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Current Issues on Long-Term-Care Insurance

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Summary: The potential for significant growth in the long-term-care insurance market underscores the need to stay apprised of current trends in the marketplace. Panelists and attendees discuss current developments in the long-term-care market focusing on the following main topics:

- *Major players in the long-term-care insurance market*
- *Growth prospects for long-term-care insurance, focusing on emerging demographic trends and the impact of the Health Insurance Portability and Accountability Act*
- *State regulatory update*
- *Emerging trends in product design*
- *Nursing home morbidity trends*

Mr. James M. Glickman: This is a long-term-care (LTC) open forum. I first want to introduce Mike Abroe from Milliman & Robertson and Morris Snow from William Mercer. I will bring up an introductory subject to get started: What are the different types of underwriting currently in use and what theoretical differences should you set up in the pricing for those different types of underwriting? Mike will make some comments on how he views the underwriting scenario in the individual market and Morris will discuss the group market.

Mr. Michael S. Abroe: We typically classify underwriting into three different categories: conservative, moderate, and liberal, or what we would call an agent-friendly category. There are many nuances of each in terms of emerging experience, driven in many respects by the sources of protected information that the

various types of underwriting processes would use. But also part of that process would be the zeal with which the company addresses the information on the application and how much it goes after the true medical history of the individual.

Mr. Morris Snow: In the group marketplace, underwriting is fairly standard right now. Most large groups have a guaranteed issue for all employees who are actively at work. That's fairly standard. I don't know of any carrier now that's doing guaranteed issues for the spouses, although there might be one or two. Some carriers have been burned on this in the past. And nobody gives a guaranteed issue on the parents, grandparents, and other associated people.

Mr. Glickman: But they probably would get good sales results.

Mr. Snow: Yes, any companies that offer guaranteed issue on parents and grandparents will have wonderful results from the point of view of sales. Some of the carriers differ on the actively-at-work criteria. Let's say the criteria for benefits is three activities of daily living (ADL). For some carriers, if you're actively at work and have three ADLs, you're automatically eligible. But other carriers don't count the ADLs that you already can't do at the time of the underwriting. So if somebody is quadriplegic, but actively at work, that person would not become eligible for benefits under some companies' criteria unless he or she could do even fewer ADLs than before. If a person can't do any ADLs now, there's almost no point in buying the insurance. That's the biggest difference between carriers in the initial underwriting on the group side.

I do want to mention something interesting on the individual side. If you look at some individual blocks of business, the underwriting of some companies is very, very loose. On occasion, that loose underwriting is translated into some very, very bad claims, as you well know. The corporation then leaves the rates where they are and tightens up the underwriting. The second underwriting is not quite as bad as the first, but it's still in the loose underwriting category. Probably we need to define what is conservative, moderate, and liberal. You have to be careful on that.

Mr. David Benz: I've seen more and more companies on the individual side using preferred classes. I'm just wondering how much of that is based on real information and how much is just sales and marketing driven.

Mr. Glickman: I would say that the underwriting classes are fairly uniform across the board. Companies are offering preferred and standard or preferred, standard, and some substandard, but most don't have data on which to base the differentials. They take what they feel are some reasonable differentials, apply those against a

total they expect to market to each group, and then make that equal to one. If they get their expectations in each group, even if it's not allocated totally right, it will give them the same morbidity results. It's somewhat similar to the way non-smoker/smoker mortality originally started out back in life insurance in the 1970s. Also, generally speaking, most companies are taking a lesser discount in each of those classes than will eventually prove to be true. We're seeing a little in spouse discounts, which we'll talk about later. And, just as the nonsmoker discount started out a little light of what it eventually turned out to be, I think you may find that to be true for the spouse discounts as well.

Mr. Abroe: I've seen both reasons for making the adjustments down to preferred or select or whatever you want to call the best class, some of it being marketing and some of it being more proper risk assessment given the style of underwriting that the company is using. I'd say, on balance, I've seen that happen more for a marketing reason than a pure risk selection reason. I've only seen one or two companies that understood their underwriting process well enough to be able to change it to get to the better class. So overall, I'd say probably most of it has been on the marketing side.

Mr. Glickman: Morris, I assume in groups they're doing a guaranteed issue, so there's no point in talking about it.

Mr. Snow: No, there's no point in talking about it. They can do it for the retirees, but I have never seen it done. I have seen a lot of substandard on the individual side that is losing substantial amounts of money.

Mr. Glickman: With respect to the substandard, it has been my experience that companies are in agreement about what a decline should be. Whether they're able to get the information to determine that is another topic of conversation. Therefore, what they're doing is determining how many risk classes they want and just divvying up into classes what is left as insurable.

One of the theoretical justifications for using a much looser underwriting style and selling policies to the medically questionable or medically uninsurable (while trying to make sure not to get the cognitive impairments) is that most of these people will die off before they become major claims. Therefore, following that theory to its next step, you don't need to charge a higher premium, even though they are substandard in the health sense, because they are not substandard from a risk standpoint, relative to the expected claim costs. I don't personally subscribe to that, but it is used by companies to justify their particular positions, not just amongst themselves, but also to the regulators. I don't think there are any strong facts either to dispute or verify it. Anybody have any thoughts or comments on that?

From the Floor: Are we addressing these questions in the studies that are coming out?

Mr. Glickman: I'm not aware that the studies being done have the sophisticated data necessary to get to those types of conclusions. One of the big problems with the Insured Data Study, for example, is that there are still very limited data. It's all essentially from a select period and from a great mixture. When the Society initially set up the study, it had a great deal of trouble getting companies to participate and provide this very proprietary data. Because some very large companies would be identifiable if they were subdivided in a particular way, the Society has been very careful not to do that kind of subdividing until there's a large volume of data on all of the different ways it's possible to discriminate on the data. Otherwise, the Society might lose the participation of the companies it most wants to get information about.

