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Session 12OF
Underwriting the Long-Term-Care Insurance Risk

Track: Long-Term Care

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Summary: Underwriting is a critical component of managing long-term-care (LTC) insurance risk. The techniques and methods employed vary significantly among companies. Determining the impact of underwriting on expected claims is a key challenge for a pricing actuary. Under the new long-term-care model regulation, initial filing requirements include a statement regarding underwriting practices, which makes an actuary's awareness of underwriting techniques even more important.

MS. AMY PAHL: I want to mention that although this session is listed as an open forum, we're going to treat it as an interactive forum. We think this topic lends itself to back and forth dialogue and questions and answers, and we want to get you more involved than an open forum would allow. With that in mind, I hope you're all thinking about questions that you would like to ask our experts.

We have a great panel of experts. Steve Rowley, who is second vice president of risk management for General Cologne Re, has been in the health business for many years. He started on the disability insurance (DI) side and gravitating to long-term-care (LTC), where he's been working for a number of years. Next is Andrew Herman, our actuary on the panel. Andrew is with Wakely & Associates and has been in LTC for nearly 10 years with a number of different carriers. Last, but not least, is Gary Jacobs, president of CHCS.

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He's been in health care for his entire career working on managed care and provider issues.

As I mentioned, we are going to operate this session as an interactive forum. We've prepared a list of 12 topics. We want to make sure we touch on the topics that are of most interest to you.

Why is LTC underwriting important to the actuary? It has always been important to the pricing actuary, but it may be more so now because of the new LTC model regulation. That's the primary reason this session was included at this meeting. We wanted to bring it to the forefront and bring all the issues out to prepare the actuary who must certify new rates under the new regulation. The actuary must have some knowledge of what needs to be considered as part of the certification.

We're going to give each of our panelists an opportunity to comment on each topic, and hopefully, you will either want to expand on their comments or will have questions on the topics. Steve Rowley is going to start with his comments on underwriting tools.

MR. STEPHEN ROWLEY: First, we want to talk a little bit about tools. These are just our opinions. I have been through some of what we've been seeing for new tools, changing tools, or changing limits within the industry. I've been in LTC for about three-and-a-half years, coming from DI. Even in that short time, I've seen a tremendous change. First, the applications are getting better at digging down to what the underwriter really needs—information on nonmedical issues. Telephone interviews are also much improved.

An area that I want to touch on in more detail is face-to-face assessments. It's an important underwriting tool and there seems to be some disagreement in the industry, yet a fairly consistent movement. A fairly informal survey I recently conducted for one of our clients shows that the average age of face-to-face assessments has decreased to 70 or 72 from 75. Some companies still haven't specified an age at which face-to-face assessments are mandatory. Some dispute the value in such a practice. I don't know if it is of value in terms of the actual information, but it clearly is important in terms of the sentinel effect. If everybody else is doing face-to-face assessments at 70 or 72, and you're not, the sales force will find your weak spot, especially if you deal with the brokerage market. This will probably occur more on the issue of frailty than cognitive impairment.

The Medical Information Bureau (MIB) is another tool. I don't know how many companies here are currently checking MIB, but I think they've added five new codes.

FROM THE FLOOR: Four.

MR. ROWLEY: Thank you. They've added four new codes that are specifically

targeted at LTC, including a code for failed cognitive tests, use of assistive devices, and two others that I don't recall.

MIB is an inexpensive tool. It runs somewhere around $0.38-$0.40 a hit once it's set up, and I can't think of anything less expensive that gives an underwriter an ability to go after a problem or provides a hint that there is a problem.

FROM THE FLOOR: I have a quick question on MIB. One of the reasons that many people don't want to use MIB is that your chance of getting a hit is fairly minimal given that the database hasn't been built up on LTC very well. But, with MIB you're also obligated to do all sorts of reporting. I had heard that they planned to cut back on the amount of reporting required on some conditions.

MR. ROWLEY: Currently, with MIB, the database is not huge, but don't forget that it contains many codes other than these four new ones that pertain to life or LTC, Parkinson's Disease, and things like that. The database isn't as small as you'd think, with only the four new codes. I think it'll be more valuable five years from now. My understanding, from talking to Charlie Erickson at MIB, is that the intensive coding that was required in the past, which can be rather labor intensive, is not required now. You should provide code information for the significant items that you see. Obviously, if you have someone with Parkinson's, you should code it, but not necessarily if you have someone with a lower-back problem. DI underwriters would want to see it, but on the LTC side, it's not necessary, as I understand it. It makes the process a little bit easier.

Another area I want to touch on briefly is an organization that researches pharmaceutical databases to provide an underwriter with an applicant's prescription drug history. I understand that the organization has about 80 percent of the pharmaceutical databases signed on. The problem is that it's still considered to be very expensive at $20 a hit. I'm having trouble getting clients to check MIB, at $.38 cents a hit. It must still be used like MIB—you can't decline a case based on a code. For example, if you see somebody is on an anti-Parkinson's drug, you can't decline the case. You still have to go after the attending physician's statement (APS). I think it holds promise for the future, although it's not complete yet, and the price is still an obstacle.

The last issue I want to discuss is the telephone application (teleapp). There are various versions of it. Last week I had the benefit of viewing a teleapp procedure that I thought worked. It's the first one I've seen in which the agent was cut out of the process. Teleapp protects the company and the agent. If a teleapp procedure can be prepared by professionals who know how to drill down, then the person completing the application can be prompted for the right questions to ask. For example, if somebody says that they have arthritis, the person completing the applications would be prompted to ask questions such as, "Is it rheumatoid or osteoarthritis?" "What joints does it affect?" This would allow the application and the telephonic interview to be combined, which would speed up the process

considerably, and probably avoid a lot of applications. It's an expensive process, but it's a wonderful new tool that has been used successfully in life insurance and by at least one disability company.

