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Session 31PD
Combining Long-Term-Care (LTC) Benefits With Other Products

Track: Long-Term Care/Product Development/Health Disability Income

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Panelists: WILLIAM J. DECAPUA
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Summary: Recent demographic and regulatory trends have spurred interest in providing long-term-care (LTC) benefits. This session explores how LTC benefits are combined with other insurance products. Popular combination products are LTC benefits with disability income, annuities, and life insurance. This session presents several viable product styles and the pros and cons of each.

MR. EDWARD P. MOHORIC: We have three speakers that are going to talk about combining long-term care (LTC) with different products. Mel Rambo is president and chief operating officer of National Travelers Life, and we really wanted to get him here. National Travelers is really the first company to combine LTC with another product, life insurance, about 10 years ago. Mel's been with National Travelers for 22 years. They've got two marketing divisions—a PPA division and a worksite division. He's worked his way up through various actuarial marketing roles and was named president of the company back in May. He's going to be talking about their experience and the evolution of selling life insurance with LTC.

Our second panelist will be Jeff DeCapua, who is vice-president and group actuary of worksite marketing for Aegon USA. When Jeff was at Conseco a couple of years ago, the idea came to him of starting a guaranteed-insurability LTC benefit that

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

could be attached to a disability product. Jeff is going to speak of the genesis of this plan, how they developed it, and then what happened.

Our third speaker is Mark Warshawsky. He was, until recently, director of research at TIAA-CREF and is currently a visiting researcher for the National Bureau of Economic Research (NBER). He's not going to talk so much about a product as he is about his research and ideas for using single premium immediate annuities (SPIAs) to fund LTC and the motivation behind making this an integrated product.

If there's time at the end, I will also speak a little bit about ways that LTC has been used in combination with deferred annuity products that I've seen to date.

MR. MELVIN RAMBO: I'm going to focus on four areas this afternoon in my discussion:

1. The beginning of this type of rider.
    - Why we designed this type of rider back in 1987
    - Product features
    - Competition
    - The regulatory environment
2. The evolutionary process that has taken place over the last 13 to 14 years.
3. Tax implications.
4. Future products, which our other panelists are also going to be discussing.

Back in the spring of 1987, National Travelers was looking for a way to position itself. We're a small mutual company, and our chief actuary at the time and the chief marketing officer went to lunch one day, and they were talking about how to position National Travelers in the marketplace. Of course, being a small mutual company, we were always trying to look at the market, as all marketing people are, to focus on how we could make ourselves unique and get positioned. They talked about how to make a product unique and have the death benefit be available early for long-term care. Also, in focusing on the design of the product, we wanted to improve our universal life premium persistency, as well as the overall product persistency.

One of the big issues, when we started the design of this in the spring of 1987, was lat the idea of putting a waiting period on the product and also a premium requirement period. We put a waiting period on of 10 years, which in retrospect was a long waiting period. But the main reason we put a waiting period on was we really wanted to focus our marketing area and our agents on trying to sell and entice the younger market to look at long-term care. We really wanted our agents—our marketing area—to go out and look at people in their late 40s and maybe their early 50s. So that was more the reason for the 10-year waiting period than anything else.

Fortunately, we had underwriters trained, and we were offering an individual major medical product at that point. So it was not an issue for us, from an underwriting

perspective, to have to worry so much about whether we had people trained. But we also didn't want to have to get into a lot of issues regarding long-term-care underwriting.

With this waiting period, we also did not have to worry so much about gatekeepers. Of course, the stand-alone, long-term-care policies until recently would have gatekeepers like a three-day hospital stay, and then you had to go into a care facility at some point within 14 or 21 days after being released from the hospital. Again, we eliminated that actual issue, and we came up with broader definitions of care facilities as well. With this 10-year waiting period, we weren't as concerned about what type of care the individual was receiving, be it skilled, intermediate, custodial, home care, or even respite care. We really didn't care. We wanted to be there at the time that they needed the benefit. But, again, we ran into issues with state insurance departments on the definitions of the various care facilities.

To make things as easy as possible initially, we introduced the product with just a level death benefit on the universal life policy. That way we could just take a percentage of that level face amount. We did not have to worry about the increasing death benefit.

Of course, with a level death benefit, you do run into the corridor issues, which you need to be concerned about at later attained ages. But again, we focused on the level death benefits. We could just take a percentage and calculate that, and the insured would know exactly what his or her LTC benefit was going to be from month-to-month.

Again, to make the calculation simple, we just used two percent of the face amount. We didn't vary the percentage by face amount. We just knew that—over a 50-month period, if the person did stay in the care facility for 50 months, that person would use up the entire face amount at that point.

We made no distinction between accident and sickness. Again, because of our long waiting period, that made it easy for us. We didn't have to go in and come up with definitions of what an accident, an injury, or sickness was.

By the time we got the rider finished, we ended up joking about the fact that we had a seven-page rider on a 10-page policy. You would sit there looking at it from an administrative standpoint, especially a claim standpoint, and they would look at it like, why are you filing this incredibly long rider? But in order to cover all the definitions that we needed as well as the interaction of the rider with the underlying base policy, it took a lot of complicated writing and coordination between those two benefits.

We also had a waiting period on the policy. Just to cut down on this in-and-out of the care facility, if someone went into a skilled care facility for rehabilitation for two weeks, we wouldn't have that person on claim status and then back out. The

person had to be in the care facility for 60 days before benefits would begin, and then they were retroactive back to the day of incurral.

We also built in a waiver of cost of insurance (COI) charges (while the person is confined) into the product, and I know a number of products have this feature now. We were concerned that, if the person was in a care facility, obviously he or she may not be able to afford to continue to make the premium payments. We did not want the policy lapsing accidentally while they were in a care facility, so we made sure that we waived the cost of insurance, but interest crediting continued into the policy.

One of the biggest hurdles in trying to administer this type of product was how to actually keep track of the payouts on a life insurance policy. As with all administrative systems, they have loan provisions and ways to handle either variable loan rates or fixed loan rates with loan interest in advance. But a lot of systems can't carry two types of loan features. Luckily, the admin system that we had at that time would allow us to carry a loan on the policy as well as a lien. So we attached a non-interest-bearing lien to the policy. Again, we did not want to be making partial withdrawals or automatic reductions of the death benefit at the time a person qualified for benefits, because you would run into a whole gamut of tax issues and be forced out of the money, should you start reducing or making partial withdrawals from that face amount. So, we went the lien route, and it's proved to be very beneficial for us. We do end up reporting that lien as a non-admitted asset on our books, but we've had very few claims to date in the 14 years that we've had the product out.

We also had a premium-paying requirement of 10 years, to coincide with the 10-year waiting period. Again, this was to get to as low of a net amount at risk as possible, when the person would go into a care facility, and keep our risk at a minimum with the fund value increasing.

Another feature was a deductible feature. Again, if someone took out a policy loan or a partial withdrawal from the product, you wouldn't want him or her coming along during a claim status and getting access to the fund value again. So these were actually deductible features, and we've had very few loans or partial withdrawals on these products. It has behaved exactly as we hoped it would.