Mr. Scott Lloyd Berlin: It's my impression that some companies are doing cognitive screening at younger and younger ages. Can you comment on what age you think is appropriate for cognitive screening and where you think the trend is going?

Mr. Abroe: A year ago, I would have said ages 72 or 75, now I'd say age 70. I'm not sure it needs to go below that, but I wouldn't be surprised if it doesn't, given the results that you get from cognitive screens.

Mr. Snow: I am in basic agreement, but maybe it will go a touch lower. I couldn't see it going lower than age 65. The cognitive impairments usually don't appear before that age, except in exceptional cases.

Mr. Dale C. Griffin: You talked about the conservative, moderate, and agent-friendly underwriting styles. Can you tell me what the typical rates are for the three groups? Are the rates much different? How are they doing it?

Mr. Abroe: We look at the various blocks of business in studying the underwriting and then make certain assumptions about what we think that implies in terms of the later durations. There's quite a bit of assumption on our part, but if you were to classify the different levels, conservative would be the base. Moderate underwriting would require a natural premium, all other things being equal, about 10–20% higher, and a agent-friendly style of underwriting, would double that—to about 20–40%, with the range being age related. The lesser amount is charged at the younger ages, the higher amount at the older ages. That's the conclusion we have come to.

Mr. Glickman: We have generally found that there is very little rate differential attributable to the style of underwriting being used. Again, it's somewhat a function of no one really knowing where these loss ratios are going to end up. And it's somewhat a function of the fact that many people believe they'll be able to fix it if they need to. Many carriers feel that if they charge a higher price, they just won't sell nearly as much as they think they should and are, therefore, just taking a chance on it.

The NAIC publishes a LTC experience report each year. It shows the durational experience. Although there are some questions about some of the validity of the numbers, overall, it represents some good overall characteristics. Just for our own information, we went through the report and marked a "T" for tight, an "M" for moderate and an "A" for aggressive underwriting next to each of the participating companies. Then we looked at each group's loss ratios by duration. We were pleasantly surprised to find that they had very definite patterns of higher, earlier loss ratios and higher cumulative loss ratios as you went from tight to aggressive underwriting. It's an interesting exercise. Of course, everybody would classify companies differently based on his or her perception. But, if you try it, I think you will likely come up with similar results.

Is this a function of the fact that the tighter you go on underwriting, the less your price should be—but it isn't? Or does this occur because business in all of these segments is so much more heavily weighted toward the early years that it gets the much better select factors, but those will tend to get minimized over future years? Or will that theory that I suggested earlier actually come into play—that the tight underwriting companies' loss ratios, when you get into 10-, 15-, and 20-year durations, which aren't really happening yet, will get much higher while the others will tend to tail off and hit a maximum because people are dying off faster? Only time will tell, but it was a very interesting experiment.

Mr. Abroe: There's another thing that can be done that gets to some of the types of data that Eric Stallard at Duke University is producing. If you take a current snapshot and identify which ADL-deficient individuals you would not insure today and then track the balance of the population over time, you get a natural underwriting wear-off process. We've done some of that on a more simplistic basis than the full mathematical calculations that Eric has put together, but it seems to demonstrate that same type of underwriting wear-off pattern, except that it seems to indicate a permanent differential, depending upon how tight the underwriting is. Ultimately 10 or 15 years after inception, there still can be a 5% or 10% differential in the overall ultimate claims level, depending upon underwriting style.

Mr. Glickman: So, if I understand correctly, you're essentially saying that it's counter to the proposed theory that the loss ratios will eventually get better, relatively speaking, on the poorly underwriting business, because the people die off and go away.

Mr. Abroe: Yes.

Mr. Snow: One thing you really should focus on, with respect to underwriting, is that liberal and conservative can be defined two different ways. One has to do with the information gathering and the other with the criteria on which the acceptance is based. Some carriers are much more diligent about who they get the information from: whether it's from a face-to-face meeting, or a phone call, or whether they'll just take an attending physician's statement. There are many different ways of collecting information, and the manner in which you collect information is critically important, as is the criteria you use once you've gathered the information. Lapses in either of those can lead to an awful lot of claims—for the former simply because there are conditions there that you didn't identify, and for the latter because you just adopted the wrong criteria. If you look at some of the criteria companies use for acceptance or rejection, you'll see that a lot of it is left over from the medical underwriting of many years ago and is not appropriate for LTC. But some companies are just being very, very liberal to try to get as many fish into the boat as they can. It doesn't seem to work very well, at least not in the short run. Maybe there's a theory behind it, but it doesn't seem to work for me.

Mr. Glickman: I'll bring up an interesting experiment we tried that many of you may want to consider. We have a lot of pressure from agents to do fewer medical records, not so much because they don't want us to have the information, but because they want the policy issued in a much more expedient manner. So we did an experiment using all the age 65 business for a period of one month. We get the telephone interview and the application right away but have to wait for the medical records, so we had the underwriters making the best decision, whether they felt they could or not, based solely on the interview and application information. Then, when the medical records came in a few weeks later, they did their normal underwriting process and compared the results.

We found that nearly 20% of those cases had different answers. Sometimes better, but more times than not, worse. It was a very interesting experiment and, while the agents don't give us any credit for still ordering lots of medical records based on that study, at least it made us feel a little more comfortable sticking to that position. Has anybody encountered other types of rationale for using either more or fewer medical records or more or fewer cognitive assessments?