MR. JAMES M. GLICKMAN: (LifeCare Assurance Company) When you say it's an expensive process, can you quantify that a little bit?

MR. ROWLEY: I know of one DI company that is setting up a procedure that they leveraged from their life operation, but I think it cost $200,000 just to get things going. For some companies, that is an insignificant expense, but for others, it may represent their total LTC sales for the year. The issue is, "Is it worth doing?" There is at least one vendor I know that has this capability now. A relationship with such a vendor would enable companies to implement this immediately and pay what I assume would be slightly higher fees over time rather than incurring the entire cost up front.

MR. GARY JACOBS: Steve, in that process, the agent does not fill out an application with the individual at all?

MR. ROWLEY: The agent would ask three or four "killer questions," after which the teleapp process begins. There are several ways it could be done. The agent could set up a time for a call back or pick up the phone right then and connect the applicant with a nurse or telephone interview professional. That person would then go through all of the medical questions, which are connected to dropdown screens in the program. I saw one recently that makes filing easy. The dropdowns aren't built into the application, but answering "yes" to a medical question triggers their phone history interview form to appear. The form prompts the user to re-ask the question and gather details.

One problem with telephone applications has involved state filings. Building dropdowns into the application itself makes approval almost impossible. This process actually defers all of those issues to the PHI, so the state filings can remain as they are currently. It's a pretty impressive process and I think it would give companies better and faster information, and save the agent trouble as well. The agent is the applicant's "buddy" when they're applying, but when a claim comes in and it's non-disclosed, the applicant usually says, "Well, I told my agent."

MR. JACOBS: I don't think I like that idea, especially on individual LTC sales. I think the agent should be involved in that process to some extent. There's a relationship issue between the agent and the prospective policyholder that should be addressed or replaced. The agent assumes an advocacy role on behalf of the policyholder with the company at the time of underwriting. I think there are some other issues as well. I don't necessarily believe that it's good to just take that person out of the process.

MR. ROWLEY: They're not totally removed from the process. We've reduced

commissions by 50 percent. Are there any other tools or issues that you've heard about that you'd like to discuss?

MS. PEGGY L. HAUSER: (Long Term Care Group) I just have a quick question on the teleapp. Do the agents still fill out the agent report, or is that eliminated?

MR. MICHAEL MAYER: I'm from Nations Care Link, and I'll address Ms. Hauser's question. We've talked with several companies about this and they all have different processes in place. The process depends on whether they plan to collect premiums up front or after the fact. It has a lot of differences in terms of what they believe their placement rate will be after the fact. I'm not sure specifically about agent forms.

MR. JACOBS: Then the agent looks like an order taker and a presenter of information and no is longer directly responsible for serving as an advocate for the prospective policyholder.

MR. MAYER: I think some agents will like that and others won't. It also provides another option for companies that work with agents who don't have specific knowledge in LTC. It gives them another option for getting that business.

MR. ROWLEY: With one disability company that I've dealt with on this procedure, the process failed because the company made the procedure mandatory, and the agents didn't like it. One DI company I know that's very successful at this rolled it out in what I think was a perfect form. It was first given as a gift to the top producers. Once you give it to them, everybody else wants it. It was voluntary. You could do the old application or the new application. Last I heard, 90 percent of their producers were submitting business by a teleapp. That was purely voluntary. They'll be discontinuing the paper application in the very near future. It's not worth keeping both processes in place.

MR. ANDREW J. HERMAN: I would say that in LTC, underwriting is critically important and it's just as important as the going-in rate. You can think you're priced adequately but if the underwriting is not there, then you're clearly going to have a need for rate increases. Also, I think that the actuaries are really aligned with underwriters.

Another comment I want to make about the changing nature of the tools is that clearly, more tools are being ordered. The face-to-face assessment is something that concerns the actuary. If you price a product after assuming that a face-to-face assessment will be used only for people older than 75, and the entire industry is shifting toward using a face-to-face assessment beginning at age 70 or 72, then you have to advise your company either to change your underwriting, revise your rates, or both. I think you really have to keep abreast of what's going on in the industry to stay competitive.

MR. JACOBS: I would like to address the face-to-face interview. I believe that it should always be done by a professional registered nurse (RN) because it gets into issues in the home environment that somebody other than a nurse might not typically identify. To be conservative, clearly, you should use a RN. To be marginally conservative, you should use a RN. I think that the RN's ability to obtain and abstract information that an agent wouldn't be able to is critical in the process.

I also think that getting APSs is a problem. The issue with APSs is that the process of obtaining information from medical records is inconsistent with the time frame for a marketer. The agent lives on commission so he or she does not like to see a prospective applicant go through a very elongated process when something pops up on a medical record. At times, the underwriter really needs additional information or tools, so it puts responsibility back on the marketing person to help with that process. It's a process that requires, in my mind, a lot more work. I don't think we've figured it out yet.

Recently, I sold one of these policies, and in the sixth week, I started getting faxes that said something about looking for, or waiting for, medical records. A few weeks went by, then finally, a medical record. I called the underwriter because the policy belonged to my best friend's mother. I advised the underwriter to take care of it. Finally, the underwriter said, "Well, on the third medical record from one of the doctors who wasn't even listed as one of the applicant's doctors, we found evidence of a taxable income adjustment (TIA). We thought it was a TIA word, but we're not sure." The underwriter asked, "Can you do some research for me?" I asked, "Why do I have to do some research? I really don't want to do that kind of research."

I eventually had to write a letter in which I explained the story as it was relayed to me by my friend and his mother. We got the policy issued about two weeks later. The process is not black and white. From product pricing, underwriting, and distribution standpoints, the process needs to be more coherent at times.