We did coordinate with government programs. We really didn't feel it was necessary, because of the waiting period that we designed, and because there really wasn't any potential for anti-selection. But we did coordinate with government programs because we wanted to make sure that there was as much death benefit available long term as possible for the beneficiary. So, if someone is receiving benefits from a government facility, we will coordinate there. Otherwise, we will give them two percent of the face amount.

We had a lot of debate at that time as to how to rate the product. As with all designs of any products you're looking at—male/female rates, smoker/non-smoker rates—we did do those distinctions, although it added some complications to our original pricing. But it was well worth the effort.

That gives you a historical perspective and the main reasons why we designed the product, some of the features we put in, and what we had to consider. We actually worked on the product for four months. We started in May 1987. We filed it with the Iowa Insurance Department in August of that year and introduced it to our field force in November. So this was a very fast-track product design, and by the end of 1988, there were actually 18 companies out in the market with variations of our design. Needless to say, one of the first changes was a reduction in the waiting period, and our agents were clamoring for us to reduce the waiting period as well. We did shortly thereafter, but, again, we were trying to get our agents to focus on a younger age marketplace.

By the end of 1988, some companies had introduced products with no waiting period for accident, and maybe a three-year waiting period for sickness. They were prorating the fund value and the face amount for the payouts. They were also putting this type of rider on whole life, excess interest whole life, and single premium whole life for the older ages. And the two different death benefits for universal life—both the level and increasing death benefits—were included. The percentages of face amount were varying as well. An example would be two percent of the face amount up to $100,000 and then half a percent above $100,000. These varied all over the place as well.

Some companies even capped the amount of face amount. They would allow for acceleration—some at 50 percent or at 75 percent. Premium requirements changed as well. But most companies stuck with the skilled/intermediate/custodial-type of care. Some would have some gatekeepers built in if you were receiving home health care. So, gatekeepers were being built in, but again, as they lowered the premium requirement and the waiting period requirement; they felt the gatekeepers were necessary to cut down on the anti-selection.

The regulatory environment at that point, needless to say, was pretty incredible. It was like, "Wow, what have we done here?" I ended up going to several insurance departments and having to talk with commissioners or their legal staff and the policy review people because they were, needless to say, very confused on how they were going to deal with this type of rider. Was it a true life insurance rider? Was it a health insurance rider on a life chassis? They were asking about loss ratios and what loss ratios we had calculated into the product—again with a focus on health insurance.

Then there were the reserving difficulties—surrounding this interrelationship between the face amount and the rider. As you can imagine and are aware of today

in filing these products, we're still dealing with definitions of skilled care and intermediate care that vary from state to state.

Here are our results, for those of you that are from much larger companies than National Travelers—and we are a small mutual company. We sold 2,000 policies over the first three years that we had this product. We were happy with those results. We've had 10 claims in the 14 years that we've had the product out, and we still have 1,500 policies in force. So our persistency has been very good. Our claims have been easy to administer with the lien approach. And actually we ended up ceasing with this type of product. By about 1993-94, we closed this block of business. Since then we've been offering long-term-care—a lump sum payout—as an accelerated death benefit product. I'll talk more about that in just a minute.

Now to the evolutionary process of this whole episode. Over the 10 years that followed, there were whole-life policies with joint features—first and second to die. There have been group universal life products that have come out with long-term-care features, lump sum versus monthly payouts, and then term insurance with accelerations. From the regulatory standpoint, there are basically two model bills that are out. There's a long-term-care model bill that focuses both on stand-alone, long-term care, as well as the rider. Basically any policy that is advertised as a long-term-care insurance product will fall under this model bill, if your state has adopted the model bill legislation. It covers long-term care involving cognitive impairment, any therapeutic or rehabilitation, maintenance, or personal care services.

There's also discussion in the model bill about Section 7702 B (b) of the Internal Revenue Code of 1986. Again, this is where the definitions finally came in, so you could use these long-term-care riders as part of calculating your guideline-single and guideline-annual premiums to fund the product. There are definitions of qualified long-term-care services, and the contract cannot be covering or reimbursing any expenses covered by Title XVIII of the Social Security Act.

There's also the fact that the product has to be guaranteed renewable. In health insurance language, that obviously means that the contract cannot be unilaterally cancelled, but you can increase premiums. So on a universal life policy, you can increase your COI charges, or on a term product or an indeterminate type of premium product, you can increase your premiums if experience would warrant. For the stand-alone products under this model bill, if there are any refunds of premiums or dividends, you have to use those to reduce future premiums in the contract or to increase future benefits that are being offered.

Then the model bill also goes into the consumer protection provisions under Section 7702 B, subparagraph (g), and again, the tax-qualified issues for this product come under 7702 B, subparagraph (e).

There are also disclosure requirements and performance standards. This also gets into your sales illustration requirements in the states that have adopted the sales illustration model bill. Again, the focus is the fact that these products cannot be cancelled or non-renewed. You have to keep them in force on a unilateral basis. Preexisting condition clauses come into play with restrictions that these cannot be more restrictive than a six-month prior to issue or a six-month after the effective date relating to preexisting conditions.

Also, they have eliminated the gatekeeper for hospitalization. There cannot be a requirement of any type of hospitalization before you start receiving benefits under this type of product. The commissioner can, at his or her discretion, adopt loss ratio standards, and this varies from state to state—Florida being probably the most difficult in dealing with loss ratio calculations. For those of you that deal in health insurance in Florida, you know what I mean when you start having to do filings in the state of Florida. You hope you can get it approved within the next two or three years.

The outlines of coverage, of course, relate to health insurance—again, describing the benefits, listing any exceptions or exclusions in the contract, listing that the product is a qualified product under 7702 B (b), and including a policy summary or disclosure statement. The summary includes the interaction of the base policy and the rider, the length of the benefit and the amount of the benefit, when the person does qualify, and then current and projected maximum lifetime benefits that will be available.

When you're in benefit status, you also need to be providing an explanation of benefits (EOB), with a monthly report showing the interaction of the rider with the underlying death benefit. This is so the beneficiary understands what's happening to that death benefit as they're in payout status.

In regard to incontestability, there are two versions:

1. In the first six months, you can rescind the contract if there's any material misrepresentation regarding any of the features of the contract or the application.
2. Then from six months to two years, there has to be material misrepresentation, and it has to relate exactly to the claim that's being filed. If someone's filing a claim for cognitive impairment or activities of daily living (ADLs), it has to relate specifically to one of those before you can contest the contract.

Nonforfeiture benefits. These mostly relate to the stand-alone, long-term-care policies again. You have to offer a reduced paid-up benefit as an optional rider for the stand-alone contracts.

Looking specifically at Section 7702 (B), of course, you get into the actual definitions here and into meeting the requirements of a long-term-care policy.

1. First of all, you can have a definition relating to activities of daily living. The person has to not be able to meet two out of either five or six activities of daily living—those being eating, toileting, transferring, bathing, dressing, and continence.
2. There's another way you can meet the requirement for this rider, and this is having a definition of disability, as defined by the Secretary of Health and Human Services. I wouldn't recommend this definition. You get into a lot of sticky issues dealing with the federal government in this type of contract.
3. Or you can go into requiring substantial supervision to protect a person due to severe cognitive impairment. This relates to Alzheimer's patients.

