessarily need to insert themselves in the middle of that. If you think of the mechanics of this, someone's sitting there doing his/her tax return on April 14, and has to decide whether or not to move some of these long-term-care benefits into income or not. He or she has received a 1099-LTC from an insurance company, but it doesn't really have to say whether the benefit was incurred under a qualified plan or a non-qualified plan, especially if somebody had switched back and forth in mid-year. The decision really is with that policyholder claimant and their tax advisor as to how they handle those benefits, whether they're taxable or non-taxable. Our feeling, though, is that it's just too easy to be able to say if you have a claim, we'll retroactively issue you something so that it looked like it occurred under a qualified policy. We would not feel very comfortable with that. We think that it's determined by the effective date of that claim.

As far as what the IRS has said on this issue, we have not specifically addressed that question to them. That may be one of those questions where you may not want the answer that they would give you, since it is more the responsibility of the policyholder and their tax advisor and the IRS.

From the Floor: I was just wondering how many companies are actually keeping track of which of their policyholders are tax-qualified and non-qualified? Especially among the grandfathered people. Are there companies who are trying to keep track of what each person has or are we leaving it up to the person to know what they have?

Mr. Garner: Yes, that's a very good question. Would anybody like to comment about the extent to which each of our companies keeps track of whether someone has a qualified or a non-qualified policy?

From the Floor: If anybody wants to take an action that would ungrandfather it, first of all, we'd give them a notice so that they know that's what they're doing, and if they did do that, we would put something on the record so we'd know that that policy was ungrandfathered. But we really try very hard not to let anybody do anything that'll ungrandfather a policy.

Mr. Garner: For policies which are, on their face, either qualified or non-qualified, it's easy to tell just by policy form number. It's most important in the situation just described where you've got grandfathered policies and policyholders who could be making changes to them.

From the Floor: With these exchanges to qualified and non-qualified policies, is there's not some taxable event, whatever that means? Wasn't it true that if you do it in 1997, you can do it without triggering some sort of taxable event, whereas afterwards there may not be some sort of event occurring?

Mr. Garner: The question is whether or not there is a taxable event when someone could exchange from a non-qualified to a qualified? There is a specific provision in the law that allowed an exchange to take place and have it not be considered a taxable event during 1997, I believe it was. The fact of the matter is, when you go back and read that provision in the law, there's really not a reason for it to be there because that typically is not a taxable event where that type of exchange took place anyway. I think it was based on the drafters' misinterpretation of why they even had to have that provision there.

Mr. Dennis M. O'Brien: I'd suggest to you that there might be an exposure there, and, granted, what the value of the exchange is is gray at best, but if somebody exchanged a non-qualified policy for a qualified policy in anticipation of an immediate claim, I think there's some logic that says that they're doing that because the new policy is more valuable to them in some way. If they do that, they're getting a value out of that exchange, and I think there's an exposure that could create a taxable event. We've gone from this period in 1997, where it was clear that we could have these exchanges, and there wasn't any problem. Then, for a variety of reasons, companies didn't get their forms approved, and January 1 goes by, and then for a few months you're doing exchanges, and you figure that, well, we're probably going to be okay. But I think as time goes by, and we talk about these free-flowing exchanges going back and forth, I think that there could be a time in the future where, if people are really buying non-qualified policies and then

making the exchanges in anticipation of a claim, I think there is some exposure there that at some point the IRS might view that as adding a value that could be subject to tax.

Mr. Garner: Yes, that could be.

Ms. Loida Rodis Abraham: I will share with you the experiences we've had with regards to the states' reaction to HIPAA and invite you to share yours as well. It's interesting, when HIPAA first came, one of the things we did as a company was to actually do personal visits to a lot of the major insurance departments in our hopes that by giving them some education, since we had been closely involved in what was going on on the federal side, that perhaps that would spur them into action with regards to the product approvals that were going to need to take place in the next few months. As those of you who have worked specifically in the long-term-care compliance area know, as a result of HIPAA many companies had to file new products in order to make them tax-qualified. For those of us who are working in multiple jurisdictions, that required almost 51 filings. That was a very challenging task to do in a very short timeframe.