One of my two issues is that a RN should collect the information. I also think there's a problem in general with the retrieval of the APSs. It's taking longer. We're spending more time when we contract with companies to do this for us, and sometimes it pays to have our nurses do it.

MR. GLICKMAN: I want to take a position counter to yours, Gary. A lot of companies—and I know you've encouraged them and feel strongly that it makes sense to do it this way—use the face-to-face assessment as the primary resource and then get only the medical records that seem necessary based on either on the application or the face-to-face assessment results. One of my big concerns, even getting away from the potential of an agent perhaps taking a too favorable a view of his client's position, is the fact that most people, in order to live with long-term, degenerative chronic diseases, have to downplay them in their own minds. After a period of time, they actually convince themselves that they don't have the disease, they aren't material, or they aren't something for anybody to be concerned about,

including themselves. Therefore, if they are able to be cognitively aware and pass the face-to-face assessment and seem to be living well, you may never get at some of these things if you don't pull medical records.

As for the teleapp, time savings is one of the big benefits for an agent who uses the procedure. What tends to happen, at least in our operations, is that it takes an average of nine days from the date a policy is signed until it's received in our office. First, it makes it into the trunk of the car for awhile. Then, it may go back to the agency. The agency then looks at it. Then, the agency sends it by regular mail across the country. If you save nine days or more in that medical records procurement process, you're way ahead of the curve in terms of the major objection to pulling medical records, which is that time delay.

I would suggest that while face-to-face assessments are very good—and I think they should be used even more than they are—they are only part of the solution. In fact, face-to-face assessments may lead to a much worse block of business if you don't pull medical records because you think you've gotten more complete information from the clients. In some cases, maybe you would be better off pulling medical records and not doing face-to-face assessments.

MS. PAHL : This is an opportunity to lead into the cognitive screens because face-to-face assessments are an opportunity to get to the bottom of the cognitive situation. Let's move into that area while still addressing Jim's question.

MR. JACOBS: To answer part of that question, the RN is your eyes and ears in the home. I think that's really important. That provides a watchdog, if you will, on the agent who may be too much of an advocate at times. What I have a dilemma with is, when does the APS process stop? How do you keep going and going and then stop, and how does that process work? How do the underwriters know when to stop? How much is the investigation, and is something triggering how far you can continue to go in an investigation? What are you doing in that process?

MR. ROWLEY: I think I'm speaking for probably every company. We want to avoid APSs. We actually have to read those things when they come in.

MR. JACOBS: I know. That's what I'm saying.

MR. ROWLEY: We don't like getting them. You try reading the doctors' handwriting. But, I would say that on average, in LTC companies, unlike in life or DI, it's rare that I see more than one APS on a case. If it's an inch thick, it's declined. You don’t want to read that.

The problem is, though, that you get an APS that says the patient saw a doctor Maybe the patient is 85, and you want to get another APS from the general practitioner (GP). The GP’s APS consists of very basic notes, but they mention that the patient is seeing another doctor for diabetes control. Your company wants to

get APSs for diabetes, but there's nothing in this record, even though theoretically, there should be. I think most underwriters will say that, if the diabetes is well controlled, they don't feel they have to go after the other APS. But if there's a hint of a problem, sometimes you do. I would say that more often than not, companies don't go after that second APS. We all try to avoid it—not only from a cost standpoint but also from a time-service standpoint. Underwriters don't like reading them so we're not eager to get a lot of them. There are a couple companies that APS everyone. That's their choice, but generally, I don't think underwriters order too many APSs.

MR. JACOBS: Do companies use the distribution to go back and get information for them in that process since they don't like doing it? Do they ask the family, "Did you really know about this? What was that?"

MR. ROWLEY: Confidentiality actually prohibits that. For instance, if I have an APS that says someone was worked up for Parkinson's, I can't go back to the agent and say, "Dr. Smith's June 5, 1999, entry mentioned questionable Parkinson's. Please get details." What I always say to the agent is, if the applicant had wanted to share this history with you, he or she would have told you on the application. You cannot specifically go back and ask about it based on the APS. If we could, it would make our lives much easier, but it would violate confidentiality.

I don't know how many companies allow their agents to pick up APSs. I am not a fan of that at all. It gives them access to information that they probably shouldn't have. Once in a million times, an agent might actually say, "Well, this page looks bad, I'm not going to submit that. They'll be declined." It gives the opportunity for questions to arise. There are a lot of confidentiality issues. In most cases where underwriting and agent relationships break down, it's because we have to live with these strict issues of confidentiality, and we can't share information with an agent.

MS. PAHL: Our next topic is cognitive screens.

MR. ROWLEY: There are a number of standardized tests available. Without endorsing any one test, the only comment from the underwriting side that I would make is that there are probably five generally accepted cognitive tests, and they have certain requirements. For example, delayed word recall cannot involve just any word. There is a set of words that has been tested and proven successful. The only thing that I recommend is that you not make up your own test. I have seen companies ask, "Do you remember which president was killed in the 1960s?" I'm not a doctor, but if I understand correctly, certain things are burned into your "hard drive." President John F. Kennedy's assassination is one of them. You could be in an Alzheimer's facility, and you might remember that one. Questions such as, "What did you do yesterday?" or "What do your car keys do?" that that can raise more concern.

Again, don't make up your own test. Similarly, if you're using a Third Party

Administrator (TPA), make sure that you maintain control over the person. I was recently doing an audit at a company and I was looking at interviews that were done by a TPA. I noticed there was a time period in which the cognitive test suddenly had changed. I asked the underwriters, "Why did you guys change the test from these questions to this?" They said, "Oh, we don't know. The TPA just did it." To me, you own the risk. You're going to pay the price. Now, if a TPA has a suggestion and says, "You might want to change to this," that's one thing. But in this case, the TPA just said, "We're changing our cognitive test," and didn't even advise the company. To me, that's absolutely unacceptable. You should be in control and use one of the standardized tests.