The important issue, as I mentioned before, with the Section 7702 B (e) being clarified is the fact that you can use the COI charges for the rider to calculate your guideline premiums. This is very important in funding these products and in keeping them in force during the lifetime of the policyholder.

Then there are consumer protection issues that also relate back to the National Association of Insurance Commissioners (NAIC) model bill. So both the tax code, 7702 B, and various sections will relate back to the model bill as well. So there are excellent cross-references there.

I will just touch briefly on the accelerated death benefit model bill. For those of you who are working on a long-term-care type of feature, if you're planning on paying a lump-sum benefit—we have a couple of riders that are designed right now—one in our independent or PPGA division, and another one in our worksite. They are voluntary products, and in those settings, we will actually accelerate 25, 50 or 100 percent of the benefit, if a person qualifies for long-term care. We purposely filed the rider under the accelerated death benefit model bill, and it has gone extremely well in most of the states. Some of them will revert back to the long-term-care model bill or other long-term-care issues, when they're looking at these accelerated types of benefits. But overall we've been pleased with the state response in looking at these accelerated death benefits. Most of you are aware that, when you think of an accelerated death benefit product, obviously you're thinking of accelerating a lump-sum face amount for heart attacks, stroke, cancer, renal failure—seven or eight conditions. But also, as I mentioned, we've been very successful with the long-term-care feature in here as well.

Tax implications. We've talked about the importance of Section 7702 B. The issues that we have run into over the years are the 1099 reporting issues. We have found in talking with our tax advisors that we end up filing a 1099 LTC form each year when someone has qualified for a benefit, and we leave it up to that person's tax advisor when he or she is filing a tax return as to whether this has to be reported as a taxable event. In most cases, the advice that we have been given is it is not a taxable event. Again, they've qualified for this benefit, but we do send a 1099 for reporting purposes.

This morning, for those of you who attended session 13PD, "Life/LTC Blends: The Best of Both Worlds," there was an excellent update on how the products are looking out in the marketplace and the activity that's happening out there. A lot of companies are referring to these types of products now as lifestyle or life-cycle changes. The products will move from being life insurance products to maybe long-term care by the time the person turns age 65. Of course, variable chassis have become important in this marketplace as well.

The other two panelists are going to be talking about other opportunities that are afforded in this marketplace. I appreciate your attention and your allowing me to give you a historical perspective, since National Travelers was the first company to design this type of product.

MR. WILLIAM J. DECAPUA: As Ed mentioned earlier, I developed this product about two to three years ago, when I was a group actuary at Conseco. Since that time I've left and gotten a new opportunity at Aegon USA, in the Transamerica Worksite Marketing division.

Today I'm going to talk to you about where the genesis or idea for the product came from. I'm going to give you an overview of the product. I'm going to talk a little bit about the pricing aspects of this product, and then I'll get into some of the filing issues. Then I'll end with a brief summary.

The product genesis. I'm sure many of you know that, during a product development process, you have to try to please all the people all the time. Some of the people we were trying to please—and this is no different than any other product development process—were the independent brokers that would sell our worksite products. They were screaming for a product that would differentiate itself from the marketplace, although they didn't give us much input into what that might be.

We were hearing this from the agents, and we were also hearing this from some of the certificate holders. They had a feeling of entitlement in that, whether it be from our company or maybe across three or four different companies, that they had carried a group disability product for a number of years. They had never claimed a benefit, and now they were getting ready to retire, and they didn't get anything out of the deal. You and I know the concept of insurance, but some of these folks felt like they should have gotten something. So that kind of spurred some thought on some things that we could do in a new product. The insurance company itself obviously wanted new sales, and they wanted those sales to be profitable.

I use my parents as an example because, about three years ago, both of my parents retired. After their group disability income (DI) product terminated when they retired, they went out to get long-term-care insurance. They found that my mom couldn't qualify—or when she did qualify and made it through underwriting, it was very expensive for her. So in trying to please my parents and talking with them about this, we came up with some different ideas.

To let you know what the product is—the base plan was a voluntary group disability product. Simply stated, we had three riders that would go along with that product.

The base plan, though, was issued on a guarantee issue basis. It covered disabilities that were related to both accidents and illnesses, and obviously it was marketed in the worksite. The key underwriting guidelines or sales guidelines—dealt with eligibility and participation requirements. We decided that if we're going to sell a disability product with group rates on a guarantee issue basis, we'd better make sure that we're getting a certain percentage of the population, and that's what we meant by participation guidelines. The benefits for the base plan involved a replacement ratio of 66.67 percent. We had various elimination periods and benefit periods that the employees could choose from. It really was just your garden-variety DI plan.

The riders, at the insistence from the field—they wanted a hospital indemnity benefit on there. We had a couple of different choices here of daily benefit amounts ($50 or $100 daily benefit) and benefit periods (90 or 180 days of benefit). The catastrophic disability benefit wasn't brand new. It wasn't an innovative idea, but it was semi-new to the group marketplace, in that the 66.67percent replacement ratio would be bumped to a 100 percent replacement ratio if the disability was related to an activity of daily living or cognitive impairment.

The long-term-care guarantee insurability (LTCGI) benefit is a benefit that allows for the DI insured to convert to an LTC policy at time of retirement—without evidence of insurability, which was the key to what my mom was trying to tell me. However, there were just a few catches that we had to put in on that. You could only convert if it was at normal retirement—age 57 or older. You couldn't be retiring due to disability and then expect to get a long-term-care policy from us. The DI base policy had to be in force for three years, and we had a maximum issue age on that of 60.

In regard to the benefits for the LTC policy, I won't go into a bunch of details. Basically it was a standard LTC policy that Conseco offered at the time, offering nursing home and residential facility and home-health care. But we did limit it to a 90-day elimination period benefit with a four-year benefit period. That was going to be the only option at this point in time that we were going to allow folks to convert to. The daily maximum was set at $80 per day, but it would compound at five percent per year that the certificate was in force. So the longer one of our group insureds held their certificate, the more benefit that they would have when they did convert to a long-term-care policy. That was important to us. Everything that would drive persistency was important to us, if we were going to try to offer this heaped compensation scale to the field.

With regard to pricing, here are some things to think about. In a second, I'll get to some of the considerations that would affect the pricing assumptions themselves.

Then I'll talk a little bit about the claim costs and the premium and then my theoretical methodology to pricing this.

Some of the considerations include the conversion requirements. Obviously, in our product, we were saying you had to be 57 or older before you could convert. It had to be due to normal retirement. These things would affect your pricing assumptions. Another consideration is the converting product design—is it a rich plan or not? The base policy rates happen to be a big one in my mind. The base policy could be offered on an age-rated basis or a composite-rated basis. Yes, we offered the products to groups on a composite-rated basis sometimes. If that were the case, then you would expect the population to be a little bit older than on an age-rated basis. And if that was, in fact true, then these people would be closer to retirement and closer to taking out their LTC policy, which would obviously affect the amount that you need to hold in a reserve. So that was an issue. We actually rated it both ways. We had a rider rate that applied if the base plan was age rated, and we had a separate LTCGI rider premium rate if the base plan was rated on a composite-rated basis.