Mr. Abroe: Can I ask a related question? How many companies actually have the data that they would need to be able to test some of those hypotheses, in terms of the types of information they're tracking through the underwriting process and subsequent to that?

Mr. Glickman: Let's see a show of hands. First of all, how many people are working with companies that are actively selling in the LTC market right now? We have decent representation. Of those people, how many pull medical records on their applicants over age 65? How many of those routinely try to avoid pulling medical records and either use the phone interview, application, and/or functional or cognitive assessments? Nobody? Has anybody in the group that's pulling the medical records lately had to deal with the marketing department complaining about the length of time it takes? Have any of you given any serious consideration to where or if you can cut down on medical records requests? One person responded.

Mr. Benz: About four years ago, we looked at everything we did on underwriting, such as pulling medical records. Most of our underwriting standards come from the medical realm, but we updated those in the early 1990s. We ended up lowering the age at which we do face-to-face assessments; we increased the number of phone interviews, but we really did not reduce the number of medical records we got. We just brought some of the requirements of the older ages down to the younger age. We did loosen up on the medical records a little, but we haven't noticed much change.

Mr. Glickman: Does anybody else have any thoughts or comments that they'd like to make on underwriting?

Mr. Philip J. Barackman: One observation I have is that, under a very broad rate class, there's a lot of subsidizing going on. I think the tendency at first is to think about the applicant in an attempt to define the rate classes, rather than the other way around. When you look at the assumptions that are made regarding accepting 5% or 10% more people, in terms of the impact on the total experience, one implication that I haven't heard voiced pertains to the people that some companies are accepting and other companies are rejecting. The implication is that their morbidity is several hundred percent higher than the total group. It's relatively simple to work out the math. Different companies will accept or reject the same people. It boils down to what was done with the five or ten people out of 100 who have a significant impact on the total experience. One of the implications in going to multiple rate classes is that those people who get separated out of the separate rate class will need to pay 300% or 400% of a one-class group rate. And those

people will start shopping the companies that have not differentiated the rate class. So there is a dynamic similar to what happened in the life insurance industry. That evolved to very refined underwriting with tables going up to several hundred percent mortality. I think we should be thinking about is the implications of how experience varies for those 5% or 10% who are affecting the overall rate. Work through the math and see what those people look like by themselves, and that'll give you a different perspective from what I've heard.

Mr. Abroe: I don't disagree with you, but I think there's a different category, where the companies have a current style of underwriting in terms of the risk that they're accepting. And some of the additional information that they now start to accept is allowing them to determine properly the rate class within the cohort of people that they're currently insuring. When they go to several different rate classes, they're not intending to insure 5% or 10% additional people; it's more a matter of just trying to refine the process that they have in place right now.

Mr. Barackman: Not all companies have the same acceptance rate, and I realize there are some marketing dynamics that affect who gets approved. Putting that consideration aside, if there are real differences in acceptance rates it seems that there is a tremendous subsidy going on. That shouldn't be surprising because, in doing life insurance underwriting, we have significantly different rates for significantly different underwriting classes. That has yet to evolve into one standard rate class. We tend to thinking that standard is this homogenous group of people, and it's anything but that.

Mr. Glickman: Most of the underwriting is being done more from a practical standpoint rather than a scientific one. Companies are seeing that some people have disproportionately high claims, such as insulin-dependent diabetics, or previous stroke victims, or those with a TIA history. Not only are companies unsure about how good that experience is, they don't necessarily want to get in two or three applications for every policy they can issue, because of the high cost of underwriting it. So someone would take a practical spin on it and say, "While this is a priceable episode, we don't want to place it." I think you are seeing the phenomenon of agents shopping four or five companies at once. This is because companies are taking the hard position and refusing to accept anyone who's ever been declined by somebody else. So the agents have learned that the way to get around this is to be able to answer truthfully that the individual hasn't been declined by sending it out to every company they can think of at once. And you will get different results.

I'll give you one interesting example that brings the art into it rather than the science. Two insureds applied to us and another company. Of those two insureds, we were willing to take the wife, but we weren't willing to take the husband. We found out that the other company was willing to take the husband, but not the wife. Both husband and wife were happy with the end result. Each took out one policy from each of us. When that other underwriter and I had a chance to talk, we both believed that our decisions were right. So this isn't the science you might like to believe, and it's probably decades away from getting there.

Mr. Glickman: I wouldn't disagree. Of necessity, it's more art than science at this point.

Mr. Abroe: Some things, however, can give you some piece of mind. First, of the business that's coming to you, do you fall in the 20% or the 80% range? Is the agent submitting 80% of the LTC business that he or she naturally writes to you and using other companies for the 20% that are the problem cases, or is it the reverse of that? If you are the 20% company, then you're getting selected against. If you're in the 80% range, then chances are you're getting the best risks that the agent runs across.

David Smith: What is the overall decline rate, recognizing that it varies from company to company, that is typical in most companies.

Mr. Abroe: I would answer that by how long the company has been in the market. I see a lot of testing of the companies' underwriting rules when they first get into the market. They can have a significant rejection rate for the first year or two until the brokerage community finds out their operating results. Then, as the broker learns, you may get a 10% ultimate reject rate.

Mr. Glickman: Of those companies in the marketplace now, how many have a decline rate under 10%? I know one or two companies still profess they have that, but they're not being represented here. How about between 10% and 15%? Okay, we have a couple. Between 15% and 20%? 20% and above? Our experience is in the 13–15% range throughout most of the companies, although, interestingly enough, it's much higher at the older ages. Our age-80-plus decline rate is more than 40%, so your mix of business can influence all that. Both the very aggressive underwriters and the tight underwriters seem to be in that 15% range, some going up to 20%. The aggressive ones tend to be at the lower end because they have a philosophy to keep up with.