We thought as a proactive strategy we would go out and actually talk to the various insurance departments, find out what their knowledge was, and see if we could help them. What was interesting in our discussions with the various insurance departments was that many of them were very concerned about HIPAA. They were also concerned about their role in the product approval process. Some of their concerns stem from the fact that they thought if they approved a tax-qualified product, did that mean it was then federally tax-qualified? Well, did they have the jurisdiction to do that? What we explained to them was that, no, they could go ahead with their regular product approval process. It didn't mean that if they approved the policy it necessarily met the federal tax-qualified requirements.

Some insurance departments, as a result of that concern, required disclosure statements within the contracts to ensure that it was up to the company to make sure that the contract was intended to be tax-qualified. If there were later regulations that helped interpret what that meant, the companies were going to necessitate the action that would ensure the tax-qualified status. That was one of the things that occurred in our discussions with the states. Some other things that happened were we knew that there were some states that, because of actual state regulations, were in direct conflict with HIPAA. As an industry, we worked very closely with the state, and, I think to the state's credit, they moved very quickly to change those regulations. Those states were Texas, California, and Kansas. Kansas had a medical necessity trigger. California and Texas required a two out of seven

Activities of Daily Living (ADL) trigger, which was in violation of the HIPAA requirement.

The interesting thing, though, that happened as a result of this good intention on the part of California to move quickly was that it triggered some market chaos. Some of you may not be familiar with what happened in California. In 1997, due to the intent of the insurance department and the insurance commissioner in California to allow their residents to have access to a tax-qualified product, the insurance commissioner used its discretionary authority to waive the two out of seven ADL requirement, allowing companies such as ourselves to file, get qualified, and get approved a product that uses two out of six ADLs. Many companies got that approval. Some of the consumers in California weren't too happy with that. They felt that the process of approving policies was too quick, that the insurance department didn't do enough due diligence in their approval process. As a result of that, the consumers group actually took the insurance commissioner and its action to court, and a court ruled in favor of the consumers. Some of the policies were tax-qualified for a short period of time in California and then had to be pulled from the market. Can you imagine the chaos that occurred? Companies were trying to move quickly to figure out what was going on and explain to their agents what was going on, and the agents were trying to explain to their public, to their customers, what was going on. Here they had a tax-qualified policy one second, and the very next second it had to be taken away from them.

In 1997, California put into place new regulations effective January 1, 1999 that would allow tax-qualified policies. The regulations do require that, if you are going to have a tax-qualified policy, you also should have a nontax-qualified. They're also requiring that as soon as you get your new products approved, you have 90 days to roll it out, and old products can no longer be sold. There are a lot of things going on in California.

With regards to some other states like Maryland and Minnesota, where it wasn't so much regulations that were an issue but interpretation of the regulations that were a big concern there was a lot of confusion with the federal tax regulation. That confusion was not solely left to the insurance company; it was also in the state insurance departments. The HIPAA regulation included what they called a third benefit trigger that was undetermined and was supposed to be put in there for any future finding. Well, some insurance departments decided that, because it was in the regulation, they would include the regulation in their state regulation verbatim, and they required this unknown benefit trigger. The difficulty of that was that for companies like ourselves having an unknown benefit trigger was very difficult to live with. It's never clear since it's unknown, and undetermined when claims were going to be filed, and how do you price for some unknown? Eventually insurance

departments were educated and realized that this was not something they needed to include today, that it only needed to be included when that trigger was so defined, and that it was only put in there for future purposes. But, again, that gave you an indication of the state of chaos that was occurring as a result of the federal regulation. Those are some of the experiences that we encountered.

Mr. McKeown: We have similar experiences in our company.

Ms. Abraham: How about Dennis O'Brien?

Mr. O'Brien: We're still trying to get something approved in California, sorry to say.

Ms. Abraham: I've heard horror stories about California, maybe due to what happened with the commissioner going to court. I've heard some stories that insurers who have applied for approval are getting 38 pages of disapproval and objections. The whole process is real lengthy. I know someone who filed in November 1977, and they're still trying to get approval in June 1998. It's not very clear what the new rules are, and I can't blame the poor analysts who are having difficulty just trying to interpret the new regulation. It's a trying time for everyone, particularly in California.