Who gets to pick the rider election? Does the group pick whether or not they want it? Or does each individual within the group get to pick? Obviously, some anti-selection would take place if the individual was determining whether or not he or she wanted the rider.

The effects of the rider. I would think that any time you're developing a product that can have riders attached to it, consideration needs to be given as to what that rider might do to the underlying base plan.

Some of the assumptions might include:

1. Lapse rates of both the underlying disability policy and the long-term-care policy.
2. Age/gender distribution of the base plan. Again, the older the population, the closer to retirement they are. By the way, all this is building up to the price and how we price the LTCGI rider premium.
3. The exercise option rate. What percentage of the insured DI population is actually going to exercise the right to convert to an LTC policy?
4. Retirement rates. Again, of the group that is actually insured under the DI plan, at what ages will those folks be retiring?
5. Interest rates, as they apply to loss ratios and an active life reserve and the present values.
6. The mortality rates for both pre- and post-retirement. These were necessary in this pricing process.

So how were the claim costs and premiums developed? As many of you know, Conseco has a rather large block of long-term-care business. We took a chunk of that business aside—the business that was specifically related to the benefit designs that we would be offering the folks to convert to, and we evaluated that

experience. Basically, we showed that it had a lifetime anticipated-loss ratio at that point in time of, say, x percent. Then we went back and said that, based on all those assumptions , what would that lifetime loss ratio then be, if we use those assumptions? An example of that would be the lapse rate for an LTC policy, where the people aren't underwritten. That is obviously going to be different from the lapse rate of an LTC policy, where the people are underwritten. So with that assumption, along with the multitude of other assumptions, we basically went back and re-priced that block of business and showed that the lifetime anticipated-loss ratio would be around, say, y percent.

So what would the conceptual premium be for this LTC policy that was not underwritten—I call it the conceptual premium—that would equal the y over x times the standard premium—or the premium of our current LTC block of business. The goal was to allow my mother to purchase an LTC policy without underwriting at the same price as everybody else got to purchase it. That was the goal that we tried to stick with through this whole process. These folks that would convert would pick from that same block of policies everybody else got to pick from, and they would get it at the same rate. Obviously, we had to pre-fund that extra morbidity. So the LTCGI premium is basically equal to the difference between the conceptual premium and the standard premium, accounting for the assumptions and bringing all of that back in time.

The theoretical methodology and the way I like to think about this—and how this was priced—is we have an increased morbidity due to the fact that we weren't underwriting these folks. That extra cost, due to that increased morbidity, is the difference between that conceptual premium and the standard premium. That extra cost is used to develop the long-term-care GI rider premium itself. That premium over time is used to fund a reserve. That reserve, at retirement for that person, would be the exact amount needed to pay for the difference between the conceptual premium and the standard premium. I think of it as a life annuity that you purchase at age 65—if you retired at age 65, with first payout at age 65 equal to that extra cost.

Now I'll cover some of the filing issues. I've got to be honest with you—I think we had approval everywhere that we wanted to in February of 2000. So it's been a while. But this is what I came up with. I do recall one state department saying, "This is casualty insurance—aren't you a health insurance company?" I said, "Yes, we are a health insurance company, but why is this casualty insurance?"

The response was, "You're insuring someone's insurability, and that, in fact, is casualty insurance." Well, I don't remember all the negotiations that took place, but it turned out that they reneged on that, and they went ahead and approved it. They ruled that it wasn't casualty insurance. One state required us to show them how we were going to hold the experience for the non-underwritten LTC policies separate from the LTC standard policies, for purposes of future rate increases that we might file for. One state where we did not get approval—we actually had to pull this rider

out of the filing—was a state that said you couldn't have ADL language in your DI policies. Well, we had ADL language in our catastrophic DI rider, which we pulled because it was obvious there was language there. But the LTC piece—the person electing to convert—doesn't have ADL benefits until that person actually converts, and then the person gets an LTC policy. At that point there's ADL language in there. So we went around and around with this, and nowhere in the policy was there any ADL language. It just was a reference to an LTCGI benefit. But we lost that battle, unfortunately.

There were various other things. There weren't just issues and challenges, we also got some accolades. I will say that, from the state of Florida, it did take a while. It didn't take two years. It took a couple months and a lot of effort. But they approved the policy, and they also complimented the company on the fact that it was the first time they had seen this—an LTC type of benefit attached to a DI policy. They thought it was innovative and creative, and they thought it offered real benefits to our clients. We actually heard similar types of things from other states.

In summary, the underlying concept was to combine the income replacement feature of disability for working America with the asset-protection feature of long-term-care insurance for those people that then retire. I think that that's a valuable benefit, and I think it's something that we all need to address more as we go forward.

MR. MARK J. WARSHAWSKY: I'm going to talk about an idea as opposed to a product. I think that might be an advantage or a disadvantage. You won't have any questions in terms of how it works because, of course, it doesn't exist. On the other hand, I won't have anywhere near the level of detail that an actual product has—such as what has been described. As a non-actuary and an economist, it is actually very humbling to realize the level of detail required to actually introducing a real product. That being said, I'm actually pretty excited about this idea.

I'm going to talk about a paper that appeared in the *Journal of Risk and Assurance* recently. It represents research that my co-investigators, Chris Murtaugh, who works for the Visiting Nurse Service of New York, and Brenda Spellman, who's an economist at the Urban Institute, and I have been doing for three years. It's based on an idea that I had over six years ago—to combine the life annuity with long-term-care benefits. This idea has had a little bit of favorable notice. The article actually won an award. It's sponsored by the Institute of Actuaries in England. They were running a competition, and we won 500 pounds. Also, it's gotten a little bit of media attention, being mentioned at the end of an article in the *Wall Street Journal.*

But, again, it's an idea. It's not a real product. You'll see that it has an academic flavor. It's not even product research. It's based on academic research. Although there are some ideas like this in the marketplace, I would call them first and second cousins. I don't think any of them—as far as I know and as far as I understand them—do exactly what we're proposing. On the other hand, perhaps that is what

can be done in a realistic marketplace. I don't know, but to my knowledge, this has not been tried.

The basic idea is to solve two problems. The two problems are (1) on the immediate annuity side and, (2) on the long-term-care side. The problem on the immediate annuity side is for voluntary immediate annuities— single premium immediate annuities. You have adverse selection, and it's sort of obvious. People who are in poor health are not going to buy immediate annuities. Therefore, the mortality is a select mortality, and that is reflected in the price. For the average population it appears to be a little more expensive than perhaps they would want. The issue with private, voluntary long-term-care insurance—and here again I'm speaking as a non-actuary—is that underwriting excludes a significant percentage of the elderly from purchasing long-term-care insurance.

I'm very familiar with the marketing ideas of trying to sell long-term-care insurance to younger people. I'm not so convinced with those, from a practical standpoint. I understand why it's a solution to the problem, but I don't believe that you can convince a 40-year-old to buy long-term-care insurance. I do not have long-term-care insurance, and I'm 43.

I think it's a very practical marketing-type issue. I do appreciate the idea of selling it to younger people. But if you sell it to the people who are presumably the most interested in it—65, 70, or 75-year-olds, underwriting clearly excludes a significant percentage of the elderly.

