RECORD, Volume 28, No. 2*

San Francisco Spring Meeting
June 24-26, 2002

Session 117PD
Combination Disability Products: The Urge To Merge

Track: Health Disability Income

Moderator: ARTHUR J. "TAD" VERNEY
Panelists: ARTHUR J. "TAD" VERNEY

Summary: Many companies have identified opportunities to combine disability insurance with other types of coverage. This session explores these combination products and the opportunities that they offer to disability insurers. Attendees gain an understanding of the types of combination products currently on the market, as well as the challenges and opportunities involved in designing new types of combination products.

MR. ARTHUR J. "TAD" VERNEY: I'm Tad Verney. By way of my background, I'm a founding member of Disability Insurance Specialists (DIS). I started that firm in 1996 with Bill Bossi. We provide a range of consulting services, risk-management services and outsourcing administration serving companies that are in the disability income, critical illness and long-term care markets. Prior to DIS, I did a couple of years of independent consulting and I grew up and cut my actuarial teeth at Connecticut General and then Cigna doing a number of roles there.

Today I'm going to share with you a case study of a product that was our initial brainchild at DIS. It's a combination disability insurance and long-term care product. It's a product we developed believing that it filled a real market need and really responded to the demographics of the aging population. We believed it addressed some of the issues in the long-term care market and that it would have broad market appeal and be a commercial success.

We still think it does all the former, but it has not been a commercial success. So the discussion today will be as much lessons learned as it is a success story. I'll

share with you the kind of the things we've been through with it. We continue to believe, as I say, that it's a good product. And I think there will be a time for it and a way to make it successful in the marketplace.

As we started putting it together about five years ago (we're a small firm), we decided to try to do this with as little fanfare as possible. Well, that was very easy being a small firm. A little fanfare was not an issue for us. But we really didn't want people to follow us too closely because we wanted to have a jump in the market and make our splash.

Having a few years of experience with it, looking back, I really wish some of the major players would get excited about this idea, go in, and develop combination disability insurance (DI) and long-term care (LTC) product. I think that some of the issues that we've faced with it would be addressed with more public recognition and more activity around that type of a product forum.

In the next 25 years, the retiree population will double, whereas the working population will grow only slightly. And the ratio of workers to retirees drops by about one-third. The population in the middle of the working years, 30 to 55, stays pretty stable.

With 60 million people by 2025 that are 65 years and older, it's going to be a major challenge for the social programs to fund elder care. Clearly, there's going to be a big strain put on the social system to provide care for the elderly.

On the product side, DI and LTC are still products that address a fairly narrow segment of the market. These statistics are probably a couple of years old, but less than half of the population has DI coverage, and most of that is through group insurance programs. And less than five percent, maybe a little bit more, of American households have long-term care policies in force.

The long-term care industry, for several years, has been talking about how to sell long-term care products to younger people. The average issue age a couple years ago was 67. I think it's down to 65 or 66 now, but it's still being marketed primarily to retirees. And the industry has expressed a desire, I think, to try to access younger markets, but it's had trouble getting the product to make a real entryway into the working population.

We have a theory on why that is. It might help to look at the way insurance products have traditionally been sold through the life cycle of an individual. In the early working years, you are first building an earned income. Your biggest asset in your late 20s to 30s is the ability to work to generate a monthly income.

As you get into middle age, you're accumulating wealth to fund your retirement years. And as you get into retirement years, you are investing those funds and trying to preserve and protect your assets. The way the insurance markets have

responded to that cycle of needs is to sell disability insurance up front. Get that income protected right up front. Sell long-term care on the back end when you're protecting your assets. And sell annuities and life insurance products in the middle years .

But from a long-term care perspective, I think the traditional approach has some disadvantages to it. For the consumer, it's somewhat of a leap of faith to believe that there will be coverage available at the time that you reach age 65 or 67, which is the typical time when people buy long-term care. And there have been a lot of companies jumping in and out of the market. The coverages offered have changed, experience is still young, and it's hard to really project out for baby boomers what's going to be available in the marketplace 20 years from now.

