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Session 105PD
The Impact of Underwriting and Risk Classification on Pricing and Product Design

Track: Long-Term Care

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Summary: Preferred and substandard underwriting classes are becoming more common for long-term-care (LTC) insurance carriers. This session discusses insurers' experience with multiple underwriting classes. In addition, the panelists discuss the impact of upcoming Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations on underwriting, risk classification and pricing.

MR. TIMOTHY TONGSON: Today in this session we're going to talk about the impact of underwriting and risk classification on LTC pricing and product design. First we have Etienne Dupourque from LifeCare Assurance Company. He is a pricing actuary. Then Caroline Lester from Avon Long Term Care Solutions will provide the underwriting aspect in a fair amount of detail, and then Alison Johnson will be discussing HIPAA and its impact on LTC.

Our first speaker today is Etienne Dupourque. He is the director of pricing with LifeCare Assurance Company. As a little background, he moved to the United States in 1968 from France, went to college in New York and California, worked with Fireman's Fund, America Life Insurance Company, and subsequently worked with GE. He is an FSA and a member of the American Academy of Actuaries.

MR. ETIENNE DUPOURQUE: When Tim asked me to make a presentation on underwriting and risk classes, the first thing I did was to think about my biography, and I went back to 1970. Pricing actuaries are asked to do projections. To do

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projections, one needs to make some assumptions about future events. In underwriting classes, a certain number of policyholders are standard, a certain number are preferred and a certain number are substandard. There are other assumptions that must be made with respect to interest, expenses and terminations.

The period 1970 to 2000 encompasses the period of a typical projection, which is 30 years. If I had been an actuary in 1970 and was asked to make a projection for 2000, what was the environment a pricing actuary would have dealt with? The first part of the presentation is a set of the historical data comparing 1970 and 2000 (where I could find the data). I will point out areas that indicate shifts that may be overlooked in a short-term analysis. The premise is that shifts in the environment affecting the underwriting risk make the assessment of risk classification an exercise in comparative analysis, i.e., to say that 70 percent of the policyholders are in a preferred class at a certain time and can pay 80 percent of the standard premium, the actuary should have an idea of what is the theoretical proportion of preferred policyholder expected in a current average LTC portfolio and what is the expected savings over the lifetime of the policy.

The first comparison shows the trend in the relative share of fixed assets between corporate entities and individuals. The trend is shifting toward the corporations. Skilled nursing homes and LTC resources are increasingly owned by corporations (versus public or individuals), and most of the LTC activities to which individuals will commit their resources will be to corporations. The effect on the risk classification is that the relationship of the standard, preferred and substandard changes over the years, due only to this shift. Most of the substandard or standard risks that would have gone to publicly owned facilities need to seek private care and insure themselves to meet the cost. This trend should increase the pool of standard risk that will seek insurance; i.e., in 2000 the proportion of preferred applicants should be lower than in 1970, everything else being equal. This may help in comparing the distribution seen by an LTC insurance company with what one would expect from a purely demographical standpoint.

In 1970 no insurance company offered LTC insurance, except maybe for Medicare Supplement plans. Underwriting for such products was minimal, if any. In 2003 LTC underwriting owes much to disability insurance. LTC underwriting classes are based on relatively short longitudinal studies with still relatively small claim experience. Current practices are very much market driven.

The median number of years that an employee stays with one company is shortening significantly. Underwriters' and actuaries' length of service follow that trend. In an insurance company, an underwriter's expected length of service greatly influences the risk classification decision, no matter how systematic it is. An underwriter making a risk classification decision or an actuary making a 30-year projection is probably not going to be around in the company through the full duration, so the accountability is somewhat diluted. The individual LTC applicant is

going to make a personal decision based on an increasing lifetime horizon.

There are statistics that indicate the proportion of the U.S. foreign-born population is much larger in 2000 than it was in 1970, and that affects the way prospective applicants look at insurance. Attitudes toward private LTC insurance are different between cultures. Since several underwriting criteria are based on lifestyles and habits, which reflect attitudes, the change in profile in population affects how the applications for LTC insurance are made.

The ratio of male college graduates to female flips: In 1970, 60 percent of graduates were male, 40 percent were female; in 2000, 57 percent were female, 43 percent were male. The share of consumer expenditure for college graduates is much higher in 2000 than in 1992 (I couldn't find the number for 1970). The underwriter is now faced with applications from an increasing number of more knowledgeable, working female applicants, not the widowed housewives of the 1970s.