My co-authors have actually done a paper on that exact subject, and they came up with numbers of about 25 to 30 percent of the population that would be excluded under current underwriting practices from purchasing long-term-care insurance. So if private long-term-care insurance—almost thinking of it from a public policy standpoint—is going to solve a significant insurance need, that's a very significant percentage of the population that cannot get the coverage.

I pose that both of these are significant problems. The solution that we're posing is to combine the life annuity with the long-term-care benefits. That way you get people who would have been excluded from long-term-care insurance who have impaired life expectancies, and you get them into the pool of the immediate annuities. So you bring the cost of the annuity down, but you're also writing long-term-care insurance for them. You basically solve both problems.

In thinking about this, there's really no reason to think that it could not apply in a lot of different contexts. In particular, I think the most natural sort of venue for it is a qualified pension plan—either a defined-benefit plan or a defined-contribution plan. I won't even get into all of the issues there, in terms of whether this would, in fact, qualify in a pension plan. There are a lot of very technical issues, and I think the answer is that it wouldn't. But we're thinking of an idea, so we could also think that the rules and the laws would change, as well, to allow for it.

Another context would be in an after-tax fixed annuity or even a variable annuity. You could even think of it in terms of reverse annuity mortgages. Let's even go further in the conceptual framework. You could even think of it in some discussions about individual accounts under social security reform. I think that, conceptually, there are a lot of different places where this could appear. I think that the most natural place is in a pension plan, because I think a pension plan is, in fact, intended for retirement income. That's its main purpose. I think the participants in a pension plan think of it in those terms. I think using a life annuity often times is the natural benefit. To have the long-term care there, as well—almost from a marketing standpoint, if nothing else—is sort of the most natural venue for it.

Since this is an academic style approach, we claim to want to show these in terms of maintained hypotheses. So the first thing we want to demonstrate is that the life expectancies of the purchasers of the combined product will be less than that of the voluntary purchasers of the life annuity. So that's an adverse selection issue. With minimal underwriting, and I will define what we mean by minimal underwriting—the cost of the combined product will be less than some of the cost of the two products sold separately. Minimal means that, if you get the product, and you're immediately in claim, then you don't get the product—but otherwise we don't have any other underwriting.

The final hypothesis is that the population attracted to the combined product will be larger. In other words, we will be able to insure most of the 65-year-old population that couldn't get long-term-care insurance.

As I said, this idea originated somewhat in research that my co-authors and I have done. It's actually summarized a little in the *Wall Street Journal* article—a lot of work on life annuities, on single-premium immediate annuities, about the pricing, and about the optimal use of life annuities. Suffice it to say that I'm a big fan of life annuities. I think they're very much under-appreciated for a lot of reasons, and I think some of them are historical reasons having to do (recently) with the phenomenal performance of the stock market. So everyone's into mutual funds. I think that's the reason.

I also think that there are some issues relating to compensation of sales. For example, financial advisors are not compensated for a life annuity. Even if they could be convinced that it's the most natural product, they're not going to sell it because they're not compensated. So I think there are a lot of institutional and historical reasons for a life annuity not being very widely used, aside from the defined benefit plans.

But I think, to be fair, there are some disadvantages to a life annuity. Probably the biggest one is lack of flexibility. I understand that there are some companies that have tried to deal with that, but I think it is a very significant issue, particularly when you're dealing with an older population. They can be scared because, basically, they're retired. They no longer have a flow of income. They're sort of

stuck. They would prefer to have the money as opposed to having a stream of income—despite all the very significant advantages of a life annuity and assuring a stream of income for as long as you live, and a fixed income, regardless of the ups and downs of the market. Those are very significant advantages, but I think there is a problem. One reason people want the sum of money, as opposed to a stream of income, is that they are concerned about going into a nursing home or needing a substantial sum of money to deal with long-term-care expenses.

So I think the notion—this is almost a psychological or marketing-type thing—is that if you could assure them that they could get the life annuity and have all the advantages of a life annuity, plus be assured about long-term care, that would be a great burden taken off of them. Now, you may say, they could buy long-term-care insurance, and that would solve the problem. You buy the two separately. I think long-term-care insurance has come a long way and is a very nice product. It has improved greatly, but there is this central issue of underwriting that I think is obviously both a problem for those who can't pass underwriting and for those who are impaired. They pass underwriting but have a significant increase of premium.

Also, when you have a product that has one-quarter of the population not being insured or has a substandard rate, that's almost an issue of a perception problem. I think people understand why certain people can't get life insurance, but those are small percentages. I think people are accepting of that, but when you have a significant part of the population that can't get the insurance, I think there is more of a public relations-type problem. So, we are trying to demonstrate the need for the combined product based on the maintained hypotheses, but I think there's also a very practical marketing-type agenda, as well.

The base product that we're looking at is a life annuity. These numbers are a little arbitrary—we just had to put in some numbers. Take, for example,, a life annuity paying $1,000 per month for life and a 10-year guarantee period. We modeled the long-term-care insurance not as an indemnity but as a disability. Now we did that for a couple of reasons. One is that it was basically easier to model. The data was put more in terms of a disability approach, as opposed to an indemnity. But the other reason is that, as economists, we like the disability approach better, because whenever you can give people money—assuming that you can deal with the fraud issues, which maybe we'll talk about a little bit later—it's better, because people prefer having the money if they're disabled. They can choose how to spend it, as opposed to being confined by the features of the product. Again, I'm giving this as an idea.

There could be zillions of very practical reasons why this wouldn't work. But we did it as a disability annuity that pays an additional $2,000 per month—if 30 days have passed after the insured has two ADLs or is cognitively impaired for at least 90 days, and it pays an additional $1,000 dollars if the insured has four ADLs. That $1,000 would be on top of the $1,000 life annuity and on top of the $2,000 initial long-term-care benefit. So that's $48,000 a year for most people. In most

geographical locations, that probably covers a nursing home. It doesn't do it in New York City, but it does in most places.

We were trying to come up with something that was easy to model but also looked interesting. We tried some variations, including increasing benefits, and we looked at the age and gender of the insured, but we've only looked at singles in our analysis thus far. We haven't looked at couples.

We used data from the 1986 National Mortality Followback Survey, which is a government survey of death certificates, next-of-kin interviews, and data from health-care facilities. It's a graveyard sample, so we have to adjust it to get a birth cohort, which accounts for population growth and projected improvements in life expectancies. In regard to the key study variables, the data asks, "Was your next-of-kin disabled any time before their death?" It also asks for limitations in ADLs, as well as limitations in cognitive functioning.

There may be some recall issues, because it's next-of-kin, and they're asking about things that may have happened a little bit before the time of death, so I'm not going to say that the data is perfect.

On the other hand, we do feel pretty confident that the data is truthful. There was no reason for people to not tell the truth in this data set. It was a government survey that was not collected for this purpose. It was for another government study. We didn't really get a sense at all that people were lying, which I think is important in terms of the accuracy of the data. That's not to say that there's no bias in the data. That's not to say that it's 100 percent accurate.