Given that there is product available, will it be affordable for the retiree population on a fixed income? Long-term care gets to be an expensive product at older ages, and it's a big share of a retiree's monthly income. And as you put off that decision, you risk the problem that you may be uninsurable at the time you're ready to buy.

To the insurer, selling traditional long-term care puts you in a fairly narrow market because you're selling to people that are potentially not too many years away from needing care. And as a result, I think you're subject to a little bit more anti-selection.

Not many younger people have long-term care coverage, but most expect that they will buy it someday. So, the question is, why don't they have it now? Later it's going to cost them a ton of money; now it's pretty cheap. A pretty substantial percentage of younger people haven't bought it because the risk they are insuring is still pretty far off. That gets right at what we think is the fundamental issue. When the coverage is most affordable, and your health is good, the need for protection is fairly remote.

So our thought was, you need to provide long-term care in some product that provides current value to the consumer. If you bundle it with a disability insurance product, you now have something that, to the consumer, looks like lifetime protection from disablement. In the early years, it's disablement and protecting your income, in the later years it's disablement and going into a nursing home where you'll have expenses chewing at your assets. But, the consumer can view that product as something that has current and long-term value to them.

So, our solution is to sell an integrated DI/long-term care policy that spans the lifetime, kind of as an umbrella over the other insurance products. The advantage of that approach is that the individual then has lifetime protection from disability issues.

The long-term care cost is much lower by funding at a lower age. You're medically underwritten while you're younger and healthier. It's got lower costs than buying

two separate policies. You know you'll have the coverage, you're medically underwritable now, and you can buy it now, so you know the coverage will be there when you need it. And you get underwritten once and you deal with one category; it's easier and it's simpler.

Those of us in the DI industry went through all the trials and tribulations of the late '80s through the mid '90s. One of the big issues for carriers was this issue of lifetime disability protection. Companies' loss ratios, financial experience on blocks of business where they provided a lifetime benefit, was significantly worse than on products that held a shorter term.

Yesterday, I heard someone ask where the sense is in providing an income to somebody who has no income to protect. DI has been sold as a lifetime product on an income basis, when in fact, as you hit retirement there is no income. The DI/LTC product is like a lifetime DI product, but it takes the benefit in the retirement years and matches it to your risk.

There are also some advantages of this product to the insurance company. It's an innovative, differentiating product. I hear a lot in consulting that companies want something that's different and innovative. We might have overshot the pits with this one. Often I think that means something similar to what you've had before with an extra-added feature, something that goes one step farther than where the marketplace has been.

We'll talk in a minute about the design approach we took to putting DI and LTC together. But we put it together in a mechanism that is fairly flexible and, as a result, can address a number of market situations. So, we think an advantage to an insurance carrier is that you can take this product and with fairly small changes to it, or even using the same chassis, can address a number of market situations, be it the high-income professionals, the rank and file work site marketing, or executive carve out programs. We think there's a fairly broad application for the product.

I think another significant advantage to the insurance company is reduced anti-selection. DI claims experience tends to go somewhat south in the years just before the coverage expires. And the conventional wisdom is that individuals, as they realize this coverage is about to disappear on them and that they've paid premiums for many years, are going to get something out of it. And as a result, the claim rates tend to go up as people decide to use their DI policy as a mechanism for early retirement or a transition into retirement.

With an integrated policy like this, we have some features that give people incentive not to go on that kind of claim. Because it is a lifetime coverage, you might have a little bit less of that mentality. I'm not naïve enough to think that nobody who can get a DI claim to fund an early retirement might do so anyway, but I think it's reduced, and we do have some incentives in there.