MR. HERMAN: I think that as the industry has matured and carriers have continued to learn a lot from experience. In the early 1990s, many companies had pricing problems. Loss ratios were high, and my guess is that a lot of it was due to not using enough effective cognitive screens. The cognitive claims are the long ones. If you miss on the long-term claims you're really going to get hurt.

The other point I'd like to make about using effective cognitive screens is that you may find that you issue more cases. Certain conditions that were previously declined will now be issued. I really can't overemphasize how good it is for your product performance to use effective cognitive tools. Clearly these tools are expensive, and I think it's hard to measure the protective value. But my gut feeling is that it's going to be worth it to use the costly ones.

MR. JACOBS: I think the most important issue is that the fastest rising age group in the U.S. is 85-plus. Statistics suggest that 50 percent of that population will have some degree of cognitive impairment and that 5,000 people are turning 65 every day. There will be a doubling of that population group from 30 million to 60 million within the next 25 to 30 years. With the statistics moving upwards, the chance of disability in this area is significant. I think that in whatever test you choose, you should be consistent with underwriting, product development, actuarial, and distribution. They all know what the rules of the cognitive process are, and that cognitive testing is not the only measure for cognition. It also should involve the clinical aspect of the cognitive piece in either the face-to-face assessment or the medical records.

MR. GLICKMAN: Has anybody done any studies or analyses regarding the age at which cognitive tests should be required? I know that most companies are doing them now at age 80 and over. Many are doing them at age 75 and over. Some are doing them down to age 72. A few are doing them down to age 70. One or two of them are even doing them with people younger than that. My questions are, from where is the cost benefit driven, and what is the recommended age at this point, based on what anybody's studied?

MR. ROWLEY: Other than vendors who might be doing tests on it, I don't know if anyone has. I would say that you certainly might have people under 65 who are

cognitively impaired. At that age, though, I think it's a waste of money to conduct tests without cause. I'm talking about telephonic cognitive tests. Certainly by age 85, 50 percent of people have some form of dementia. Not to conduct cognitive testing at 85 is insane. To do it at age 65 and under though, is probably unnecessary.

I would probably advise splitting the remaining age groups at ages 70 and 75 and doing telephonic cognitive screens at ages 70 to 75 and face-to-face assessments at age 75 and over. Face-to-face assessments are better for long-term issues. If a nurse is out doing a face-to-face assessment, you should do a cognitive test then. Most of the cost of a face-to-face assessment is the nurse's travel time.

MR. LAWRENCE SCHEINSON: I'm with TIAA-CREF. Is anything being done to detect people who may be predisposed to cognitive impairment but are not yet cognitively impaired?

MR. ROWLEY: That's what all the screens are designed to get at. If they're cognitively impaired, it should jump out at us.

MR. LAWRENCE SCHEINSON: Genetically or family history?

MR. ROWLEY: Not that I'm aware of.

MR. JACOBS: Isn't that already priced into your product? People who have genetic predispositions don't necessarily know that they do. For breast or ovarian cancers, for example, there are no good markers, at least no excellent markers, let's say. There are markers, but they're not proven effective at determining specificity and sensitivity.

The whole purpose of cognitive screening is to identify a cognitive impairment to the individual or their family. Perhaps the individual is in the early stages of a cognitive impairment but is not aware of it. Isn't that already priced into products because actuaries are doing community rates that have been lowered somewhat by underwriting? I think that someday we'll have to confront that issue when it comes to genetic testing for Alzheimer's. Cognitive screening is going to improve. Today, we see people who have a one or both parents who, in their 50s, were demented. If they have an uncle who also has dementia then this person probably has a much higher probability of suffering from dementia in the future than someone who doesn't have the same family history. There aren't many people using that type of information right now. I know that some individuals who see medical records that indicate an individual has the positive gene for Huntington's disease will use that in underwriting.

MR. ROWLEY: That's actually about the only disorder I know of that we will decline based on family history. There are very few others. But you're right. What we're trying to do is to use cognitive testing to avoid people who are anti-selecting.

Often, their children are prompting the sale because they've seen early hints of symptoms. I don't think anything's being done yet to identify which people are going to become cognitively impaired. It is not even on the radar screen for the immediate future.

MR. JACOBS: How predictive are the cognitive tests used today? If you have a normal test today, and you get a cognitive claim 24 or 30 months from now, did that cognitive test fail? Maybe not. Maybe these tests are only protective for 12 months or even for six months. No one can tell us that right now.

FROM THE FLOOR: I think this comes back to the point that, from an actuarial standpoint, if you are community rating across the board, you have to price assuming that a majority of the age 85-plus population is cognitively impaired.

MR. DOUG PRICE: (Wakely and Associates). I'm surprised that insurers don't ask, "Have you had a genetic test done?" That's what I'd want to know. I'd be worried if they went and had a genetic test. I think you can ask that question. I don't think you can ask what the results of the genetic test were, but I think you can ask them, "Have you had it done?" And, if they had, I'd decline them.

MR. ROWLEY: I think you'd run into all sorts of legal issues if you did. It might be a fair question, with all the talk of genetic testing, but I really don't see anyone going to their doctor for genetic tests based on the APSs I see. I don't know if I've ever seen a case where someone comes into their doctor saying, "I want to be genetically tested," even if they have a family history of breast cancer, for example. Family history may show that they're very likely to get it sometime, but I've never seen an APS where somebody went in and said, "Do genetic testing on me." It may happen, and it might be a good question to ask. I'm sure the lawyers would have to read that question and consider what the underwriter's going to do with it very, very carefully.