Table 1

Prevalence and Length of Disability among Persons Dying at Age 65 or Older in 1986

	Percent with Limitation at Some Point in Last Year of Life	Percent with Onset after Age 65 among Those with a Limitation in Last Year of Life	Mean Years of Limitation among Persons with Onset after Turning Age 65
ADLs Typically Used as Benefit Triggers			
Bathing	62.8	96.9	1.7
Dressing	55.1	96.7	1.6
Toileting	54.5	97.2	1.4
Eating	38.8	98.2	0.9
Other ADLs			
Walking	56.4	95.5	2.1
Cognitive Functioning	17.6	93.7	3.2

Look at the prevalence and length of disability from this data in Table 1.This is among persons dying at age 65. We thought that the data looked pretty good and pretty reasonable, in terms of the percent with a limitation at some point in the last year of life. We also looked at the percent with onset after age 65, and there were a few people—about three percent of the population—that had some of these problems before age 65. We looked at the mean years of limitation among persons with onset after turning age 65.

We felt and were told that these numbers looked pretty reasonable. The basic idea and basic analysis here was to construct pools of purchasers and nonpurchasers under the two scenarios—in other words, the current underwriting or the current method of observed sensible buying of life annuities—and then compare that to what we thought were the purchasers and nonpurchasers of the combined product. The key point here is—under the first regime, which is the current world—the people who buy life annuities are also those who can get long-term-care insurance. In other words, they're the one-in-the-same group. Those that are underwritten out of buying long-term-care insurance have impaired mortality. They have impaired life expectancies, and they will not buy voluntary life annuities. So they're the one-in-the-same group. Similarly, when you combine the product, those who are excluded from buying the combined product are a very small group that would go into immediate claim. So those are the purchasers and nonpurchasers, respectively, of the two approaches.

Table 2

Effect of Reweighting to Make Projections for Persons Age 65 in 1995

	Before Reweighting All Persons Dying at Age 65 or older in 1986	After Reweighting All Persons Turning 65 in 1995
Number of Persons	1,470,110	2,070,000
Mean Years of Life after Age 65	14.8	17.8
Meeting 2+ ADL Disability Benefit Trigger		
Number of persons[a]	950,794	1,417,950
Percent of all persons	64.7	68.5
Mean years with 2+ ADL benefits	1.9	2.2
Meeting 4+ ADL Disability Benefit Trigger		
Number of persons[b]	695,491	1,049,490
Percent of all persons	47.3	50.7
Mean years with 4+ ADL benefits	1.1	1.3

[a] Persons meeting the 2+ ADL benefit trigger have 2+ ADLs *or* cognitive impairment starting after age 65 and lasting 120 days (90 days to qualify for benefits plus a 30 day waiting period).

[b] Persons meeting the 4+ ADL benefit trigger have 4+ ADLs starting after age 65 and lasting 90 days (90 days to qualify for benefits with no additional waiting period).

We did a re-weighting of the survey data, as I described it, because this is a graveyard sample (Table 2). So we had to get it up to birth cohorts. We did it so that it was representative—so it matched the 1995 Social Security cohort life tables for males and females both at age 65 and age 75. This table shows the effect of the re-weighting. It increases life expectancy. It slightly increases the mean years with the disability.

We did a mortality comparison (Chart 1). We included a version of the Annuity 2000 Table, but we did a slight adjustment. It's the Basic Annuity 2000 Table, with a projection of mortality improvement. The annuitant proxies are basically what we came up with as the mortality of those who we say would, under current conditions, buy life annuities and could buy long-term-care insurance. The point here is to show that, at early ages, they're pretty close. So we felt fairly good that we were coming up with something that was reasonable. At early ages, from 65 to 75, they're pretty much the same. Only in later ages do they diverge a little, and, actually, I think there's something else going on here.

The reason the Annuity 2000 table shows better mortality than our annuitant proxies is that our annuitant proxies are from the general population. So it includes people of socioeconomic situations, including very poor people, who we know have poorer mortality. We also know that people who buy life annuities are not poor people by definition and money. That largely explains the difference between the two. We were largely pleased with this result. We felt as if we were getting at some real information in terms of the selection effects and the mortality effects.

Now we come to the proof, if you will, which is the premium estimates. We make some assumptions, which include the following. We do this as a lump sum at purchase. We do it by calculating present value of discounted benefits. We have some loadings. The nominal interest rate was six percent, and we look at it both with and without some inflation protection.

Table 3

Mean Survival, Risk of Meeting Benefit Triggers, and Number of Years Receiving Benefits for Hypothesized Purchasers and Nonpurchasers of an Immediate Annuity and Disability Benefits at Age 65

	Percent in risk category	Mean survival (years)	Percent meeting 2+ ADL benefit trigger	Expected years of 2+ ADL disability	Percent meeting 4+ ADL benefit trigger	Expected years of 4+ ADL disability
All Persons	100.0	17.8	68.5	1.5	50.7	0.7
Purchasers						
Current annuitant proxies	77.1	19.5	69.0	1.5	51.6	0.7
Expanded purchase pool	98.0	18.0	67.9	1.4	50.2	0.6
Nonpurchasers						
Current LTC underwriting practice	22.9	11.7	66.8	1.5	47.7	0.6
Minimal underwriting only	2.0	5.9	100.0	5.8	74.2	2.0

Table 3 is the first set of results, and I want to focus on four numbers.

1. The mean survival in years for current annuitant proxies—people who would buy annuities—is 19.5 years, according to our analysis, at age 65.
2. The expanded purchase pool. In other words, bringing in those who are excluded from long-term-care insurance brings the life expectancy down to 18 years. That's sort of the first result related to our maintained hypotheses.
3. We were actually almost a little surprised by this one. The next column shows the percent meeting the two-plus ADL benefit trigger. In the annuitant proxy group—those who would currently buy long-term-care insurance, it's 69 percent of the population.
4. In the expanded purchase pool, you actually have less. It's actually slightly lower—67.9 percent. In other words, the poor people, who are currently excluded from long-term-care insurance, actually have a slightly lower probability of having an ADL.

That doesn't mean that insurers are crazy in terms of their current underwriting. This occurs because the people who are currently excluded from long-term-care insurance, to the extent that they do have a claim, are going to get the claim pretty

soon. With the way long-term-care insurance policies are currently sold, which is as an annual premium, it's not economically viable to sell them a long-term-care policy. If they were, in fact, to be single-premium policies, that would be a sensible thing to do.

The point here is that you're actually not so bad off by including these people. You've reduced the life expectancy of the average person in a pool, which reduces the annuity cost, and you haven't increased the long-term-care cost. That's the key result.

Another key result, which again refers to our maintained hypothesis, is that the number here is the combined premium. Under current underwriting or the annuitant proxies, the combined premium is $161,800. Bringing in those who currently can't get long-term care into this combined product, the premium is $156,300. So it's reduced by 3.5 percent, and that's the other result in terms of our maintained hypothesis.