From the Floor: I'm sure that companies are issuing non-qualified plans in California in hopes of converting those to qualified in the future, or are they just not selling anything?

Ms. Abraham: As far as I know, most companies today are selling non-qualified policies. There are, I believe, only four or five companies that have had tax-qualified products approved since the new regulation took effect. I don't think that the chaos that occurred in California actually stopped people from selling in California, which is part of your question, but I do think that it did take a little longer to get the tax-qualified products out the door.

From the Floor: I think many companies also converted, in a way, to the qualified plan when the qualified plans got approved. I think one of the problems is that what was the intention before is not what is real today because the insurance department changes the rule as it goes along. The end product may be a product that is not easily converted into.

Ms. Abraham: Dick, is there anything from your experience?

Mr. Garner: My knowledge of what's going on in California is that all the major companies have continued to sell very aggressively. It's a huge market, and they're just trying to struggle to get the tax-qualified products, but in the meantime they'll sell the non-qualified ones.

If I could answer Bob Darnell's earlier question that had to do with the new limitations on premiums, I did locate them in my notes here. I mentioned that the benefit limit on per-diem policies has increased from $175 in 1997 to $180 in calendar year 1998. If we move to the question about premiums, the $200 limit which in 1997 applied, I believe, to ages up to age 40, is now $210. The limit for the next decade of issue ages was $375 in 1997 and is now up to $380 for 1998. In the next, $750 was increased to $770. In the next, $2,000 was increased to $2,050. And, for the final age group, $2,500 was increased to $2,570.

From the Floor: The $375 limit didn't make a whole lot of sense to me.

Mr. Garner: Since we are all mathematicians and incredibly bright people, I will leave you to figure out the algorithm that makes those numbers make sense.

The moderator asked me to address contingent nonforfeiture. This relates to an NAIC issue that has been a hot topic for the last few years. When HIPAA was passed, the industry was very active in making sure that there was reference in the law to the NAIC model and certain consumer protection features that were in the model. This reference goes back to the December 1993 version of the NAIC model. The reason for that was that between 1993 and when HIPAA passed in 1996, there were a couple of very troublesome, very onerous requirements that had been put into the NAIC model that the industry didn't agree with at all and a lot of commissioners in the states didn't like either.

One of those was the mandated nonforfeiture requirement. If you looked at the NAIC model, it said every policy had to have a nonforfeiture benefit in it. The NAIC made that a part of the model, but, of course, when you got to the states, every commissioner looked at that and said I don't want that in my state. People really didn't want to use that provision at all. The problem was then that you end up with an NAIC model that the states themselves have very little respect for, and certainly the insurance companies had no respect for it. We had to use HIPAA language that avoided that. Finally the NAIC got just as concerned about this as the companies did, and they said, look, we'd like to get this thing out of there. Can you help us do this gracefully somehow? They worked with the HIAA and ACLI. We came up with a compromise, and what that entailed was removing the mandatory nonforfeiture provision from the model, and removing the rate caps provision from the model. This latter provision is too complex to get into, but it basically said if

you take a rate increase on a long-term-care policy, those rate increases can bump into certain caps under certain conditions.

The NAIC agreed to take both of those provisions out of the model and then replace it with something that they thought addressed the concerns that they had. They just didn't want companies low balling prices and then going in and increasing prices on people who were ill-equipped to pay those higher prices as they became older. What the industry came up with in working with them was something called contingent nonforfeiture, which basically says that we set up a table of rate increase caps which, should an insurance company bump into a cap, the company would have to make available a nonforfeiture benefit to anyone impacted by that rate increase, or by any other rate increases that came after that time whether or not it was in the original contract. That was then adopted by an entire hierarchy of committees within the NAIC. The NAIC is having a meeting in the near future and will finally pass, in their plenary session, which is the ultimate group that has to vote on this kind of thing. The agreement that I just described will make this contingent nonforfeiture a part of the NAIC model. We will have an NAIC model once again that the industry trade groups can support, without these onerous provisions regarding rate caps or mandated nonforfeiture. That's how that came to pass, and that was about a two- or three-year project that is in its final stage.