On the DI side, or the LTC issue side, people that want to anti-select against the carrier, tend to buy cheaper, term and more narrowly defined products. If you want to go on DI claim the month after or two years after you purchase your DI product, you're not going to buy a product that has long-term care in it. You're going to go out and get a cheaper DI product. So, I think this naturally steers away from folks that may want to anti-select on the coverage right from the purchase point. And, of course, it establishes a long-term care program for insureds at a younger age.

Some of these should be advantages to the agent as well. It's an innovative product, it helps them get access into the younger market, and brings them something new to sell to the baby boomers.

Okay, let's talk about what exactly we did. We developed a disability policy form. Our strategy was to call it lifetime disability coverage. Our hope was that it would be easier to file, a little less subject to multiple regulations and that it would be a little more manageable as a disability policy form. We set it up on a guaranteed renewable basis. I don't think anybody should ever consider doing this on a noncancelable basis. If you think about projecting claims cost for long-term care 25 years into the future, it would be highly risky to do so on a noncancelable basis.

You're projecting the morbidity and the health of the population as it ages. You're also projecting utilization factors. You're projecting the service environment, which is changing. It's really the interaction of those things that you are projecting when you do long-term care costs.

You're also projecting mortality, and you're doing it all with fairly limited insured data on which to build. So a guaranteed renewable basis is really the only way to go with a product like this.

We built an integrated benefit structure. It's all elective at issue. It's not a conversion and it's not an option at age 65 to buy more insurance. You decide at time of application what you want your benefit configuration to be.

What we offer prior to age 65 is a disability income, income replacement vehicle. It's a fairly stripped down DI product. After age 65, it automatically converts into a long-term care product, similar to what's available in the long-term care market now, based on a lifetime pool of benefits with a daily maximum. Benefits are triggered by the inability to perform activities of daily living (ADL). There is also a cognitive impairment trigger similar to other LTC coverage's, and benefits are paid as an expense reimbursement.

Prior to age 65, recognizing that you do have catastrophic disabilities that may not be fully protected through the income replacement benefit, we added a supplemental benefit called a CAT DI that, in the event of an ADL disability, provides an additional monthly indemnity. But we set that up like a DI benefit, not like the long-term care expense reimbursement benefit. So it's a monthly

indemnity; it's a percentage of the base.

For the premium structure as we priced it, and we'll talk about the pricing in a little bit, we offer two options. One is a paid up at 65, thinking that that might be attractive in the executive carve out market. It recognizes that it may be easiest to fund your long-term care needs during your working years, before you go into what could be a fixed-income environment. So, we priced it to be paid up at age 65.

In essence, that gives the insured the ability to buy a product that becomes noncancelable by age 65, because there are no premiums payable beyond that point.

The other premium option is a step down approach. The ratio of DI premium components to the long-term care premium tends to be about three to one or so in this product. And so we weren't comfortable with a level lifetime premium providing the DI coverage. So we do have a step down whereby the premium continues for a lifetime basis. But at age 65, it drops down to the amount that would have been a lifetime level premium for just the long-term care coverage.

We didn't link the amounts of benefits between the DI and the LTC together. So you can buy a little bit of DI and a lot of long-term care, or a little bit of long-term care and a lot of DI. We set age 65 as the conversion point. That was pretty much just arbitrary. There are a lot of moving parts in this product as it's designed. And the idea of trying to make that conversion point another variable was overly daunting, and we did not provide an option there. It's certainly feasible to do it with other conversion points.

The long-term care benefits are pretty much the current industry standard in terms of skilled nursing facility, home health care and other service options. We wrote flexible policy language under the premise that the service environment is changing. And if you are too narrow or too specific in how you defined the services that are covered, you could end up in situations where very legitimate claims didn't fall into your definition, because the service environment has changed.

Some cost reduction features are inherent in the policy. We integrated the DI benefits. As I said, it's a fairly stripped down DI coverage. We integrate it with social insurance. We've got financial incentive in there for return to work. And one of the neat features, I think, of the product is that we've got this provision that says if you have no DI claims during your working years, at the point it converts over to long-term care, we'll bump that pool by 10 percent.