Let's move to our next topic. I presume everyone has been hearing what's going on at the federal and state level. We'll bring up a couple of activities just to make sure

that everybody is up to date and see if there are any comments or thoughts on them. Representative Nancy L. Johnson (R-CT) put a bill up before Congress to make LTC deductible without the medical inside limits. In other words, you could take a deduction right off of your adjusted gross income (AGI) for LTC. It had a fair amount of support and was originally scored up as costing only $250 million over five years. It had the misfortune, then, of getting rescored when another member of the House of Representatives brought up a technical correction to include some small additional segment of the marketplace. They went back, rescored it and realized they had made a mistake on their first scoring and changed the $250 million to $1.8 billion. At this point, it just got deferred away.

One of the things I found interesting was that the reason it scored so low initially—which, to my intuitive sense, seemed extremely low, given AGI deductions—was the fact that the deductions were still going to have the HIPAA inside limits: $200 in the lowest rate band, $375 in the next, and so forth. So even though the concept that it was tax deductible would have been a real big push for LTC, it wouldn't have been quite the panacea that I had originally envisioned they were proposing.

Supposedly it is going to be brought up before Congress again next year. I know that all of the industry groups are pushing for that. Certainly everybody in this room who wants to sell LTC is pushing for it, so maybe there is some chance it will pass.

Mr. Abroe: One thing we did to prepare for this session was to pull a title listing of all of the bills from the Internet. There are two or three different categories of types of bills, such as the federal employees' bill, featuring the full deduction of the premium. A couple of bills pertain to studying whether Medicare can cover LTC.

Mr. Glickman: We should move on and talk about what's going on at the state level. As everybody knows, the NAIC has been working on defining up both the concepts of contingent non-forfeiture and perhaps the concept of loss ratios that would not be standardized, but would be controlled, in terms of how you can do future rate increases.

I'll briefly describe the contingent non-forfeiture proposal. Essentially, the concept is that the current mandated non-forfeiture benefit, which is offered at an extra price and very rarely elected by the consumer, would be mandated to be added at no additional charge whenever an insurance company did a rate increase that was beyond a certain percentage. The percentage most currently in favor is 50% of the original amount, or a scale that varies from about 200% at the younger ages down to as low as 10% at ages 80 plus. Tom Foley is the biggest proponent of that right now and, if I'm not mistaken, New Mexico has already adopted that mandate. It

still requires the same loss-ratio certifications that are currently in place as the loss-ratio standard. The other proposal, developed by Bob Yee at GE Capital Assurance, eliminates the current minimum loss ratio standard and replaces it with a standardized national index that would control the future right of a company to change premiums. Therefore, each company could charge any price it deemed desirable for the policy. However, they would then be locked into that premium structure, and would adjust it in the future based on the change in the cost index, not based on the actual experience. Therefore, if experience caused the company to lose money, they would not be able to change rates to correct the problem.

Mr. Abroe: Although New Mexico passed the rate stabilization and the contingent non-forfeiture provision, is it a big enough state that companies are worrying about adverse risk issues associated with that? If Florida or a more populous state were to pass the same requirement, would it become a bigger issue? I haven't seen much concern in the industry about it, I think, because of the size of the state.

Mr. Snow: Rhode Island and Montana both proposed it and more states will adopt it. I know Wisconsin is looking at it. Wisconsin already has rate stabilization. One thing companies are going to want to do before they make a decision is to determine what kind of impact that has on their pricing. Whether they can theoretically price for it with the increase or have to price for it up front is going to depend on each company's pricing strategy. I think Tom Foley's action is one step in a number of steps in getting at what he feels is the significant underpricing of LTC in the marketplace and he has decided to address that.

Mr. Glickman: That's a very interesting point. Usually one or two key people in the NAIC can have a very disproportionately heavy influence on the direction of various regulations, especially the ones oriented towards the pricing aspects. When Tom Foley was the actuary in Florida, rates were often being challenged as being too low. In many cases, we had to increase the rates arbitrarily, because that's what was insisted upon. Now, a few years later, Tom Foley has moved up to North Dakota and Frank Dino is the actuary in Florida. And Florida is taking the same rate filings that we filed, challenging them as being too high, and forcing us to make them lower. So it can have a very strange impact.

One of the other issues that continually comes up on the board is the qualified versus nonqualified issue on the federal level and what the taxation situations will be. One of the things that has tended to make nobody really interested in defining it at either the IRS or in the legislature is the interesting fact that nobody's ever been asked to score what is the cost or revenue produced by any of the three logical scenarios regarding taxability. The three logical scenarios are: (1) nonqualified benefits are tax-free, (2) nonqualified benefits are taxable, but the corresponding

medical expenses can be deducted after the 7.5% AGI, and (3) the benefits are taxable and because they were reimbursed by insurance they're not deductible as a medical expense. The third position is a bit obscure, but certainly an outside possibility.

I have suggested to some of the Congressional people, who made the mistake of talking at conferences that I've attended, that they should figure out what that baseline is. In other words, they should force the Government Accounting Office (GAO) to come with an estimate of what each of those three positions are—revenue generating, revenue neutral, or revenue cost—because nobody has ever bothered to say what nonqualified is *not*. In fact, that's a big problem because nobody knows whether the benefits they receive will be taxed. If Congress made that determination, they would, by default, be taking a current position on nonqualified. They then would either have to propose legislation to change it or, in effect, ratify it by virtue of it having been scored by the GAO. If any of you have any influence at that level, it might be a good way to push it because the government seems very reluctant to take a position on something that will end up alienating some segment of the population. Politicians don't like to take positions that somebody can pin them down on. And this is one of those types of positions.