From the Floor: Can you clarify what it means for a company to make contingent nonforteiture available? Does that mean it's given as an option for the customer to purchase or it's automatically provided free?

Mr. Garner: It might be easier for me to explain by example. If someone had purchased a policy, and they were age 62, for example, there's a limitation, which I don't remember because it varies by age, but let's say the limitation would be 30%. If a policy gets a rate increase of, say, 10% for three years in a row, in that third year you would, by compounding, have crossed that 30% threshold by taking a 10% increase on that policy, At that time you must offer to that person that either they can accept the rate increase and keep their benefits the same, or you would offer them the ability to keep their rates about the same and take a reduction in their benefits so that they didn't have to pay more money, or you would offer them a third option. This third one is the contingent nonforfeiture option, which says if you wish to lapse your policy at this moment because you don't want to pay that additional rate increase, we will give you a nonforfeiture benefit, and that nonforfeiture benefit is the standard nonforfeiture benefit that's in the NAIC long-term-care model. Basically, to compute the standard nonforfeiture benefit, you add up all the premiums that have been paid to date under that policy, and then that becomes a benefit bank for you should you have future long-term-care expenses. That amount is maintained by the insurance company, if you ever have a claim in

the future, you submit it, and the company will pay the benefits according to the original policy until that bank is exhausted.

From the Floor: Do you subtract previous claims?

Mr. Garner: I believe you do not subtract previous claims. Also, this has nothing to do with whether something is qualified or non-qualified. Before contingent nonforfeiture affects anything, of course, some state has to adopt that portion of the NAIC model, and from that point forward policies sold under the law, in effect in that state at that time, would have this provision and would have this practice followed.

From the Floor: What if someone had bought a nonforfeiture rider at the time of issue? How would that affect this?

Mr. Garner: The contingent approach would not apply. The existing nonforfeiture benefit would control in that case.

From the Floor: How soon do you expect states to adopt the new regulation? How soon will this go into effect?

Mr. Garner: That's a good question, and I don't have a good answer for that. It's very much a local phenomenon whether or not a state or a legislature feels that they need to modernize their long-term-care regulation. It does require action in every state, so it would require legislation if they changed their model act. Of course, you could just adopt some of these things by regulation, and the insurance department may have the authority to just update their long-term-care regulation in that state to include some of these things. It's very much a unique procedure for each state, and we just have to watch that.

From the Floor: Does the company have to disclose the percentage to the applicant when they're soliciting a policy?

Mr. Garner: That's an excellent question. The question is does the company need to disclose this table of rate? Some of the numbers in there can be startling. For example, at the very youngest issue ages the contingent nonforfeiture doesn't kick in until rate increases cumulatively are more than 200%. This could look like a horrendously large number, and, of course, if you think of the small premiums that are involved at very youngest issue ages on long-term-care, and you think about the 40 or 50 years potentially that coverage would exist, it makes sense that there would be a large number there. I think consumers might be startled in seeing a number that big. Of course for somebody who's age 65 the number is 50%, I think,

and it gets smaller for the later issue ages. The question is do we need to disclose that at the point of sale? I honestly don't remember if that whole table has to be disclosed there or not. Do you remember, Loida?

Ms. Abraham: I don't believe that's been discussed to date.

From the Floor: Under the model, can a company offer an alternative nonforfeiture benefit that actuarially is richer than the NAIC standard?

Mr. Garner: Yes. I believe that you could.

From the Floor: Including a different form of nonforfeiture benefit?

Mr. Garner: Yes. I think the tendency has been most of the time for companies to fall back on that NAIC standard, but I believe you have the ability to use anything that would qualify as a bonafide nonforfeiture benefit. I think the NAIC law gives you two or three different alternative approaches that would still be bonafide nonforfeiture benefits.

From the Floor: Who pays for contingent nonforfeiture?

Mr. Garner: The impression I get from most companies is that they would pay for that out of the rate increase calculation that they do when they determine they have a need for an increase. It is expected and accepted that additional cost could be calculated into the determination of what increase is necessary.