So, it rewards favorable experience on the DI side, which is another reason I think financially motivated claims close to retirement, will be significantly less on this.

And we've got rehabilitation, managed-disability provisions that are kind of a state of the art DI coverage that allows you to manage the DI claims as they come in.

We've got a number of optional riders, such as, guarantee of insurability (GOI).

We put in inflation protectors through the cost-of-living adjustment (COLA) provisions, and inflation protection on the LTC. And, we built a long-term-care nonforfeiture piece, which was also pretty much a regulatory response. We didn't feel that the market really needs nonforfeiture on this, and it is expensive, but from a regulatory standpoint it was desirable.

We've got significant savings relative to the purchase of two contracts. The savings come from two sources. The DI benefits are integrated with social insurance and there are expense efficiencies inherent in doing one underwriting and one policy issue, with one policy to administer.

I don't think I'd be comfortable going out and illustrating on this basis, but if you think about the integration of benefits provision and the incentive for no claims in the DI period, whereby you bump the long-term care benefit at retirement, in essence, you're buying 10 percent more long-term care than you would buy from a stand alone long-term care for that same level of premium dollar, assuming you don't have any DI claims.

So, if you think that you're not going to have DI claims, you can get an additional 10 percent effective discount on the cost of your long-term care, because of that bump in coverage on the long-term care side. I don't think I'd illustrate that, due to regulatory issues. But consumers may come to that conclusion on their own.

Our hope, when we designed this integrated structure, was that we could get a premium for the integrated policy that was in the same ballpark as the old loaded high-end DI products. And we pretty much succeeded at that. In fact, I think on competitive comparisons it was probably a little lower than the old loaded DI contract.

Any comments on the design? Any reactions to the approach we took to it?

FROM THE FLOOR: If someone retires prior to age 65, what happens to the coverage?

MR. VERNEY: As I said, we fixed that conversion point to age 65. So, to the point that somebody retires prior to the age 65, it acts like a DI policy. It handles the benefits on a DI basis, the same way it would if it were a stand-alone DI, which has provisions around your occupation prior to your claim and what your income loss was.

So, you don't get long-term care benefits, and it would be fairly restrictive in what it provided on the DI side as well. If you are disabled and you're ADL disabled at the point of the conversion, your ADL benefits kick in at that point. There's no requirement that you be healthy at the point of conversion.

If you go into a facility prior to age 65, you get the enhanced monthly indemnity that's the combination of the base DI and the catastrophic benefit. And we fixed the catastrophic benefit at 50 percent of the base. You could un-link those, but in our first version we had those linked. So in essence, if you had a policy that was giving you roughly 60 percent of your salary, if you're less severely disabled, you'd get more like 90 percent of your salary if you are disabled and in a facility prior to age 65. So it's a higher amount, but you're not into the long-term care pool yet.

FROM THE FLOOR: Could you develop a multi-life discounted version of this product?

MR. VERNEY: I haven't really thought that through in too much detail. Certainly you could if you tied your discount to commission reductions. The same underlying forces that would cause you to discount on the DI side would apply to the combination product. It may be a bit less discounted because the long-term care component probably is less affected by the factors used to discount the DI coverage.

FROM THE FLOOR: Would there be an application for this product in the executive benefits market?

MR. VERNEY: I think one of the attractions in that market would be the fact that you can provide your executive group a retirement benefit in the form of a paid up long-term care policy. I think the nature of the coverage is something that should have some intrinsic appeal to an executive benefits designer. So, if you're looking at just the DI, yeah you wouldn't drift to this. But if that long-term care component is attractive as a benefit, I think it's got a lot of appeal relative to selling a DI and selling a long-term care policy to that market.

FROM THE FLOOR: How does the policy work for claimants with disabilities that last longer than the DI benefit period?