Mr. Snow: James, why don't we ask the audience how many nonqualified plans are being sold. My impression is that there isn't much being sold right now.

Mr. Glickman: Of those people who are selling LTC now, how many offer qualified-only?

Mr. Snow: I think you should separate the question between individual versus group, because I think you get a different answer.

Mr. Glickman: Very good. The first caveat is that, if you must sell a nonqualified plan, for example, in California, we will exclude that as participating in the nonqualified process. We'll also do individual first and then group. On the individual plans, how many sell qualified-only, wherever they can? It looks like about five or six hands. How many sell both qualified and nonqualified? It looks like a nearly equal amount. Of those who sell qualified and nonqualified, how many only want to sell qualified, but are allowing the nonqualified because the agents say they want to have the choice? Is anybody selling both of them and would really want to sell qualified-only? I guess everybody who's selling both qualified and nonqualified believes it should be a consumer choice. How many people are selling in the group market? Do you want to give us your perception of what is going on in the qualified group?

Mr. Snow: In the group market, just about everything is qualified. I haven't really seen much nonqualified at all, except maybe by some of the smaller carriers. Even in the individual market, it's my impression that most of what's being sold is qualified, even if both are sold side by side. Is that correct, Mike?

Mr. Abroe: The top product of this year's market leader would be a nontax-qualified product because it has a one ADLI/ADL type benefit.

Mr. Glickman: Let's steer into some product development issues. Does anybody want to bring up any topics that they think would be interesting?

Mr. Phil Barackman: What is the current lower interest rate environment doing to affect the pricing of products?

Mr. Glickman: This is a good question not just for new product development, but also for current product pricing.

Mr. Abroe: For the last product that we analyzed for a company, we kept on asking, "Don't you want to reduce the interest rate assumption? Don't you want to reduce the interest rate assumption, or at least start out lower and grade it up over time?" And the answer was "no."

Mr. Snow: This is a question not only for LTC, but essentially for all products. I can only second what Mike is saying. When you talk to any carriers about this subject, they just say, "We don't see it," and they don't. The reason is simple: They know that if they lower that interest rate assumption, the prices will go up, and they won't sell any product. They just pray that interest rates will go up. It's a tough one because some of those interest rate assumptions are not realistic any longer.

Mr. Glenn A. Tobleman: One of our clients has a queasy feeling; not just about the general level of interest rates, but it also was one of those lucky companies that, in the good old days, had inflation riders that were at 5%. Companies are backing off on that because 5% may have seemed like a reasonable increase back in the 1980s, but it isn't any more.

Mr. Glickman: Let me add another quick comment to that. I have been noticing in the product revisions being done by the major companies. There have been about two or three of them and another one is coming out in January. The pricing has tended to move up, but it has been disguised to a certain degree. The way it's been disguised is that the companies have been expanding their joint discounts or their insurer discounts. They said, "We need more money so we're going to leave the

joint rates where they are, but increase the discount." This way, they make the single life rates significantly higher and feel they've corrected an incorrect discount amount on the joints and done an overall increase on their portfolios. I've noticed that fairly uniformly across all the filings that I've seen since the beginning of 1998, which is about the time the smoke first cleared from everybody scrambling around doing the qualified/nonqualified in 1997.

Mr. Abroe: I'll make a contrary comment to that. We saw what we believe is one of the top 20 individual sellers that came out with a rate filing at the end of 1997 with an 8% across the board interest rate assumption that looks fairly good right now. That decreased rates on average in excess of 50%.

Mr. Glickman: Obviously, there's still a lot of market play, and it will be interesting to see how this all works itself out, especially in light of some of these rate stabilization and nonforfeiture proposals that are clearly going to shift some risk.

The next logical extension of that discussion and a topic that's very similarly related in the pricing, at least from my experience, is the lapse assumptions. In fact, I found very close to a one-to-one relationship between dropping 100 basis points on interest rate and dropping 1% on your ultimate lapse rates. We saw it in the study, but I think all of us have seen it individually on our blocks of business, that the persistency is getting much better. Surprisingly it's getting better at the longer durations. We would expect that, where lapse rates were 15%, 20%, and 25% ten years ago, now they might be significantly less than that. In fact, I think most companies are under 10% in the first year nowadays, but I expect that, say, a 4% or 5% ultimate lapse rate would start to look rich, relative to what's going on.

One interesting thing in that regard is that, in life insurance as an example, there's some amount of antiselective renewal that also operates at the same time that you get worse persistency, so that the contrary to that would be that, with better persistency you might get better renewal selection. Nobody really has any idea of what that dynamic is, certainly for LTC, and I suspect that there's some base point at which it doesn't really get any better. The few lapses you get are random, so you don't get any positive impact. Has anybody been dealing with those issues on lapse rates? Any thoughts, Mike?

Mr. Abroe: The thing that bothers me about the experience studies is that companies aren't tracking their death rates. So the question is, how much of those lapse rates are really deaths? They could be overstating the natural lapse rates already in the marketplace, forgetting where we think it may go five years from now. That's the big concern that I have with the study.

From the Floor: If somebody stops paying the premium you don't know if it's a lapse or a death.

Mr. Abroe: That's the whole point, you don't know.

Mr. Snow: You could do a Social Security match up at the end of the year. That is one way you can do it.

Mr. Glickman: I would say that would be high on the list of companies' priorities. Within the study material, some companies have been trying to separate it out and some companies haven't. If you age select it, one of the things you can do is put a reasonable estimate on what those mortality numbers look like.

Mr. Abroe: That's right.