Mr. O'Brien: I'd just like to suggest that we adjust our thinking, as I have over the last couple of years, on who really pays for contingent nonforteiture. When companies implement rate increases on long-term-care policies, they're going to induce lapses. The lapses create a release of reserves that theoretically represents a forfeiture of the equity of the people who lapse that inures to the benefit of the persisters. One way of looking at how this contingent nonforfeiture benefit gets paid for is that it eliminates this subsidy and restores equity by allowing the people who lapse to retain the equity in their policies. An alternative view I've heard described is that if the rate increases are higher, the persisters have to pay for it and subsidize the people who lapse. I prefer to think of it as, and I think it's even fair to think of it as, just eliminating what in current practice would be an inequitable situation between the persisters and lapsers where the lapsers get no value out of their policy at the time of rate increase.

From the Floor: In those calculations, what if everybody chose to lapse? You really can't collect any premium then. Would that be biased for companies to rely on the rate increase calculation to fund that?

From the Floor: If everybody lapsed, there would be no way to charge, no increase in premium.

From The Floor: I think it goes back to what Dennis said. There should be enough reserves to pay for that even if everyone lapses.

From the Floor: Of course.

From the Floor: If you were setting your reserves up that way. Normally you wouldn't have set up a reserve for that nonforfeiture benefit.

From the Floor: I think in most cases it would be enough to cover that. Typically, people aren't going to, and that's the part that I'm talking about, it was being released before, giving a windfall to the persisters so that their rate increase could be less than it ordinarily would be. But I think that a lot of people are going to keep their policies. This is really kind of antiselection in reverse in terms of what happens at rate increase time. The sick people are going to want to hold onto their policies. They aren't going to lapse. The people that lapse are probably going to have good morbidity experience. They're going to be the people that think that they're not going to use the services. We're a long way from knowing what kind of experience we're going to have under those paid-up benefits if and when they're ever granted, but there's a lot of reasons to think that maybe there won't be a run-away clause.

Ms. Abraham: Yes, I think that this is really interesting. The current NAIC activities in some way are sort of a historic event. For once the industry and the regulators have come together with a unified solution that they think would solve the problem of rate stabilization. I think what your questions are leading to are very interesting because although it goes into the model act and regulation, we don't know what the states are going to do, exactly how they're going to word their regulation. As we've seen from the past, you have a regulation go into the model act, but the way states actually approve it in their state is very different from what was in the model act. The issues that you're raising now are also very timely in the sense that, because we know this is coming, we know there are going to be states that are going to be passing contingent nonforfeiture in the next few months. New Mexico has already passed a regulation that includes contingent nonforfeiture. Do you assume everyone's going to lapse? What if you don't? Those questions are very timely because I know a couple of pricing actuaries are going to be thinking that very

thing. What do you assume when you price for this benefit? If you assume everyone's going to lapse, that's going to increase the rate significantly. On the other hand if you don't, what is your company's tolerance for the loss? I can't imagine everyone's going to lapse, but the problem is the ones who are probably not going to lapse are the ones who are going to need the high rate increase, and then you're going to see spiraling rate increases. It's kind of a scary thought. I'd be curious to hear what others might think about that.

From the Floor: I think another thing to think about is that in terms of the lapse exposure, if you're looking at increasing rates 10 or 15 years down the road, even the healthy people aren't going to really have much of an alternative. They're going to want to keep their policies. If they lapse, and they want to have coverage, they're going to have to buy at attained rates from some other company, and typically that rate is going to be several times greater than their issue age rate, so that there really isn't going to be a lot of incentive for people to want to lapse their coverage. I think that in times of rate increases we're not going to see much higher lapse rates than the typical, low, voluntary lapse rates.

Mr. Garner: Yes, I would agree on that.

Ms. Abraham: I think what surprised me is that I've heard, and some of you may know about this, that some companies have implemented high rate increases, and, despite that, the shock lapses that were expected to occur did not occur. People still continued to persist.

From the Floor: We're talking about how the regulators and the industry finally worked together on something, but you still have the regulatory actuaries that don't think contingent nonforfeiture is a big deal, and you have a lot of people here that think it is a big deal, and still think they're not done yet with rate stabilization. They don't think this fully addressed the problem.