MS. PAHL: Let's come back to this issue if time allows, but let's move along to lifestyle underwriting. Gary, what are your comments?

MR. JACOBS: From my perspective, lifestyle underwriting is significant in two areas. First of all, I think it's important from the telephonic or the face-to-face interview you're picking up basic lifestyle issues that may include driving history, lifestyle, and activities that suggest whether one is active or not active—the 'couch potato' syndrome.

The second area in which I think lifestyle factors are significant involves multiple-rating classes or preferred or substandard rates. In the substandard or preferred rating example, if someone's lifestyle habits involve not smoking, physical activity, and no driving history, one might say that would put them, along with their other testing criteria, into a higher rating category, and therefore, they are more likely to be issued a preferred rate. The substandard issue tier rating may actually work to

the advantage of the potential insured. If you have multiple tiers, underwriting lifestyle factors may gravitate somebody up a tier. But I think that in any healthcare underwriting, you have to factor in lifestyle, and the interview process must at least include those questions. Then, from an underwriter's perspective, you must decide how they're going to include them.

MS. LOIDA ABRAHAM: (John Hancock Life Ins Co.) Gary, I had a question about lifestyle underwriting. How do you verify that what they're saying on the app is, in fact, true?

MR. JACOBS: That's a tough question. I think that the face-to-face interview is the only place you have a chance to verify those issues. You can see by a person's physical body. You can see what they are like in their home environment. It's the only way I think you can verify the information.

MS. ABRAHAM: But if you're going to use it for preferred, how do you do that? Preferred usually applies to younger people who are not required to undergo face-to-face interviews.

MR. ROWLEY: I think you could ask some questions that would help. We can't verify 90 percent of what we do.

I recently saw a company ask not only if the applicant exercised, but also what types of exercise. They were asking not only what you do, but when was the last time you actually did it? You see a lot of disparity in those interviews, and it's rather entertaining.

A representative from Mutual Protective commented at a Society meeting in Miami about something that I found very interesting. They have two similar policies, and both have a preferred discount. On one of the policies, the preferred rating is based solely on nonmedical information. You must answer “No” to three out of five lifestyle questions, such as, “Do you drive more than 10,000 miles a year?” The other preferred rating is based on medical information only.

The one that is based on medical information has performed roughly, as expected. The one for which the preferred is based on non-medical information has performed significantly better than expected, and I thought that was very interesting on a case study basis. Here's one company that took two approaches and was able to measure the difference in impact. Nonmedical underwriting has really had a favorable impact on the business.

MR. JACOBS: There's one other item here, too. We find that fractures are the number one issue presenting for an LTC claim. Fractures are a direct result of deterioration of the muscle-skeletal system and bone density. If you do activities that increase the strength of those parts of your body, there is less likelihood of you falling and breaking something. Just intuitively, I think that anybody, whether

they're 80, 60, or 30 years old, and actively works to build that strength may be a better risk. Most 80-year-olds who fall die within two years, based on our experience with LTC claims.

MS. ABRAHAM: This is the follow-up. You talked about how lifestyle underwriting has a bigger impact on preferred underwriting. Is it your sense that it's a permanent morbidity savings that allows the preferred underwriting, or is it due to the reduction of the underwriting selection factors in the first years?

MR. JACOBS: I think it helps get somebody to a preferred class. I won't even guess about the latter part of the question.

MR. HERMAN: I'm going to suggest that aside from determining which risk class somebody goes into, my experience has been that underwriters basically rely on medical files when they have them, and medical factors override any lifestyle considerations.

MR. STEPHEN K. HOLLAND: I'm with Long Term Care Group Inc. Two data points—smoking is the number-one issue for lifestyle, and number two, one that we don't consider often, is being single. People who are married or have a companion claim at a much lower rate ultimately. We don't usually use that, but it is a factor. The marriage discount is real for those people.

MR. ROWLEY: Gary had mentioned that we often go back to the medical records. One ongoing question is, "How much weight do you give to the nonmedical issues?" I've had arguments with individuals who felt that nonmedical issues are 80 percent of underwriting. I don't agree. I do think a good underwriter reads the medical records. But, if there's an area of medical concern, they go back and look at the lifestyle that goes along with it. For the borderline cases in which someone has great lifestyle factors, you're going to try and do something better for them. If someone has poor lifestyle factors, you might lean toward declining them.

For example, for most companies, it is standard practice to decline an applicant if surgery is planned or highly recommended in the near future. I had a 70-year-old woman whose doctor had been telling her that she was going to need a knee replacement. It could be a significant surgery, a significant LTC claim, or at least a short-term LTC claim. Most companies would have declined even with a 90-day earned premium (EP).

This 70-year-old woman was an avid mountain climber who traveled the world to climb mountains. I had a gut feeling that this person was not going to lie back and say, "Poor me, my knee was replaced, and I'm just going to sit here and collect home care forever." This woman was going to get herself back up because she had a zest for life. We took that case.

Normally, for someone facing knee surgery, it is significant. You don't want to take

somebody who's heading into that. However, I looked at the lifestyle. I went back, it was a gray area, and I said, "I feel good about this person. I don't think there's going to be a problem." We took her, and as far as I know, a claim hasn't come in, and the surgery's probably been done. Helping you with the gray areas is, I think, the real value of looking at nonmedical data, and that's not easy to quantify.

MR. JACOBS: Another example is if the underwriter was a runner, and an applicant was also a runner, the underwriter would be much more apt to think that a runner is a healthier person because runners feel that way.

MS. PAHL: With that, let's talk about underwriting styles. What defines loose versus tight underwriting?