Mr. Glickman: Just check it out yourself.

Mr. Abroe: What I would prefer to see is a total decrement rate and then the ability to back out some type of an assumed mortality rate, so that the balance of the two assumptions would, in total, match what's coming out of the experience study.

Mr. Barackman: I have one other thought on the assumed lapse rate companies use. I would always add the lapse rate and the mortality assumption and thereby implicitly assume a much higher lapse rate than the explicit assumption. I wondered if anyone has a comment on that. That is the issue in terms of the experience study. Maybe the approach that should be taken is that the combined decrement is adjusted by some reasonable mortality assumption by the Committee. The fact there was separation may provide a more reasonable basis than maybe what the original pricing assumption.

Mr. Abroe: If you know what the total decrement is of voluntary and involuntary combined, then you have the ability to make some assumptions, but at least you have a comfort level about what the total decrement is.

Mr. Benz: Our company is able to track deaths, partly because we refund unearned premiums upon death. Everyone wants that refund, so they will report the death. Second, about 85% of our LTC owners also own life insurance with us. So we are fairly confident in our tracking of death versus lapse rates. A lot of this is select experience, but we have even put select factors on the 83A annuity table and we are at about 75% of that, with the select factors into six to ten durations. So I think

you're right—people could be estimating mortality at the high end. At least in our company, mortality overtakes the underlying lapse rate at about duration five

Mr. Glickman: Does anybody want to talk about what I'll call the marketing styles that have surrounded product development? I have noticed in the last few years that there's been a tendency for companies to go to the pool of money design, where there's a pot of dollars, rather than benefit phase or benefit years, as well as putting all the benefits together into one pool. And another trend I've seen is to go up and down on issuing home health care-only policies. For a while, it was expanding and in the last few years, it's been contracting. Any comments?

Mr. Abroe: I've only seen one organization that's been successful at selling a standalone home health policy.

Mr. Snow: I haven't seen anything on the group side in home health only and I believe New York State doesn't allow it as a matter of public policy. I do know that there have been a lot of complaints coming to insurance departments about the home health only policies, in that people become ADL dependent, get forced into the nursing home, and don't get any benefits. They're screaming about that, so I don't expect the product to survive a long time.

Mr. Glickman: Is anybody selling home health care-only policies?

Mr. Andrew N. Perkins: We're not on the direct side, but we do have clients who sell home health care-only policies. That may not be all that they sell. I wouldn't say that they're a significant portion of total industry production, but we have some clients who consider them a successful part of their portfolio.

Mr. Abroe: I doubt that they've got a significant portion in Florida, however, which seems to be where most of the problems have occurred for home health care.

Mr. Tobleman: I agree that there is not a whole lot of home health care by itself, but you are seeing more and more packaged products, where LTC is combined with home health care. You hear a lot of interesting arguments about the interrelationship of the benefits. Some say that particularly the institutional claim costs are significantly reduced because of the home health care benefit. It's a more viable alternative than going into institutional care. In reserving and in pricing, people say, don't worry about the home health care; it's all covered in the LTC pricing. I'm curious about what your thoughts and reactions are to that.

Mr. Abroe: My first reaction is, that's the way the health care delivery system is going—having the home-based approach toward LTC. Let's try to keep the people in the home, rather than in the nursing home. By having a combination policy, you're better able to handle the changes in the health care delivery system. With disease management and processes, and so on going on, it makes a lot of sense to have that type of a product.

Mr. Snow: When you're talking about home health, it's a lot more critical to talk about exactly what's covered than it is with a nursing home. When you're talking about a nursing home policy, a nursing home is a nursing home. But in home health, there are many differences, including which kinds of services could be provided and who has to provide those services. The most liberal companies will allow home health services to be provided by friends and neighbors and don't require any licensure of any kind. That can be subject to a lot of abuse, but it's probably the easiest and most efficient way to supply care. But it makes a huge difference in terms of your assumptions as an actuary. If you're going to restrict your coverage to licensed agencies performing certain tasks, it will probably cost a lot less than if you have a much broader definition. You have to pay attention to those kinds of things. There is no simple answer, and I've seen actuaries argue that home health care costs nothing while others say you're going to break the bank. I think the truth is somewhere in between and you have to be careful about how you define it.

Mr. Glickman: I have an initial concept of most of the cost of home health care being in the nursing facility claim cost. I agree that there's a significant amount of shifting from what would have been a nursing facility to home health care delivery, because that's the preferred way to get it. And, if you're being compensated, you will search out those methods before you resort to the facility. But the home health care delivery is running well beyond just what would have been institutionalized before. So, even though there's some overlap, it's a minor piece, rather than a major piece of that whole cost.

Second, and this is something that we won't know for quite a while, the existence of the home health care for people who have been taken care of in the system—primarily by spouses, primarily for free—is going to have a changing dynamic as people who bought these policies, which have only been offered the last five to ten years at the outside, age. In a typical scenario, a much smaller-built wife will be trying to take care of a much larger husband. She will be moving him in and out of bed, bathtubs, and chairs. She may find that having the policy benefit that will pay you $50 or $100 a day, perhaps inflated 5% compounded, will be an attractive alternative to get people in there to take care of those less desirable and physically difficult tasks that right now are being taken care of for free. I don't think we've

seen much of that in the claims scenario. Most of the claims that are coming in on home health care now are of an acute nature, because the policies were underwritten fairly recently. We haven't gotten into those longer-range people going downhill and needing assistance. Any thoughts or comments on that issue?

Mr. Abroe: Two comments. One is that I agree with you in terms of the interaction between the two products. But in addition to that, looking at home health care only, there would tend to be a significant surcharge to cover an increase in utilization that we would put into our actuarial models with the standalone home health care policy.