As for home ownership rates, the over-65 population owns more homes now than it did in 1970, but also the one-person household is more common, and home health care would be something that a single homeowner would be looking for in retirement. The percentage of over 65 over median household income is going up, as opposed to the percentage of under 65 over median household income, which is going down. One could expect an increase in well-to-do older applicants, even if the overall average issue age is going down. This may indicate an increase in substandard issues.

Other general environments: pensions are shifting from corporate or public defined benefit plans to the individually owned defined contribution plans, like 401(K). A well-funded plan may allow direct purchase of long-term-care services. I included the political environment because that affects the privacy of information, which we're going to touch upon. The 9/11-related events are changing privacy issues.

Computer technology gives individuals more tools to make financial analyses for their decisions. LTC-insurance applicants and their agents have spreadsheets and mathematical tools that were available only to actuaries or specialized financial professionals. As an actuary in the 1970s, I used commutation functions, but now it is not necessary to use such actuarial functions to make complex projections about what LTC and LTC insurance cost. The Internet allows access to data previously only available in technical books or reviews, and agents or financial advisers can use the data to make a risk assessment for a prospective policyholder. A corporate actuary needs to have a very good idea of the financial implications of the individual applicant's LTC needs and expectations. Rate margins are not only reduced due to competition but due to increasing market sophistication.

Rapid developments in medicine can make an uninsurable applicant insurable, but

can also change the expected length of claim for individuals. In a few years, uninsurable applicants may become eligible for standard rates and the standards for medical necessity will change.

Rising public and private debts increase pressure on alternative financial resources, such as insurance, to seek additional services, such as LTC. As an aside, I must point out for actuaries who make pricing projections based on fixed interest rates, that the federal discount rate in 1970 was about 5.5 percent. In 2000 it also hovered around 5.5 percent. Anyone who did any pricing in the 1980s knows that the interest rates went much higher than 5.5 percent. In 2003 I am asked to use fixed interest rates of 4.5 percent or 5 percent, and yet within 30 years I really doubt that will remain the case.

The cost of health care is going up rapidly, and long-term care follows. Cost-of-living-adjustment (COLA) riders are very popular, and an underpriced rider can quickly be subject to arbitrage.

If I make some assumptions about the distribution of standard and preferred, and this distribution does not hold true, what are the financial consequences? I used the 1984-99 Intercompany Study (available on the Internet); I assumed no termination and no interest to better see the results of the underwriting. The Intercompany Study indicates that the underwriting selection wears out in about eight years. Although this is mostly reflected by selection factors in pricing, if this were to apply to underwriting risk classes, the claim savings would end after the eighth year but the premium discount would remain for the duration of the policy. After eight years the average claim stays standard; under this example this would result in a 5 percent increase in loss ratio. This analysis applies to policies classified as "preferred" based on current underwriting guidelines but whose status changes to "standard" due to a change in claim profile.

The second issue is if I misjudged the proportion of preferred to the standard, and there should be no discount on half of the preferred risk (i.e. 50 percent of the assumed preferred risk is standard). That raises the loss ratio, of course, and it can go up to 10 percent. If the assumed profit margin is 5 percent, then a rate increase may be in order. When considering the requirements for moderately adverse deviations that are assumed on each single set of assumptions with respect to morbidity, mortality, lapse, and interest, this would be an additional problem if risk classes are misjudged even if, in aggregate, claims turn out to be as expected.

Unisex rates combine female and male rates using an assumed distribution. With the difference in risk class per sex, the resulting combined rates would change. Distribution is based on the standard assumptions, but I varied the female and male distribution in the risk classes from assumed, although they add up to the composite distribution. I use two approaches to calculate final claim rates: one calculates claims based on each sex and then calculates the aggregate, and the other approach is to use the aggregate claims. These approaches produce different

results. In this example, for one dollar of daily benefit the difference may be negligible, but in the aggregate the dollar variance may have a significant impact on the viability of the portfolio.

In conclusion, incorporating risk classes into the pricing of a long-term-care product requires broad as well as detailed considerations because of its long-term horizon. Long-term changes in lifestyles, technology, economics and health care make risk classification a very critical element in the rate sufficiency of a long-term-care portfolio. The incorporation of strict underwriting guidelines is necessary for a successful LTC portfolio, but not sufficient.