I don't think I have time to go over all the other results. We looked at this without inflation protection and with inflation protection. Then we actually broke it down by the various underwriting classes—people with various impairments. There's one group that really should not buy the combined product, and that's people who have heart conditions. That makes perfect sense, because they're going to die soon, and they won't get long-term care. So, neither purchase—the life annuity or the long-term care—makes any sense. But for pretty much every other group, they're better off with the combined product than they were with the separate products. We did it with inflation protection, and then we looked at it by gender. Everything else we've looked at heretofore has been combining the two genders. We looked at age 75, in addition to age 65. This is all in the paper.

Finally, we did some sensitivity analysis. Basically, what we were concerned about was that, even though we felt the reporting was accurate and unbiased, it might not have been entirely accurate. The other thing we were concerned about was that we felt that people were truthful in this survey, but people won't necessarily be truthful in real life when making a claim, particularly if it's a disability product where you get money. So wanted to do a little sensitivity analysis as to what the impact would be if there was what we call ADL creep. For example, it's the people who, in fact, only had one ADL limitation but claimed they had two. So we showed what the impact on that. The whole point of showing all of this is that we felt the results were robust.

Let me just conclude with some other issues and then some next steps in research that we're pursuing. We recognize that a disability approach is more difficult to administer. There is more scope for moral hazard problems, but we still like it. It's something that we prefer, if possible. As I mentioned early on, I think the natural place for this would be in a qualified retirement plan, but there are very significant tax qualification issues that really have to be dealt with. In the paper, we also go

through some strengths and weaknesses of our data methods and assumptions, and clearly there's more work that can be done.

The next step in our research is that we're actually working with the 1993 version of this survey. We're also looking at some more sensitivity testing of economic and other assumptions. We're going to try to look at differences by socioeconomic and marital status. Then—and this is way down the road if we can manage it—we'll also try to look at an indemnity approach.

MR. MOHORIC: That's a fascinating idea there, to potentially increase the pool of LTC people with actually reducing, potentially, the cost of the overall pension package. I'm going to just finish up here with a very short, practical discussion on the way I have seen people tie together mostly deferred annuities and LTC.

I'm indebted to John Hancock and Shawn Williams of John Hancock, in particular, for the information that I'm about to present, regarding the "Care Solution +" plan. This is being presented with John Hancock's permission.

The interesting product that they have come up with is to have an LTC benefit that would be a monthly enhancement to your account value and would add one percent of your initial account value per month for a period of three years. So it would be an LTC benefit that you could take out, payable if you could, if you were unable, of course, to perform two out of six ADLs. It's pretty typical. And the kicker in this is that there's no underwriting on their product.

How have they managed to do that? They've added a product where the benefit is not available for a seven-year period after purchase. They also have a few other caveats and restrictions.

- They have an inflation benefit beginning in year eight.
- You have to be under age 75 when you buy the product.
- It's only available if the owner is the annuitant. It's not available if the owner and the annuitant are separate people.
- They only allow it if you have at least a $25,000 minimum.
- And the annuity value all the way through the product must be at least 25 percent of the initial investment. If you surrender or annuitize too much, the LTC benefit does go away.

So, the point here is that they've allowed a no-underwriting LTC benefit of one percent of your account value for a 36-month period without underwriting, but it's a seven-year deferral.

They charge for this. They charge 35 basis points on the initial purchase every year. So, if you buy a $100,000 annuity, as an example, it will cost you $350 a year for a $1,000/month LTC benefit that would pay for three years, again without underwriting, but with a seven-year deferral.

Is this a reasonable product to offer? Is the pricing right? Is the underwriting going to work? Well, I think, as Mel alluded to on National Travelers' experience, a lot of times, while the underwriting is critical on LTC in a single purchase, you see that LTC, in combinations with some other products, actually has somewhat better experience. You could look at these rates, go home, and put your own pencil and paper to figure out whether this is priced reasonably or not. This is relatively new product, and since there's a seven-year deferral on benefit, the real answer won't be known for another four or five years yet.

There are a number of companies that will waive the surrender charges on their annuities to give you access to your full value if you have two out of six ADLs or if you go into a nursing home. I have seen one company explicitly charge a 10-basis-point fee for this. But, in fact, most just embed it in their interest rate and make some small adjustments to the interest rate that they credit for the M&E charges to account for this benefit.

Another way that I've seen LTC and annuities work together is really not from anything a company did, but just from the agent's perspective in packaging and marketing products together. It's where an agent would actually put together a combined illustration, on either a deferred or an immediate annuity, and the agent would set it up so that you could use just the interest or the interest plus some of your free partial withdrawals to fund your LTC premium. It illustrates very nicely that you can put $100,000 into an annuity, and that gives you, at a five-percent interest, $5,000 a year. And, depending on your age, of course, you can buy a certain amount of LTC benefits with that $5,000. Just pull your interest straight off of the annuity every year and use it to pay for LTC. The agent can then collect just one amount at one time from you and not worry about actually making the collection. They can have the amount assigned toward the LTC premium. It can work with one company. The LTC company can be different from the annuity company. It illustrates very nicely. It's actually a very powerful-looking sale.

It can have some problems in that there are no guarantees. And if you're presuming a five-percent interest rate, for example, and the funds drop, or the rate credited dropped, or if you're doing it on a variable, and you have stock market problems, you just may not have enough money to fund it without draining your principal. Or if the LTC company raises its rates, that starts the dynamics off in a different direction. So while it illustrates very nicely because it's not a linked guaranteed product, which is what Mark was alluding to, it looks good and can be good. But it's fraught with some difficulties if, in fact, one of those events happens.

Lastly, one variation that we had talked about and worked briefly on with a client is the idea of combining a single premium deferred annuity (SPDA) sale with a very long elimination period on LTC. The nature of this sale would be, basically, that you have a certain amount saved up. Why not put $30,000 or $50,000 in an annuity and fund the first six months, year, or even two years? Then, to protect yourself against long-term care, rather than deal with the zero or a 30-day elimination

period, why not have a one-year or even two-year elimination period that protects you against the catastrophic, very long-term-care risk? It becomes a very cheap LTC premium with a one- or two-year deferral, and it actually makes a lot of sense in tandem, because it reduces your LTC premium costs if you need the LTC and you do blow through your annuity and your cover. If you don't need the LTC, you have your annuity back for your heirs.

It's a great concept, and it illustrates well, and it can work really well. In doing this, there will be regulatory issues. The regulators, within the parameter or the box that they're allowed to think in, are very down on long elimination periods. In a number of states, you cannot have more than a six-month elimination period, which, in concept, voids this idea. But with proper explanation, some pressure, and some law changes, it actually would be a very good concept, help lock in a lot of sales, and keep the price of LTC very reasonable to a lot of people.

So we've had life. We've had guaranteed purchase options attached to disability, SPIA, and deferred annuities. If there are any questions, we can take them now.

MR. STEVE P. COOPERSTEIN: By the way, the last product—there is a company with a product like that on the market, and they have a patent pending on it. So, if you do develop that last product, be careful.

MR. MOHORIC: It's hard to get a patent on insurance products. We tried that once.