The second issue is that I'm not sure where this is all going with the federal government's cutback, or intent to cut back, on abuses in the home healthcare industry. How is that going to interact with the policies out there right now that cover what Medicare doesn't cover? As home health care starts getting ratcheted down on the Medicare side, is that going to mean an increase in claim costs on the LTC side? I'm not sure how much that's going to be, since right now only 5% or 6% of the policy cost is covered by Medicare.

Mr. Glickman: Here's another scenario to consider. One of these days it's going to dawn on the government that there's no reason in the world that Medicare should be primary and that LTC insurance should be secondary. I think it may pass some legislation reversing that, because there are some dollars involved. In that case, you'll definitely get that full hit of 5% or 6% immediately.

Mr. Abroe: That's right.

Mr. Glickman: Does anybody want to talk about the limited pay and even the single pay concepts that are starting to appear with some regularity now? Is anybody offering products that have either a 10-, a 20-, or a single-pay concept with their policy? I have seen a number of them and, interesting enough, some of the carriers offering them were very large ones. I don't know if any of the top three or four are doing it, but I know at least two or three in the top ten that offer either single pay or 10 or 20 pay, or sometimes all of the above.

Mr. Abroe: Even though I've seen companies starting to develop those types of options, what I haven't seen is the companies taking the next step and looking at it from a valuation actuary perspective to identify the potential downside risk. The proper reserving for these types of products should involve some traditional non-can or life insurance type cash flow testing. I haven't seen that happen yet, which disturbs me, given the type of limited-pay concepts or products that are out there.

Mr. Snow: These products have two negatives against them from an actuarial point of view. One involves the extent to which you rely on lapse assumptions to reduce the cost. Because you're going to have fewer lapses with limited-pay policies, you have to lower your lapse assumptions and raise your premiums. The second negative is that there's a lot more risk associated with limited premium policies than there is with lifetime premium policies, simply because the period of time you have to adjust premiums is smaller. So, as an extreme example, if you have a single-pay policy, then effectively you're not selling a guaranteed renewable, but a non-can policy. That means that you can't adjust premiums and you have to charge more for that kind of risk, as well as the fact that there are no lapses. People who pay in one shot think that they should be getting it cheaper, when, in fact, the insurance company has to charge more for it. That's a definite reason this will not be an interesting policy for a lot of insurers. However, I am seeing a lot of interest in single pay, especially from people cashing out at retirement and wondering what they can do with the money. They say, "Maybe I can take that money and buy a single-pay, LTC policy and never have to think about LTC again." So there is some interest, but there are some challenges, too.

Mr. Glickman: I'll make some contrary comments. Companies that are offering a 10-pay policy, for example, are significantly modifying their voluntary lapse assumptions. Two companies that I know of in particular, are using a 5% first-year lapse rate, grading down to 1% over six years, and then to a zero voluntary lapse after that. I don't know of anybody doing a single pay who doesn't use the 0% voluntary lapse as their assumption. It would be a mistake not to. Even though there is a lot of interest in the product, there isn't a lot of competitiveness in that marketplace yet. The 10 pays and the single pays are very richly priced, relative to the annual pays. Likewise, they have been made non-can by their nature—single pay immediately, 10 pay at the end of the 10 years—but, for most companies, that's practically from day 1 anyway, because it's not likely they will have enough experience or enough payment periods left by the time they discover a problem, if there is one, to deal with it. However, they are dealing with an indemnity style benefit, where, in theory, you can fund to some fixed annuity value and, in that, you can make some reasonable assumptions about how high some of those factors can trend. So if you are given enough of a cushion in the pricing through lack of competitiveness, you probably can price a product that is prudent and safe.

Now, I will offer a caveat by saying that, as more of these products come onto the market, competitiveness will creep in, just as it did with non-can disability. And you'll see people do things that aren't rational, given that it's a non-can product. But I wouldn't toss out the whole concept of non can generally, which I don't think will be successful in the marketplace on an annual pay basis. The reason I don't

think it will be successful is not because it's unsafe, but because most people buying guaranteed renewable, don't realize that it's not non can. So how are you going to compete with a true non can against an apparent non can. But as far as a 10 pay or single pay go, I do think that they provide a useful consumer service and that they can be priced, not with the same level of comfort perhaps as an annual pay, but with a good, solid expectation of being able to do it. And I'm sure we can find enough room as reinsurers to help reinsure some of it, if any of you do want to venture into that area.

Mr. Abroe: I'll be interested to see how the LTC risk-based capital formula (RBC) will address the limited-pay products.

Mr. Glickman: I'll be curious to see how the RBC formulas come out for the regular LTC. Even though it seemed to have disappeared from the scene recently, a few years ago regulators were looking at 35% and 25% of premium as the standard. I don't know where it is right now in terms of the calculations.

Mr. Snow: It's where the rest of health is.

Mr. Glickman: So there isn't any larger RBC, which most people think is appropriate.

Mr. Snow: Right, there's not.

Mr. Glickman: That's an interesting concept. You brought up the issue earlier when we were talking about a client feature called "Alternative Plan of Care" (APC).

Mr. Snow: I don't know if any of the companies represented here are offering APCs.

Mr. Glickman: Let me ask. First of all, I assume everybody here is offering some version of APC in the individual market. Who is using APC definitions of some sort in their policy? Does anybody have individual policy forms that don't have any mention of APC in them?

From the Floor: Some old ones, but I think that they offer it informally anyway.

Mr. Glickman: So let's start with the ground position that everybody offers APC definitions in their policies.