MR. VERNEY: The contract would work similar to a DI policy with a limited benefit period. If you have waiver of premium, the coverage remains in force for as long as you remain disabled. If you recover, you may resume paying premiums, in which case you have coverage for future disabilities. So the coverage continues to have some residual value just like a stand-alone DI coverage would have.

FROM THE FLOOR: Do you offer benefit periods other than to age 65?

MR VERNEY: Yes, we do. Your question gets at one of the reactions we had from regulators, and we'll talk about that in a minute.

There are challenges to the product, some of which are fairly minor and some of which are more significant. It's a little bit of a pricing challenge. The regulators are a significant challenge. Lawmakers are a little bit of a challenge. Tax policy is an

issue for the product. We've found marketing and distribution to be a fairly significant hurdle. Administration is not much of a hurdle.

We priced it by looking at the separate components. We set assumptions for morbidity and allocated expenses between the two and then price each component. The expense allocation creates some mix risk, because you can choose the amount of each coverage component. We adjusted the claims cost assumptions to recognize incentives and overlaps.

In our first vision of this product, our intention was to grade off the disability benefits as the individual approaches age 65, and to grade in the long-term care benefits. So, in a ten-year period, it was morphing from one to the other. The input that we got back was that agents were uncomfortable selling something in which the DI benefit started to disappear as you hit age 55, and we filled that in and left the DI benefits in place to age 65, and started providing LTC benefits at that point. So there are not as many transition points in the ultimate design as we initially had envisioned.

In setting assumptions, we pretty much used LTC assumptions for the LTC, and DI assumptions for the DI. We think we've got a good shot at doing better than the DI and the long-term care assumptions, because of the reduced anti-selection at issue, and reduced financial incentives to go on claim as you approach retirement.

Another assumption was mortality. Lapse was another interesting one, in that long-term care is so much more sensitive to your lapse assumption, and is where we tend to be conservative in our approach to pricing. We use a different lapse assumption on the long-term care piece than on the DI piece, and that was something that we wrestled with a little bit. With your policies, you can't lapse one without the other. Either the whole thing lapses or neither one lapses.

We justified the different lapse assumptions on the basis that if policies have a greater long-term care component, they probably will have lower probability of lapse experience closer to long-term care insurance. If it's more heavily weighted to the DI, it might behave more like DI. So we use different lapse assumptions for the DI and the long-term care, recognizing that when you put them together you end up with a melded lapse assumption.

Interest is also important in the long-term care component. You are funding in the early years for benefits that are primarily payable well out into the future. So, you develop fairly significant reserves and you need to be careful with the long-term interest rate assumption on those reserves.

Another consideration in the pricing is waiver of premium. One of the dangers in pricing in pieces is that if you go on claim, the whole premium is waived, not just the premium from the DI claim. Any claim waives the whole premium, so you need to make sure that as you're pricing the DI that you don't price a waiver of just the

DI premium. You have to price and anticipate the combined premium and provide for the waiver of the whole thing.

Nonforfeiture can be very expensive. As you know, in long-term care, a lot of the funding of the future benefits is from termination of the policies in the earlier years. When you add a nonforfeiture benefit to the policy, you really increase the price quite a bit. We priced one, but we priced it only to apply to the long-term care. Basically, it satisfies regulatory needs to have a nonforfeiture benefit for the long-term care policy.

And on reserving, we assumed independent coverages. Each coverage holds reserves meeting the appropriate statutory requirements.

On the regulatory side, we filed it as a DI policy. We hoped that would give us easier, more rapid, smoother review by the regulators. Most of the states reviewed it as a combination product. We didn't fight them on it. We didn't call it long-term care, but in our discussions with them, we pretty freely used the words long-term care and they used those words back to us. We didn't deny that it is really a combination product, and that's how they reviewed it.