MR COOPERSTEIN: I have one on an immediate annuity. I know of two or three other products out there with a patent on them. I did develop such a product with one company, and we got held up for two years in New York state. Because of that, people have changed, and we never got it to market. But you talked about a decrease in benefits—a decrease in net cost, and we didn't see that. For instance, what about chronic arthritis, where the person might have a long life expectancy but also might have a long life expectancy and long-term-care benefits? And we thought we had to watch the underwriting. There were a number of cases like that, where we thought that it would be difficult to even bring down the cost. We were hoping not for a higher cost but a smaller net cost.

MR. DECAPUA: Well, all I can say on that point is that actually the data we used did not have arthritis as a separate condition. So it could be that there are pockets, but all I can say is the data that we used did not demonstrate that problem, and that issue has been raised before. We're aware of it.

MR. MAX KLICKER: I thought you all did a really good job on covering the different underlying products or chassis, as you would say, that a long-term-care benefit might be attached to. As I was sitting there, though, I was thinking about another possibility, which is making the long-term-care policy the chassis. What could somebody put on there? I know there are lots of regulatory problems with

doing that, but in the short period of time, I can think about only one thing—it might be a dumb idea, but on a long-term-care product that has a return-of-premium benefit, say, at the end of 10 years. You're looking at a person that has, assuming he or she had no claims, a bit of money there. Now, perhaps that person could use an SPIA , and that monthly premium or annual premium could fund the premium decrease on that person's long-term-care plan and a number of other things. Perhaps it's not a contractual benefit. Maybe it's just pointing the agent in the direction of where to go. That's about all I could come up with. I think I threw out the idea that you've got somebody with some dollars there—maybe a single premium life benefit. I have my doubts about that. Has anyone thought about putting things on a long-term-care plan?

MR. MOHORIC: Regarding the idea of an SPIA attached to a return on premium (ROP), I know a few companies that are at the point in which they're starting to pay out some significant ROP benefits. Sounds like a neat idea as an option to offer them.

MR. JAMES M. GLICKMAN: I'd like to offer an observation and get some comments on it. It seems that everybody has been talking about this from the standpoint that it's been developed and from the standpoint that we needed to react and differentiate the product—give the marketer something additional to do. Now, if you tried to isolate—and I'll ask just Mel, as the person who indicated his products had the most experience up there—if you looked at just the rider premium itself and the costs associated with it, without even getting into some of the issues of the difficulties, how much premium would you estimate you're taking in? How much expense is there associated with the rider premium-only? I realize there are a lot of other potential advantages from a marketing standpoint. In fact, it's almost been my sense that some of the companies have gone at this from the standpoint of, "We really want something that sounds neat," and if they never sell it, that's all right, too.

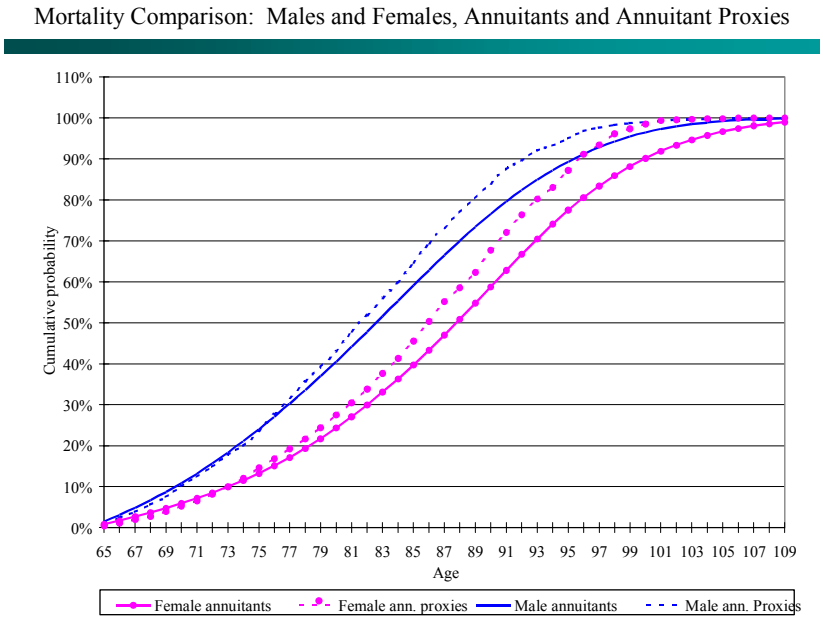
MR. RAMBO: Some of our agents commented early on, back in the late '80s. I'll just use an example. Let's say we were charging $10 per thousand for the underlying universal life product at whatever age, and we added another $0.25 or $0.50 on for long-term care. Instead of putting the long-term-care rider on, if you were to take that $0.25 cents or $0.50 cents and actually help fund the universal life policy with the higher interest rates at that time, you could actually end up pre-funding going into a long-term-care facility. So we did run into that with a number of our agents, but the point that we made was, obviously, you've got people here. At this time we came out with a product where we increased the waiting periods to three years. But we said to the agents—obviously this is insurance, and we're trying to cover the risk early on, let alone when the person reaches age 85 or 90, and they seemed to be more comfortable with that as we went forward. But, again, with a 10-year waiting period, they were fighting us, and we're running the illustrations with and without the rider. So it did become difficult.

MR. GLICKMAN: Let me ask one follow-up. For example, for the year 2000, how much rider premium would you estimate that you sold as a company? And how much expense do you think there was associated with the marketing materials, the training, and some of the other things that came, in effect, right off the top of that before you could get into whether the rider was a profitable item on its own?

MR. RAMBO: I would say in the year 2000—looking back at 1987, when we were first designing this and looking at all the costs that were involved in going to the insurance departments—we did not recoup that. Now that our admin systems are set up, and we're using it in two of our marketing divisions, we are covering our expenses with the number of riders that we are selling. We are not selling that traditional version. It's more of an accelerated death benefit, so I feel that we've covered the cost. Looking back on that original version—no, we did not. With the consulting cost, as well as all the travel, and only selling 2,000 policies, it did not happen back then, but we realized that going in. We wondered, with the costs that we were incurring, if we were going to recoup them. So it was not a surprise at the time, but I'm definitely glad that we did it. We learned a lot during the process, and it led to a lot of other accelerated features and other life cycle products.

MR. COOPERSTEIN: I just want to follow up on what Jim's talking about, to some degree. I'm involved in an expert-witness case now, where some people in the industry would say that some people in a particular area are at the line of marketing versus pricing. In other words, the marketing is pushing the pricing. Some of the products, even the John Hancock product—this is my own personal opinion, I haven't really studied the John Hancock product in detail—but to me, there was no underwriting on it. So, from the point of view that there's no underwriting—there's no comparison, so the price should be higher. The price is quite a bit higher than somebody would get in the open marketplace, if that person was underwritten. It's pretty clear that that's true. We push the products because of the marketing combination that makes them attractive. You're buying a deferred annuity. So why shouldn't you buy it? It's a perfect combination. I think we need to be careful that we don't go too far and use the marketing to sell the long-term care and end up hurting the product in the long run, just from a PR point of view.

Chart 1


Mortality Comparison: Males and Females, Annuitants and Annuitant Proxies
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Cumulative probability
65 67 69 71 73 75 77 79 81 83 85 87 89 91 93 95 97 99 101 103 105 107 109
Age
Female annuitants
Female ann. proxies
Male annuitants
Male ann. Proxies