MR. ROWLEY: I think it's based on the requirements because in most companies that I've audited, whether they're considered loose or tight or if their rates are higher or lower, if they find out somebody has problem X, the decisions are pretty similar. If a company does not require face-to-face assessments at any mandatory age, to me, that is loose underwriting because there are things that will not get picked up. If you've chosen to go with a $3.85 telephone interview, that's loose underwriting. Now, if that $3.85 interview tells you of osteoporosis, most underwriters I've seen will make decisions similar to those of a company that has a very rigid interview. I think "loose" means simply not getting a lot of material or a lot of requirements. One frustration I have during audits is that I'll come away saying, "I think the vast majority of the decisions I saw were correctly based upon the information gathered." However, I probably would have gathered more information. I don't think loose underwriting is done deliberately on the underwriting level. It's prompted more by trying to reduce costs and sometimes being penny-wise and pound-foolish.

Let's say that you're with a company that does loose underwriting, and you're going to charge 50 percent more for your product. My impression is that the marketing side of the LTC industry is still rather immature, and producers are learning to find each company's weak spot. I can't believe that just charging 50 percent more to cover your claims is going to give you a decent risk pool.

MR. GLICKMAN: I think the market is much more sophisticated than you think. We regularly get requests from agents if we haven't given the reason for the decline. They ask, "What's really the reason?" That way they know which company to take the decline to get it issued. Sometimes it's based on the fact that they know the second company will take that decision, but most of the time it's because they know that company doesn't pull medical records or doesn't do face-to-face assessments. Therefore, they have a much better chance to push the application through the system.

MR. ROWLEY: It goes back to the sentinel effect. How much do you take that into consideration? For example, DI companies lost their shirts on applicants who were

doctors. When the industry changed and said, "Well, we're going to get really tight on docs," one company that hadn't had poor experience said, "Our personal experience is not bad." Guess what changed in the next 12 months? All the agents sought them. How many of you factor in the sentinel effect? Do you care, as actuaries?

FROM THE FLOOR: I don't know what the value is, but I think the sentinel effect can wreck a company. If you're the only major provider with a certain practice, they're going to find you.

MR. GLICKMAN: The question is not so much who's worried about the sentinel effect. It's a question of when are the actuaries bringing a case back to management? You can't speed up the underwriting process so much for marketing that you forego some of the tools, particularly the medical records, which can be a key part of the process.

MS. KIM H. TILLMAN: (Lutheran Brotherhood) I was wondering how a decline ratio might fit in. I read an article once about the tools and it labeled underwriting as tight, medium, or loose, based on these tools. I went to our underwriters and tried to tell them they were tight underwriters because they use all of these tools and they were just shocked. They didn't want to be called tight. They said, "Well, our decline ratio is about the industry average. We're middle-of-the-road, right where we want to be." How much does the decline ratio vary across the industry, and what does that say about what kind of underwriting a company does?

MR. HERMAN: I'll address that one. I've seen a lot of different companies and observed declination rates from as low as the 5 to 10 percent range all the way up to 40 percent. It's difficult to interpret the data because it's sensitive to age. It's also sensitive if a company is new and whether it's being tested. It's sensitive to what the distribution is submitting and what kind of business is coming in. I think you have to take the statistics with a grain of salt, but if a company has a high rate of declines, I think, as a pricing actuary, you should feel comfortable that the poor risks are being weeded out. I think the other thing a pricing actuary will do is look at statistics such as declination rates and get a company's public experience and look at early loss ratios and formulate an opinion as to whether a company is a tight or loose underwriter. A company will get a reputation that way.

MR. GLICKMAN: I agree with Andrew that it's almost all art. The decline rate tells you almost nothing directly and we've done some studies of it through that *Broker World* survey. You'll find that companies that have been in business a long time all have the same decline rates and it's not because they all have the same underwriting. It's because the agents have learned enough about those companies to know what they will and won't take. They don't want to waste their time, especially given the fact that there are so many companies now that will look really hard at a case that has answered the question that is on most apps now: Have you been declined previously? They try to send it to the right place first. They do a lot

of that self-sorting.

The really oddball high decline rates are from somebody who is brand new in the industry, because marketers will all try it out. In fact, the really low decline rates are from the companies that say, “Hey, we're really tough. Don't send it to us unless you think we can issue it because you're wasting your time and disadvantaging your client.” You'll wind up with a really low decline rate, not because you necessarily were tough, but because you told them you were. Therefore, you didn't get the marginal cases.

MR. ROWLEY: I think Andrew's point on age is probably the biggest one. It's a frustration. Sometimes we'll be called in to do an audit of declines by one of our clients who is concerned that their rate is too high. That is always my favorite thing to do. I think the average age in the industry of LTC is around 65 to 66. This company that was concerned had an average issue age of 77. They are going to get a lot more declines than a company that has an average issue age of 63. Common sense tells me that if your only product is a zero-day elimination, lifetime benefit, or confined-in-home care product, and you don't have something to counter-offer with, such as a 90-day EP, or a two-year benefit period, then you're going to get more declines as well.

MR. JACOBS: There have been 600,000 policies sold each year for the last several years. There's been no major increase overall in the number of policies sold in LTC. The distribution part of the puzzle from this issue gets back to the product design and development processes. Underwriting is a significant component as part of the team of actuaries and distribution that decides what the rules of the game should be before a new product is released. You can then anticipate if you are a loose underwriter or a tight underwriter. You've factored that into the equation when you designed the product and everybody knows what the rule is going in.

What I have seen with a lot of companies is that the rules change. Once the rules have changed, you can go from being tight to loose or loose to tight, and then distribution will leave and go to other places. The truth is, though, that not enough people are buying LTC in this country anyway. We still have to figure out ways to encourage the sale of more of our own products, and that requires a strategy that integrates underwriting and the needs of distribution.