A big hurdle is that some states will not approve combination contracts. New York was the most vocal about it. We told them that it's really a lifetime disability coverage, and it's just the nature of the triggers that change. Their bottom line was that someone that purchased the DI contract with the long-term care at a time when they think they need both; over time they cannot lapse the DI coverage if they decide they don't really need it anymore without losing the long-term care coverage. They said policyholders are left carrying a coverage that they don't really want just in order to retain the other coverage.

So, they did not like that element of it. There are probably creative design approaches to get around that. They did suggest that we create a conversion rider that we can put on a DI policy and leave it at that. The UnumProvident policy had been filed and approved in New York and they felt that that was a more beneficial approach to addressing consumer needs.

California and Texas are the other two big states that had problems with combinations. So, although most states will approve the combination products, some of the big ones have problems with it. The minimum loss ratios may be higher for long-term care. It's not a real big issue for this contract, because you're funding benefits that will be payable far in the future through premiums that you're collecting during the working years. You build up fairly good reserves, and assuming that your earned interest is higher than your valuation factor, you end up with a fairly easy time meeting the loss ratio hurdles. There may be commission limits on the LTC piece, and there may be required long-term care provisions, such as the nonforfeiture.

We've done two versions of this product now, the first was for a regional carrier in the Northeast, and we filed it in 12 states. We ultimately had 11 states approve it; unfortunately, the carrier was domiciled in New York and New York was the one of 12 that would not approve it. So, that was a little bit of a body blow to the product as we initially designed it.

The second time through this we filed it in 45 states, and we got 24 approvals. At this point, we've got three more that I think are close. When we went through the second round we didn't have the nonforfeiture piece filed with it, and we've got nine states that I think will approve it once we add the nonforfeiture. So ultimately, I expect that 36 out of 45 states, or about 80 percent will approve the product.

But as I say, New York, California and Texas are states that won't. So, that 80 percent is a little bit of an overstatement in terms of potential policyholders that would have access to the product.

For the nine states that have disallowed, it's really an objection to the combination of the coverages in a single policy form. Seven states require the nonforfeiture and a few states have put us through some hoops on loss ratios, but those are surmountable issues.

The long-term care regulations that as a combination product this product is subject to, have a lot of consumer protection orientation to them and are focused on protecting the older population.

So you end up having to do some things on the product that are designed to meet needs of elderly people, when in fact you're selling it to baby boomers. And you get some anomalies there. The most significant one probably was in one state we were told that our guarantee of insurability provision fell into an inflation protection-type coverage.

And as a result, it was subject to the requirements on the long-term care regulations that say inflation protection or benefit increases cannot be subject to the health of the insured. So the position the state took was that anybody on claim could exercise the guarantee of insurability increase. Our response to that was that 0 percent are going to exercise the guarantee of insurability while they're healthy and 100 percent are going to exercise it once they're on claim. So you're telling me to price it just as the full benefit. If you can double your coverage, the price of the rider is the same as the price of the underlying policy with some minor expense differences.

They agreed to that, and we decided to pull the GOI in that state. So, they tend to apply some things that just don't tend to make a lot of sense to this product. You end up doing some anomalous things to meet their requirements.

Tax treatment gets a lot of discussion, the question being, is this a qualified plan or

not? Does it qualify under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)? Our position is that it is not qualified. HIPAA very specifically talks about stand-alone long-term care and long-term care policies added to life insurance polices and annuities. It does not say anything about long-term care added to a DI.

I think it was just an oversight. It makes a lot more sense to me to put a long-term care policy with DI coverage than it does to put it with life insurance coverage. But it does not make a provision for these combination products, and as such, I think we're stuck with it not being qualified.

On the other hand, the benefits of qualification may be fairly minor in this marketplace. The long-term care premium tends to be fairly modest. The deductibility of the long-term care premium for a qualified plan is subject to the medical expense limitation hurdles. And for people in the target market, there may not be really any true deductibility of the premiums.