Mr. Garner: Yes, that's a good point. One of the things that we kept repeating to ourselves as we were going through this process on contingent nonforfeiture is that this ought to be the solution to these problems. We tried to drive that point home, but there's always the risk that you get a few new faces at the NAIC, and all of the sudden somebody likes the idea of mandatory rate caps after all, in spite of the fact that contingent nonforfeiture is out there. That's a difficult thing to deal with, and I think we want to be very vigilant about any other proposals that come back from regulators. The thing that we try to do is at least try to identify what it is that's a problem, what the problem is that we're trying to solve. You very often run into situations where you've got solutions in search of a problem when you're dealing with the regulators, and we're trying to make sure that we have some real problem

that we're trying to solve before we move very far along on any new proposals or additional regulation.

Mr. Perkins: I think there's discomfort on the part of some regulators with the whole issue of loss ratios, which is certainly related to some of this.

From the Floor: Just to follow up on an earlier comment, I think there's an understanding from the part of regulators that the industry is going to continue to work beyond contingent nonforfeiture. Some of the actuaries that aren't here have chosen to go to the Boston NAIC meeting and they are coming up with a blue sky list of other things that could be done with respect to rate stabilization. Contingent nonforfeiture is far from being over. A lot of industry people think that it may have been the answer, but there's a lot of other things being discussed like improved disclosure of past rate increase history to regulators and to applicants, and also agent training, education, and licensing.

Also, there's a Loss Ratio Working Group from the Accident and Health Task Force. I think the regulators and the industry feel as though loss ratios don't work. They can be gamed. They haven't worked in the past. They feel that they can be gamed, and so the regulators are working with the industry to come up with some alternative, and that's what a lot of these discussions are about. I don't know if we'll be successful in coming up with something other than loss ratios, but alternatives are being discussed.

Florida has two regulations that have been passed. The one is 4–149, and it applies to all health products. It has some features in it that seem illogical in terms of measuring loss ratios. That's the best way I can describe it. They're illogical. What a company has to do is when they file in the State of Florida, they file basically an asset share that shows the expected loss ratio, lifetime loss ratio, by duration. At issue typically companies file a 60%, but if you looked at calendar or policy duration one, two, three, because the premiums go down for a cohort and the claims go up for the same cohort, there's an increasing loss ratio by duration. The way the regulation works for 4–149 applies to disability insurance as well as long-term-care is that if a company ever needs to do a rate increase, as we all understand it, the loss ratio that the rate increase will be subject to will be based on what you originally filed and what the duration is.

For example, at duration 10 after issue, for a cohort with an 80% loss ratio, then the rate increase portion would be subject to an 80% loss ratio. In 20 years that might be well over 100% because the premiums are going down, the claims are going up, so when you look at the 20th duration it could be in excess of 100% which says that the rate increase that you need isn't even enough to cover the extra claims, let

alone the expenses and profit margins. We've worked with the trades diligently, and we know that Florida understands the issue, but over the past year we haven't made a whole lot of progress on that. There's been some other issues with respect to credibility and pooling, and if anybody's filing new products in Florida, I'm sure you've seen the objections coming back, they're lengthy. That's the 4–149 that applies to all health products. There's another one called 4–157 that applies to only long-term-care where companies are trying to work with the insurance department through the trades to get some relief on this prospective loss ratio lock-in.

From the Floor: Dennis, are those passed or proposed?

Mr. O'Brien: Both the regulations have been passed, but they're looking at proposals or amendments to existing regulations in place.

Ms. Abraham: I understand that something got revised just two weeks ago and that the new rules in what had just passed are actually more complex. Their concern is that, because it's more complex, again it's going to be harder to interpret. It's going to be very arbitrary. My understanding is that under these new rules, I haven't gotten a copy, I just saw this in my e-mail today, that the result of these new rules is that in order to be able to effect a rate increase as soon as your experience is bad, you've got to file it immediately. My understanding, too, is that the department is trying to get support for these new regulations, and they're talking to the HIAA. There's a meeting in July 1998 with the HIAA, although the HIAA is trying to postpone that meeting so they can get further understanding of these new regulations.