MR. GLICKMAN: Andrew, I know you’ve worked for both loose and tight underwriters, and I assume you've had a chance through those experiences to get a sense of what it is that they did differently that led to those two types of results.

MR. HERMAN: I think a lot of it depends on how much of it is controlled by management and how much is controlled by the field force. If you have a field force that's basically running the company and applying enough pressure, then I think the company will be a loose underwriter. But many factors go into it, and I think that companies continually change. One company that I previously worked for was

what I considered to be a loose underwriter, and they're probably not today. I think you can change, and it's not necessarily straightforward.

MR. GARY L. CORLISS: (AUL Reins Management Services LLC) I'd like to comment on what determines the declination rate and sometimes the withdrawal rate. Certainly some of the things that have been mentioned, such as age and the maturity of the field force or the distribution force, are important. Another item is how long the company has been in the business. We tend to see that also. The maturity of the underwriting staff can have a lot to do with the declination rates and, obviously, the financial results coming from that.

Amy, you should be congratulated on this list of topics that you've put together because I think it's good for us to be dwelling down on the individual pieces of the underwriting process. When we had meetings like this 10 or 15 years ago, the question was "Do you order APSs or not?" not, "How many do you get?" or, "When do you stop?" It was, "Do you get a cognitive screen?" not, "How many are there?" Being able to talk about all of those issues is really a major step forward, I think, for our industry. But when we get done, because most of us are actuaries, the thing we have to keep in mind is that every company is going to be different. They're going to be different in their results. They're going to be different in their underwriting and we just hope that the actuaries will take whichever ones they're really using and use that when they're coming up with the price associated with the product so that we all, 15 to 20 years from now, still will have careers in LTC insurance.

MS. PAHL: Thanks, Gary. Let's move on to underwriting guidelines. Are they enough for the pricing actuary, and what do they mean to the process?

MR. HERMAN: I think the guidelines themselves aren't completely sufficient. For instance, if you're administering a cognitive screen that asks, "Who is the president?" the interpretation of the applicant's answer is important. I think it's more than useful; it's absolutely necessary to have the underwriting guidelines. You would be remiss to develop a product without knowing what the underwriting would be, because your rate level probably wouldn't be right, especially in light of new requirements. California has already adopted a bill that requires an actuary to make a statement about the underwriting.

You have to have the guidelines and some idea of the protocols at the time you're pricing the product. I don't think it's quite enough. The experience on LTC business has varied so much by company and distribution channel that I really think that when you're developing a rate, you have to take into consideration a whole assortment of issues, such as the company's history. Do they have adequate staffing to do underwriting? Are they going to use a TPA? What does the product look like? Is it a stand-alone coverage, or is it comprehensive? In which region is it going to be sold? Many issues supplement the underwriting in terms of how your product is going to perform.

MS. PAHL: Another item, and Steve, I think you can speak to this, is the fact that if a company is looking to a reinsurer to help with underwriting guidelines, you must know who that reinsurer is when you're developing your product. If you do it after the fact, it's too late.

MR. ROWLEY: That's a good point, and we're starting to see more of that. I chuckle when pricing actuaries say they take underwriting into consideration because 80 percent of the time that we get involved, the products are already filed. Then, someone's coming to us and asking, "Can you help us develop underwriting guidelines? Who would you suggest for a TPA?" Clearly, 80 percent of the time the price is filed, the actuary signed off, and then they start to run into problems. They had assumed "X" in their pricing, but the telephone interview is going to cost them significantly more. The guidelines are more conservative than they thought, or they want to do new rate classes, and then they re-file.

I would like to see, and we as a reinsurer would prefer to be involved early in the process, even though they might not even end up reinsuring in the end. We have our manual. Other reinsurers have their manuals. Are you going to use ours, or are you going to use your own? Are you going to develop one? Are you going to buy one? Rarely do I see actuaries that actually went through that process. Usually, during the discussion we'll hear, "I hadn't thought about it." Yet, the product's priced and filed. Now they're looking for reinsurance.

MR. JACOBS: We're utilizing a point system with a lot of folks with whom we work. The point system is basically a risk-management process, from underwriting through claims. Then when somebody has a claim, we go back to find where we rated them from a risk point standpoint when they were underwriting. We give that data back to the carrier.

A lot of companies don't collect the basic data that connect between the underwriting process and the claims process. They don't factor in issues such as co-morbidity and lifestyle. Generally, it's tough to get that information if you're only managing one part of that process such as the claim. If you're managing the underwriting and the claim you can collect that data. We have found that a point system that helps your underwriters and the actuaries bridge some of the gap of information and knowledge and brings them all on the same team is a very useful tool.

MR. ROWLEY: I'd encourage actuaries not only to look at the written underwriting guidelines, but also to go out on the floor and talk to the underwriters. Not the underwriting management, but the underwriters, because we all bend the rules. That's what good underwriting is. It starts where the textbook case is, but there are shades that move you to something better or worse.

I had an experience with a company that is not a client of ours. Their written field guide laid out all of their underwriting rules, including when they're going to

decline, what they offer when, and their special situations. It was probably the best I have ever seen. I wanted to do business with these people. They were organized. But their actual underwriting reflected absolutely nothing that was in their guidelines. This was not somebody using a TPA. This was an in-house underwriting operation. I was absolutely blown away by their guide; it seemed they had addressed every issue you can possibly imagine. It was a wonderful guide, but it was not utilized. All of the rules were being bent; I don't think the underwriters knew they existed.

With my prior company, where I worked for 10 years, I can say I knew the name of only one actuary, our chief actuary, and I never had a discussion with any of them. I've learned through the discussions I now have with actuaries that it's important to have that feedback.

MS. PAHL: Let's move on to the next topic, limited underwriting. Can it be done for LTC insurance? Let's touch on some of the big issues and then continue on. Who wants to start on this one?