MR. TONGSON: Etienne brought us up to where we are today in a number of aspects. The next speaker is Caroline Lester. Caroline is the senior underwriting officer at Avon Long Term Care Leaders, which is a reinsurance intermediary and LTC risk manager and a subsidiary of Manulife Financial. She has over 12 years of LTC underwriting experience on both direct and reinsurance sides. Caroline was previously the assistant vice president of LTC underwriting for AUL Long Term Care Solutions. In this role she managed the risk selection process, developed work site underwriting programs, designed an integrated knowledge-based underwriting system and maintained medical underwriting guidelines for multiple client companies.

MS. CAROLINE LESTER: I'm here to talk to you about LTC underwriting as it pertains to the preferred and substandard risk categories, and to give you some insight into what an LTC underwriter considers in developing guidelines for preferred and substandard risk.

You might want to know about the data and where I came up with this information. I took information from 14 of the top 20 carriers for 2001, and when I put this presentation together, that was the most recent information I could find. It encompasses early 80 percent of the total premium in force in the LTC industry. Many of the observations or data in the presentation are from my own experience of over a decade.

First we're going to talk about what "preferred" is in LTC underwriting. We're going to talk about how the underwriters analyze the risk and the tools that they use to do so. We're going to talk about differentiating the discounts because it's not the same among carriers, and we're going to talk about some of the underwriting criteria for preferred. Then I'm going to get into the substandard risk categories. We'll talk about substandard risk classes that we're seeing in the industry, some of the underwriting criteria, and what makes a risk substandard versus not insurable.

We're going to talk about preferred first. What do we mean when we use the term "preferred risk"? I thought it was important that we try to distinguish what we're talking about. Are we talking about a preferred lifestyle discount? Are we talking about a preferred health discount, or are we talking about a preferred rate?

In the preferred lifestyle discount, typically health status has not been the primary factor in making somebody eligible for a preferred lifestyle discount. We're talking more about lifestyle. What do I mean by lifestyle? I'm talking about the activities that a person performs on a regular basis, daily or weekly, such as going to work, volunteering, hobbies and exercise, and we're looking at habits. Is the person a smoker? Is a person a non-tobacco user? Is the person a tobacco user? Or is the person a non-smoker? That's all very different.

Let's talk about a preferred health discount. Analysis and classification are definitely based on health status: their medical diagnoses, their build, the medications that they're taking. Some companies look at medications and they say some are acceptable; other companies say that no prescription medications are acceptable. Again, lifestyle and habits are looked at, as well as preventative health measures. Is a person having regular physical examinations? Is the person complying with a doctor's recommendations for preventative measures? Age may also be a factor. We've seen some of the intercompany studies that show that as a person ages, the likelihood of needing LTC is greater. The likelihood of developing diseases that make that person a significant risk is also greater.

Then there is the preferred rate. You need to be careful, because a preferred rate may just mean the base rate. It may not be a true preferred discount at all.

Let's talk about what an underwriter does to analyze the risk and determine if somebody is preferred or not. The tools that we use are the application, a phone interview, a face-to-face assessment and an attending physician's statement (APS). What do we get off the application? It depends on what types of questions are asked. We do obtain medical history, medications and the physicians that the person sees, height and weight. There are some questions about lifestyle, and there are some questions about habits.

The phone interview is a verification tool but also your opportunity to dig deeper and find out more about that person's medical history. There are questions about functional level. It's not just a verification of whether the person can perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), it's how you ask the questions: Do you have any difficulty with going up or down stairs, do you experience any weakness in your legs when you do so, do you have any shortness of breath? We look at lifestyle and habits again; we dig deeply into what do they do on a routine basis. We're looking to find out if this is a person who is sitting on the couch and watching soap operas all day, or is this somebody who is out meeting friends for breakfast, then going to the golf course and then doing some volunteer activities. As far as habits: Is this person using any tobacco products, and to some extent, is the person using any alcohol and how much alcohol are they using?

Face-to-face assessments are done typically in the home with the applicant, usually

by a nurse or a paramedical who has an understanding of geriatrics. There's a verification of the medical history, but there is in-depth analysis of functional status and cognitive status. During a face-to-face assessment, a person is typically asked to do what's called the "get up and go." You get up from your chair, you walk across the room 10 paces, you turn around, you come back and you sit down. We're looking for any signs of stability or mobility problems. There are many different tools out there that are used for cognitive evaluations. The attending physician statement gives you the comprehensive medical history and medications over a period of time for the applicant. There are usually some comments about functional status and cognition as well.