From the Floor: I'd just like to say I think part of the motivation on Florida's part for both the current 149 and the proposed revisions is that they want companies not to be able to recoup past losses with future rate increases. It sounds like a reasonable thing. But what happens is if you get out to duration 10, they make you file what you think the loss ratio is from that point forward, and, as it was originally envisioned, it was without reserves. For long-term-care that could be 300% or 400%. What that effectively meant was that when you did rate increases you were locked into a 300% loss ratio on the increment due to anticipated future claims in excess of anticipated. You not only couldn't recover, you were locked into a large loss on excess claims from that point going forward. Part of what's amazing is that Florida didn't seem to understand that it meant that. The industry didn't seem to understand that it meant that. As we looked at what we were filing, and we thought about it, we said what's going on here? It was just so complex that nobody knew what was going on. I think what's happening in Florida is that we're getting another set of even more complex kinds of loss ratio requirements. Florida's motivation seems to be to, whenever experience deteriorates, lock in the bad and force the

companies to swallow the downside and not allow them to recover. I think in the new things that have been proposed, they have a built-in ratchet, and they try to ratchet your expected lifetime loss ratio up from your original 60%. If you had bad experience, and it becomes 62%, well, then it's 62. It's not really an acceptable situation or an acceptable risk. I have been excited about this but it's been going on for so long that we seem to lose a sense of urgency about it. We need to get people to look at what these regulations say, both the current and the proposed, and get together and to try to get the situation resolved because we're all writing business under these regulations. I think we're out on a limb because we've been thinking for a year or so that we're going to get some relief on this. For a while it seems that we're making progress, and other times it seems like we're back to square one. It's not just a long-term-care issue either. It's particularly pronounced for long-term-care because those prospective loss ratios get very large, but I'd invite all the long-term-care actuaries and also the people that are just in any kind of health business to look at what they've gone on the hook for in Florida and look at it carefully and see if you feel comfortable with it.

Mr. Perkins: Is there something we're not covering that you wanted to get to, you wanted to hear about, or you wanted to discuss in this session?

From the Floor: Valuation.

Mr. Perkins: Valuation? Anything specific about it?

From the Floor: The current status of the task force report.

Ms. Abraham: As a member of the Valuation Task Force, and Dennis is also a member, my understanding is that the proposals were made by the task force. The Life and Health Actuarial Task Force of the NAIC looked at it and decided that they wanted to maintain the one-year preliminary term. This is one of the issues at hand because reserving for this product was a big issue, and I think that's still where it's at.

Mr. O'Brien: As somebody who was on the task force, I can tell you that it was very difficult to come to grips with a lot of the difficult issues that were involved in long-term-care valuation. I'm sorry to say that I think in some ways we probably didn't satisfy what the regulators were hoping to get from us, which would have been a 1980 nursing home table that they could shove down everybody's throat like the hospital table or some disability income table. There's so many variables in long-term-care and home health care that we just didn't feel like we could do that. I think in some ways that didn't answer what was hoped for by the regulators. I don't know if any of you have read the lengthy report that the Society of Actuaries

Valuation Task Force produced, but I think it's more an educational document for actuaries that are trying to do a good job in valuing long-term-care insurance. It's probably not realistic to think that it's anything that can be easily translated into regulation. I suspect that there'll have to be a new task force after the intercompany experiences have been more fully developed. Maybe there'll be some more simple tables that can be promulgated.

Ms. Abraham: Gary Corliss, do you want to say any more about the intercompany experience study, what the status of that is?

Mr. Gary L. Corliss: We had been waiting for some time for one particular company who had a significant amount of data in the first study to make that contribution. That contribution is in, and the data is being sent out to varying parties at this moment. We started sending it out in June 1998. Our expectation for the next follow-up to the January, 1995 study is that we will have our next production out by the end of 1998. It will extend some of the tables that we had in the prior study, and it will have one additional section where we're going to try to talk about some trends that we seem to have seen. We briefly talked about that in the last study, but now we've gone further down the road, and we hope to have that information in there at that time.

Mr. Perkins: Loida, you had some specific issues of regulatory changes in a couple of states. Could you pick out from those some key things you thought were important?