MR. HERMAN: I'll comment a little bit from an actuarial perspective. We obviously want to insure people and would like to do limited underwriting. The first question becomes, "How do you set your morbidity assumptions?" I think that as long as you're not doing guaranteed issue, you're asking some questions on your application, and you have some underwriting, you can probably price it.

There will be some question about the morbidity load. The first thing you do is take away your steep selection factors. But then you might also introduce a morbidity load of something like 40 percent or even 50 percent because you think you need that to cover the extra risk. Unfortunately, you may end up with a product that won't sell because it's too pricey. But I think other factors will help support limited underwriting. Instead of doing the most risky product, you might have a limited nursing home benefit with which you could feel comfortable. I'd do guaranteed issue if I could cover the whole country, but that's going to be the challenge.

MR. ROWLEY: I think we're already doing limited underwriting to some degree. We don't get personal history information (PHI) at a certain age, and we don't do cognitive exams at all ages. We're limiting the underwriting anyway. I think the area that we all struggled with when we prepared for this is guaranteed issue. Coming from the DI world, on a voluntary basis, if I was going to get less than 50 percent participation, it scared me. Yet in LTC, if they get five or eight percent participation of a group they're pretty excited. Unfortunately, I don't know enough to comment on that because those numbers scare me. If you're getting five percent voluntary, I think it's probably the wrong five percent, but I'd like to be proven wrong.

MR. JACOBS: We debated that in our discussions. Frankly, historically the penetration into group enrollment has been so low that five percent may seem

small to somebody who's underwriting or somebody with Steve's point of view. But from my point of view, that five percent represents people who made a business decision to buy LTC insurance, and they didn't do it necessarily on health status. I may be wrong. No one really knows the answer to that. But the question is, "Why is only five percent of the population in a group buying the product?" We're not getting the message out of what the product is and what we need to protect.

MR. ROWLEY: The five percent that needs it will buy it.

MR. JACOBS: I don't believe that at all. I think five percent is just the beginning of the awareness. We're going to go through a major example with the Federal Employees Health Benefits Program next year, and we're going to see a huge population exposed to LTC. We'll see numbers, and small numbers really are large numbers in the context of a program that size.

I think they'd just be convinced that they finally have it offered to them, and now they can buy it at a reasonable price.

MR. ROWLEY: In other product lines that are individually underwritten or guaranteed issue, the lower the voluntary participation is, the worse the experience. I think that holds true across almost every line, be it disability, life, or dental. If you have low participation, you're going to have worse experience. Now, how low is too low? It might vary by every product line.

MR. PAT HENNESSY: (AUL Long Term Care Solutions) I just had a question for the panel regarding the limited underwriting. Don't you think now that the average age of the individual policyholders is dropping? Isn't there a way that we could look at people in their 50s, for example, combined with some conditions and really come up with some ways to keep these agents happy? Obviously, the risk of these is pretty attractive. I would think that given enough data, we should be able to come up with some way to speed up the issue process without getting ourselves into a profitability issue.

MR. ROWLEY: Absolutely. At the younger ages, if we're talking pure guaranteed issue versus limited issue—and I think they're two different worlds—we have developed a speed underwriting program that we think works.

There's a point where you have to start to worry about how young is too young. As an LTC underwriter, I'm going to start to worry if I get a 45-year-old. It raises a red flag. Now, maybe his or her mom is in a nursing home, and it made a lot of sense, or maybe he's Hepatitis-C positive, HIV positive, or just diagnosed with multiple sclerosis (MS), and that's a long claim. These are issues. Some companies have actually started blood testing at younger ages, which is something pretty much unheard of in LTC. They're testing for Hepatitis-C and HIV. That's a huge concern in that age group.

MR. HENNESSY: I think that's where we're all headed. As a TPA, we're looking to really speed up the issue process, putting together a combination of age and conditions that will really help the industry without compromising profitability. I think that scenario is not too far away and we have enough data to make sure that it is a profitable venture.

MR. ROWLEY: On any speed program, even though its value now is still limited, but growing, I would strongly advocate the MIB. You're giving up something, and you're saving a lot of money on the underwriting process. Spend $0.38 cents and run the MIB check if you're going to go into speed. It's cheap, and if you're going to start taking chances, at least cover yourself there.

MR. JACOBS: But the issue you raise is significant because more and more baby boomers are being influenced by parental issues. Most people you come into contact with, if you are 40-plus, have had an issue with LTC in their family or through a friend. That is probably the number one reason people become interested and then purchase the product. I think that, coupled with an above-the-line tax credit, will greatly increase numbers among the younger population buying the product. We have to respond.

MR. ROWLEY: I want to throw out one other comment on underwriting guidelines. We're redeveloping our manual right now and we're going to try and underwrite it assuming the standard tax-qualified two of six Activity of Daily Living (ADL) cognitively impaired reimbursement contract. Our philosophy is that, as the triggers vary, the underwriting probably should too. If you have an indemnity contract that's paying $200 a day, maybe it's not a big deal. If you have an indemnity contract that's going to pay $300, or as high as $500 on an indemnity, and you're using only $50 a day on home care, you still get $500 every day. I believe underwriting should be tighter if you include the medical necessity trigger. If it's on the nursing home portion only, maybe that's not so bad. If it's on assisted living, maybe we've got to think about it. I don't think anyone has done it, but if you put these two together—$500-a-day indemnity with medical necessity—I'm going to go over the edge and say you're nuts. There's no underwriting that could cover that. Welcome to the disability industry—if you want to go that route.

Today's underwriting is for standardized products, but the products are starting to vary all over the place—medical necessity, indemnity, different triggers—and those have to be thought about by the actuary and hopefully by the underwriters when they're making their decisions.