Let's talk about the characteristics of a preferred risk. Typically it's a non-tobacco user; it's not just a non-smoker. Lifestyle and activities are important, as is their build (height and weight). They don't have any complex medical history (I'm going to talk about that later). They've had a physical exam, or they've been compliant with preventative measures that the doctor has recommended. Are they taking any medications, and if so, what are those medications? They've never used LTC services, they've never had any home health care, they've never attended adult day care and they've never been in a nursing home. They don't use any devices, and by devices, I am still talking about a single point cane. People that are receiving preferred discounts usually are not eligible if they're using a single point cane. They're independent, obviously, in their ADLs and their IADLs. There might even be age limitations like we've talked about and even benefit limitations. There are some carriers out there that may not want to give a preferred discount to somebody who is applying for a very large or a maximum benefit.

Let's talk about the complex medical histories that make people ineligible for a preferred discount. Automatic declinable conditions are: Alzheimer's disease, Lou Gehrig's, insulin-dependent diabetes and co-morbid factors such as congestive heart failure with chronic obstructive pulmonary disease or a diabetic who has had a stroke. But even more so than the automatic declinables, it's the progressive or the significant medical conditions that would exclude somebody from receiving a preferred rate: anyone with a history of alcoholism; typically any diabetic, even oral-controlled diabetics; coronary artery disease; somebody with a history of cancer, lymphoma, leukemia; someone with a history of depression; people with joint replacements—and we're usually talking about weight-bearing joint replacements such as your hips or knees; osteoporosis and rheumatoid arthritis. These are just some examples. This isn't meant to be an all-inclusive list by any means.

The percentage of risks that are qualifying for preferred is definitely influenced by a number of factors. The number of criteria that are used is the most important. As we talk about each of the discounts, you'll see that it's a building factor. It starts off at a 5 percent discount. The higher the discount percentage, the more factors that are added to the eligibility criteria. The criteria that are used: If you're using a build chart, what are the parameters of the build chart? If you're allowing medications,

which ones are you allowing? If you're allowing some medical conditions, what are they? Then there is the average age of the sales. If your average age is up in the 70s, you're going to have a much smaller percentage of people receiving the preferred discounts versus if your average age is in the 50s. The preferred discounts that are being offered with most carriers are a 5 percent, a 10 percent, a 15 percent or a 20 percent discount. Definitely the most prevalent are the 10 percent and the 15 percent discounts. Definitely the more stringent the criteria, the higher the discount the person receives.

The 5 percent preferred discount is more, I would say, of a lifestyle preferred discount. They are typically non-tobacco users who are performing activities outside the home on a regular basis, for at least 10 hours a week. They're working, volunteering, exercising or performing a regular hobby. Looking at driving status, are they capable of driving their own vehicle, and have they had any violations within the last set period of time, typically two years?

For the 10 percent preferred discount, again we see the non-tobacco and we see the lifestyle. But now we've added in a few other factors. You have the build; they have to be within the preferred limits. They typically don't have any complex medical history, although controlled blood pressure may also be allowed under this 10 percent preferred discount. When we say blood pressure control, what we're looking for is somebody who's had blood pressure that's been under control and on medication for a period of at least six to 12 months—it depends on the carrier—and the person's readings have to be below a certain average. I'll give you an example of maybe 140 over 70. The person's average readings over that time period need to be below that.

The 15 percent preferred discount includes those criteria in the 5 percent and 10 percent discounts, but there are additional items. A physical exam in the last, let's say, 18 months is required. (This is just an example; I'm not saying this is what every single carrier that offers a 15 percent discount does.) There's no use of LTC services or devices. There are no anticipated procedures; their doctors have not recommended any procedures or recommended any surgery to be done that has not been performed.

The difference in the 20 percent preferred discount is the physical exam, typically in the last 12 months. Something else that you might see is an age break in the physical examination criteria. Some carriers would say applicants age 65 and younger need to have seen their physician for a regular physical exam in the last 24 months versus applicants age 66 to age 75, who have to have seen their physician for a regular physical exam in the last 12 months. Treatment is typically of a preventative nature only. If they're going to allow any medications, acceptable medications would be: medications for some thyroid conditions; over-the-counter digestive aids; female hormones; PRN, which means as needed; use of a non-steroidal anti-inflammatory for somebody who has a mild case of osteoarthritis, maybe affecting non-weight-bearing joints like your hands; or hypertension that's

controlled. There may be an age restriction on the discount. For example, you may not want to offer it to people who are age 80 and over.