Ms. Abraham: In terms of some of the state-specific issues that are going on, we've already talked about California being a problem state. Another state that's come to mind recently is New Mexico. New Mexico is one of those states that had tried recently to come out with a new regulation that would include a choice on the part of the insurer of mandatory nonforfeiture or contingent nonforfeiture, a 65% loss ratio requirement, and then, more recently, an addition of a three-year minimum rate guarantee. This was something that was proposed by the New Mexico regulators, and although the industry was familiar with some part of the regulation, the two-year guarantee was a surprise. In some ways the process in which the proposed regulation had come about was something that concerned some of the industry members. Since then there has been some discussion about trying to get it into exposure, to change some of the wording in the regulation, and I think that was not happily received. However, these regulations are not going to be effective until, I believe, January 1, 1999. There is some time for changes. It's not clear whether changes will be made. But it is the first state that included contingent nonforfeiture.

Another state that I guess created some chaos last year, or I believe it might have been the year before, was Colorado. It wasn't so much the regulation that was introduced, but what the regulation that got introduced implied about what Colorado was trying to do. Colorado passed a regulation that those who wanted to get long-term-care products approved had to have what they call a basic and standard type product. The concern about this regulation was that it was going to stifle product innovation because basically these products were going to be the same, and the only difference was going to be in price. In a time for long-term-care where innovation is important to get consumers' needs more expressed, that was disconcerting. Fortunately, the trend did not move to other states and actually didn't have a very big impact on the business.

Other than Colorado, New Mexico, and California, the other regulations that I know of have to do with agent compensation and agent training requirements. I don't know if many of you are affected by that, but several states have developed specific regulations on compensation, whether it has to do with the level of the first-year compensation in relationship to renewal, whether the renewal rates have to be levelized, or whether the replacement compensation has to be defined in some terms. Just recently Pennsylvania changed their interpretation of their replacement compensation regulation. I don't know if some of you are familiar with that. In the past they required that replacement compensation rates had to be equivalent to the renewal rates. More recently that interpretation was changed to allow for increases in premium being able to trigger or generate first-year compensation rules.

Mr. O'Brien: Speaking about agent compensation, I don't know if anybody would be willing to share where they think agent compensation has to be filed, and to what extent companies file each and every nuance of various agent compensation packages that they may have and the states where they think filing is required. I'll volunteer for New York Life. In New York we file everything in sight. We file every possible compensation scheme that we can possibly use. California also has a requirement to file compensation, or it appears to, and it's buried under some section that has the main heading of "Replacements and Agent Compensation." Our calls to the department have gotten conflicting information on whether they, themselves, think that that requires the filing of all agent compensation packages for long-term-care. I'd just be curious to know what companies are doing and if they're filing commissions in California. Are they filing every time they change anything at all?

Ms. Abraham: I'll speak for John Hancock. I do know that we do file in New York and in New Jersey. I have not heard about California. That is news to me.

From the Floor: It was news to some of us, too.

From the Floor: When a policy gets replaced, some states have a required level of renewal compensation for the first year. Do you know which states or how many states there are that require that?

Ms. Abraham: As far as I know, New York is the only remaining state with that policy. It used to be Pennsylvania and New York, and just recently Pennsylvania changed their interpretation.

From the Floor: I think you better watch out a little bit on that. A number of other states have requirements on compensation regarding replacements, and in some cases there's some language where if the company determines that the replacing policy has substantially better benefits, then they get paid full commissions, otherwise it's renewal. I think there are about five or six states that have some kind of wrinkle regarding replacement commission.

Ms. Abraham: You're absolutely right. I can give you a list of the states that I know have wrinkles: Alabama. California. Indiana. Kentucky. North Carolina. Pennsylvania. Wisconsin.

From the Floor: New York.

Ms. Abraham: Of course, New York. But I think you are right. I think the difference, and I should be clear in what I said a while ago, was that in some states, regardless of whether the replacing policy can demonstrate better benefits or has a higher premium, you're required to pay a renewal rate. In these other states, if you can demonstrate higher premium or better benefits, then that increase could generate first-year commissions. It's in the level of the replacement regulation that they differ.

From the Floor: I think California allows you to pay first-year commissions only on the increase.

Ms. Abraham: Exactly.

From The Floor: There are even wrinkles within wrinkles. It can be rather complex.

Ms. Abraham: That's right.