Our position, although we don't give tax advice, is that it is taxed like a health product. The individual pays the premium, then the benefits will be tax-free at retirement. So, we don't think the tax issues are significant on it, although it is something that you have to address when you're talking to people about the product. And it may become more significant if the deduction for long-term care premiums jumps to an above-the-line deduction.

Marketing and distribution is the other big hurdle here. When we designed the product, we talked to all of our friends that are baby boomers and asked what they thought of this coverage. We received many positive responses, and we charged ahead. And actually, we talked to several agents who liked the idea.

As we got it designed, and in front of agents, we found it hard to generate real enthusiasm by the agents. You tend to have agents that are active in either the DI market or the long-term care market. You don't have a lot of agents that do both, which means that they need to be trained on both. You also need to train them on the fact that you have an integrated coverage. So agent education is very important. It is going to be a new market for most of them. You need the agent to educate the consumer.

As part of the education of the agent, you need to give them sales tracks. You need to help them learn how to sell this product. We did get some reaction that the price level is high relative to a single product sale. And the feedback that surprised me a little bit is that agents may not be real excited about this idea of having taken two potential sales and collapsing them into one at a lower total premium.

Some of the feedback said they'd rather have two products, and go in and sell one this year and one next year for a total premium that's greater than the cost of the combination product. With higher premiums, as long as I can sell it, I get higher

commission. So they weren't quite as sold on this idea of value to the consumer that had gotten us excited about the product.

And, on the administration side, you do need some ability to administer the contract, but you can treat the long-term care policy as a rider and those are not really too cumbersome of a hurdle.

Claims handling is another challenge. You do need expertise in handling long-term care claims as well as DI claims, but again that's fairly manageable.

So, in summary, what I'd say is that we're enamored with the product. I'd like to buy the product. I haven't yet, but I will. It's approved in Conn. I'm not sure which version of it I'll buy. I like the product. I think it fills a market need. I still can get excited talking about the value of the product to the marketplace.

At the same time, I'm a little bit discouraged and beaten down by the difficulty of trying to get a distribution channel anxious and active and vibrant out there in front of the market in selling it. And there have been frustrations on the regulatory side as well. As I said earlier, my hope is that other companies will see some value in this kind of approach or variation on the theme and that you might see more combination products start to emerge, and thereby get more acceptance from the distribution channels, from the consumers and from the regulators. I hope that it will start to take off and really meet a market need.

So, I think there's a good future for it eventually, but it's going to take come creativity in terms of how to get over those hurdles and get it going.

FROM THE FLOOR: Did you have any reaction from state regulators about the ability to change rates, and would they either limit them or require anything additional in terms of changing rates for DI or the LTC component?

MR. VERNEY: We really had no pushback on that from the potential rate increase perspective. Just as an aside, and probably not entirely germane to your question, but from the same state that gave us the difficult position on the guarantee of insurability, we had a reaction to a provision we had in the contract where we guaranteed the rates on the contract for three years from issue, and subsequently from three years of any rate change, thinking that that would give some element of comfort to consumers. It wasn't a big give-up from our standpoint. From a practical standpoint, it's hard to develop experience and go through the whole process of getting a rate change within a three-year period. So we really thought it was a no–give-up. But we had one of the regulators say that they had very big problems with that because we were jeopardizing the solvency of the carrier, and that was way too much risk for the insurance carrier to take. They wouldn't allow us to make that provision to the policyholder.

FROM THE FLOOR: Are there any reinsurers that participate in this program?

MR. VERNEY: Yes, there are. It's fairly heavily supported by reinsurance in the versions we've done so far.

FROM THE FLOOR: Do you consider the marketplace appeal of a stand-alone, long-term care product that has a paid-up-at-65 premium option associated with it, that in which you could, in essence, get the low-cost, long-term care and get something that was marketable to younger ages?