Mr. Snow: Then the question I have for members of the audience is, Do you have well documented rules about how you're going to decide which plans are or are not acceptable and whether or not you have any concerns about the legal aspects of APCs? They are notoriously fluid. You just say, "Regardless of what's in the policy, if it makes sense, we'll give you something else." And if Mr. Jones comes in and asks for an APC and it makes sense, you provide it to Mr. Jones. Then Mr. Smith comes in and asks for another APC and it may not make sense to you so you say no. Then what happens if Mr. Smith says, "Why did you give Mr. Jones this treatment and didn't give it to me?" Do you have any legal problems with any of that going on? And, do you feel comfortable with the APC? I want to get a sense if anybody here has struggled with that and what kind of resolution you've reached.

Mr. Abroe: I know one of the first carriers to have an APC has had a lot of problems restricting the effect of their original provision. However, their current provision is much more restrictive. Whether you argue that it's the contract language, the sales materials, or the way in which a product was sold, I don't see what they're currently selling as being as much of an issue as what they had sold in the past.

Mr. Glickman: The original APC made some sense, that is, if you can be taken care of more cheaply and you and your physician agree, we will agree to take care of you more cheaply that way. However, it got translated differently, especially in that wonderful state of Florida. Agents took it to mean that, if you could be taken care of at home for $50 a day instead of in a nursing facility for $100 a day, that was cheaper and, therefore, you would be able to get that without buying the home health care rider.

The company that originally started this didn't have good definitions, so companies have come to realize that their language has to be more specific. Most have taken one of two positions. They have either said that you first must be confined to a nursing facility before they'll consider an APC, or they try to define specific low-cost modifications or device aids that they will cover while saying that this is not a substitute for home health care. Generally speaking, if you keep your language tight enough to avoid having the agent give the example we just cited, and then having somebody be able to claim he or she relied on the information, you're probably on reasonably safe ground. But I think that everybody wishes the clause would just go away.

Mr. Benz: We will not put it on our nursing facility only plan. We will only put it on the plans for home care. That way, you don't get the illusion of home care, if they don't buy that additional coverage.

Mr. Glickman: A lot of companies have taken that approach recently, because that is where the major abuse is. Many companies feel that if you bought the comprehensive plan, especially the pool of money design, APC wasn't anticipated in the policy language. I know of several companies that have used the APC on their older policy form before assisted-living facilities were specifically provided for. They've only done it on their comprehensive plans. Generally speaking, if they have a nursing facility plan, it still only covers nursing facilities.

Mr. Snow: Does your company limit the amount of APC to the amount that's provided for home health? If it was $100 a day for the nursing home and $50 for home care, could your APC give $75 a day or only up to $50?

Mr. Benz: Our contract is open on that. It depends on whether we would agree to that or not. But, if it would make sense for them to get services one day a week for more than we would have paid for home health care for that one day, but without an APC, they would have gotten five days a week of service at a lower rate per day, that's something that you would definitely consider.

Our company is in its infancy on this. We have not been faced with a situation like this, but we are hopeful that the way we have worded our contract is right. We have retained the right to approve or veto any payments under the APC. If the structure of care is being set up wrong, then hopefully we will not get "ripped off."

Panelist: Good luck.

Mr. Abroe: There are studies that have been done on social HMOs, various programs in Arizona, Colorado, or Oregon, that have looked at this issue on the Medicaid population side. The results seem to indicate that, through managed care, you might be able to get the total cost down somewhere between 20–25%, depending upon the types of medical management. The one that sticks out in my mind is Arizona, whose ALTEX program was originally developed as a substitute for the Medicaid program and has demonstrated, over time, about a 19% net savings.

This 19% is the net decrease in per capita costs realized in going from an unmanaged home health and nursing home chronic care operation to a home-based, community program. The nets of the reduced nursing home utilization offset against the increased home health care and disease management type programs. We've also seen some organizations get into this type of a dynamic in some of the LTC programs that they're doing.

Mr. Snow: Don't some of the studies also include medical costs in their analysis? Also, isn't this the effect of caps? Our policies have $100 a day nursing home cap.

Mr. Abroe: I'm talking about state population studies, rather than how they work on the insurance side.

Mr. Snow: So you have to translate that analysis to all policies, which may not be quite the same.

Mr. Abroe: That's correct.

Mr. Snow: You have to be very careful in directly translating 19% in the state population to what's happening in insurance, although I think it's very interesting material.

Mr. Barackman: I would think the effects would vary quite dramatically between, for example, a lifetime policy and a two-year policy. Under a lifetime policy, probably most of the benefits are going to someone who's well beyond a managed care situation, in terms of their treatment or type of care. Under pool-of-dollar type policies, it's not clear that lower cost of care translates directly into savings for the insured or necessarily a reduction in the premium. Outside of that dynamic would be very specific to the lifetime maximum benefit, under a pool-of-dollars policy. I would second the concept that it's premature or unwise to make broad assumptions about reductions in terms of morbidity.

Mr. Abroe: There's a philosophical issue that the company needs to address: How much are they willing to participate in the care, or do they want to have the traditional third-party relationship? I think that's a big nut. I'm waiting to see whether or not HMOs will take the acute care or try to put the full continual care together by bringing in the LTC benefits and get aggregate cost reductions through both programs combined. I still haven't seen that yet.

Mr. Snow: Metropolitan Life, when I was there, was trying to do exactly what you are talking about. Group Health of Puget Sound had an agreement with Metropolitan Life that went back about 12 or 13 years. It was trying to figure out whether or not that was true. Unfortunately, there were other issues involved and the project did not go forward, so we don't know that answer. I don't mean to say that it's not possible to achieve some savings, by the way. I don't want my comments to be misconstrued.