MR. VERNEY: There are carriers out there that have products available for the younger ages. So we didn't give it a lot of thought, because we thought that this would be a better way to go at that market. And we do have the flexibility to have a fairly limited amount of DI coverage with a CAT benefit and the long-term care.

So, to the extent that your interest is primarily the long-term care, you could configure the policy so that it's primarily a long-term care policy. But we felt that there were companies out there already that had a younger age product available. I don't know that they're doing a premium paid-up-at-65 option, though. That's the one difference in your question that I'm not sure exists out there.

FROM THE FLOOR: Are you running this through several companies or just one company's paper?

MR. VERNEY: It's available through one company's paper, through their own distribution channels. It's their product. We had a second version of it that we basically were doing on an issuing carrier basis and then taking most of the risk through to the reinsurer. And we were marketing that through distribution channels that we had identified. That carrier, because of difficulties not related to this product, is no longer accepting new applications of any products and we're a little bit out of the water on it right now, in terms of our own distribution channels.

But we'll see where we'll go with that. The product is approved on two companies' papers, but one of the carriers isn't actively in the market anymore.

FROM THE FLOOR: Can you give us a price comparison of combining products versus stand-alones?

MR. VERNEY: When you put it together, you end up with about a 15 percent discount from buying two separate policies, which puts you in about the same range as a lifetime benefit DI own occupation-type coverage.

FROM THE FLOOR: Would this product work well for someone who needed both DI and LTC coverage?

MR. VERNEY: Well, that's where we took the position that we would allow you to

dial in the amount of benefits that you want on either side. If you've got a group insurance coverage in the workplace that is giving you 60 percent income replacement, but to a maximum of some amount, such as $3,000 or $5,000, you may actually have some need for some supplemental DI.

And in that case, since you already have some DI, you probably dial in a little extra layer of the disability coverage. You would probably get that catastrophic coverage to cover you for expenses. The premise of 60 percent income replacement on a group DI coverage is fine in terms of just meeting your income needs. But if you've also layered on some expense issues on top of that, now you might find that coverage less satisfactory. So the catastrophic gives you another layer there.

But you can, in essence, dial in that fairly limited DI piece as a supplement to your other DI coverage and buy a larger long-term care component to the policy. So we think there's enough flexibility to make it apply in a lot of those situations. And if you're loaded up on DI and you want to buy just long-term care, you probably ought to just go buy a long-term care policy.

FROM THE FLOOR: Do you see ADLs being incorporated into DI policy as a definition of disability?

MR. VERNEY: Yes, there is some move in that direction, but it's usually done in the form of a catastrophic additional benefit. I don't think you're seeing it terms of your standard DI coverage trying to define disability in terms of ADLs.

If we had just done our DI as an ADL trigger, then it would be fairly limited in terms of application. But that ADL benefit component is another layer, on top of a traditional DI coverage, which is defined in terms of your inability to make an income as a result of accident or sickness. It stays away from the ADL focus, but it will kick up the benefits if you happen to have an ADL qualification as well.

FROM THE FLOOR: How many ADLs?

MR. VERNEY: Two of five. I think if we're doing it again, I'd do two of six, just because it's more standard and more readily accepted. Our premise was that toileting and incontinence were fairly closely linked, so we combined those together and did two of five, but if I were to start fresh, I'd do two of six.

FROM THE FLOOR: You first said it would be a mistake to offer this coverage on a noncancelable basis, but then by offering it to be paid up at 65, it becomes noncancelable at that point. Isn't that a problem?

MR. VERNEY: Your question is right on the mark. Your ability to protect your financial results is limited to the working years, so you need to monitor experience and make adjustments sooner rather than later. But no doubt about it, you add an element of financial risk to the carrier by providing that paid-up-at-65 feature.

FROM THE FLOOR: How do you meet the long-term care reporting requirements?

MR. VERNEY: We do our accounting on a component basis. When we do our illustrations, we lump it all together, but we do our accounting on an unbundled basis. So, we can do just long-term care reporting on the long-term care component.