What are some reasons *not* to offer preferred discounts? Most of you are actuaries, and so I don't need to explain to you that it can impact your standard rate. Two of the most important factors are that it can complicate the sales process and it requires more complex underwriting. The producer has to be able to determine with some degree of certainty that this person is going to be eligible for a preferred discount. Otherwise, if the producer is quoting preferred in the home but can't determine from the criteria in the agent's guide if the person is eligible, the producer is going to have to resell the case when he or she goes back out to deliver a standard policy. You need to consider that when you're developing your guidelines.

Another factor is additional underwriting requirements. It's very rare that you're going to see a carrier issuing preferred to somebody just off the application unless it's a much younger applicant who is applying for the coverage. Typically a phone history interview, a face-to-face assessment or an APS is going to be needed, and those are usually a function of age. We need to monitor exceptions. You can't have large numbers of cases going through where the underwriters are bending the rules a little bit to let risks through, because every little bit that you bend means more and more are falling into a preferred category that aren't truly preferred.

Let's talk about trends. I told you at the beginning that some of this is based on my own observations, and I did talk to a few of my friends who also work in underwriting departments in LTC just to get their philosophy on what's happening in the marketplace. We are definitely seeing more carriers offering preferred or being interested in offering preferred discounts than five years ago. If they've been offering preferred, now they want to offer ultra-preferred, maybe the 20 percent preferred discounts. There's definitely more emphasis on health than there was in the past. Typically five years ago it was a lifestyle discount; they had to perform a certain amount of activities, and there were some health habits involved.

I'm going to transition now into my substandard risk discussion. Fewer carriers seem to be willing to participate in the substandard market. What is a substandard risk? It's not easy to define, and the definition varies greatly across carriers in the LTC industry. Generally the term applies to people who have higher mortality and higher morbidity. Medical conditions, though, can vary greatly across carriers, and an example of that is chronic obstructive pulmonary disease (COPD). There are plenty of carriers out there that might say it's a standard risk. There are plenty of carriers out there that say it's a substandard risk. Then what does it mean that it's substandard? Is it just a pure rating that's applied to somebody who has COPD, or is it a benefit limitation and a rating that's applied to a person who has COPD, or is it a decline outright? Substandard rates with benefit modifications are definitely becoming more prevalent in LTC insurance. You're not seeing a large number of carriers that have a substandard rate that's going to be allowed on an unlimited

risk.

So who receives the substandard rates? Risks with medical conditions that have a higher occurrence rate receive the substandard rates. What am I talking about there? I'm talking about cancers, circulatory diseases, somebody who's had a stroke, somebody's who's had a transient ischemic attack (TIA), or somebody who has peripheral vascular disease. Risks with progressive medical conditions receive the substandard rates. Examples are: somebody with rheumatoid arthritis in the weight-bearing joints or rheumatoid arthritis that's requiring several medications to get it under control, a diabetic or somebody with a history of congestive heart failure. Risks likely to need assistance in the more immediate future receive the substandard rates. These risks include osteoporosis of moderate to severe severity, and co-morbid conditions.

Looking at the guidelines, the most common substandard rate classes in LTC are 25 percent, 50 percent and 100 percent rate increases, and usually carriers are offering two of those. That's not to say that everybody does that. Other classifications that I was able to find were: a 35 percent, 40 percent, 65 percent and 70 percent rate increases.

These are some examples of substandard medical conditions (this list is not meant to be all inclusive by any means): anyone with a history of alcoholism; bipolar depression; carotid artery disease; cerebral palsy; emphysema and chronic obstructive pulmonary disease, which I've already mentioned; fibromyalgia, leukemia but it could be any type of cancer, any type of lymphoma; definitely weight is a factor; peripheral vascular disease; or a history of stroke or TIA. There are plenty of carriers out there that will still consider stroke or TIA on a substandard basis, but I think that there's even more of a trend that they're declining them outright.

Some examples of substandard with benefit modification types of conditions: somebody who has a stable but chronic congestive heart failure, a combination factor of a chronic fatigue syndrome and a fibromyalgia, lymphomas, some cancers maybe, moderate to severe osteoporosis that does not have any fractures associated with it, or rheumatoid arthritis that's requiring multiple medications or it's in multiple weight-bearing joints.

My experience in the past had been that we could make alternate offers. We would make one offer where there was a rating on it and then we would make one offer where there was a benefit modification, but I've been enlightened. When you do this, what can happen is that you are allowing a substandard risk into a standard risk category. You need to be careful when you're allowing it to happen, but there are some conditions where it might be appropriate. For example, let's talk about a cancer where the person has been recovered for a certain period of time. You may not want to give the person a zero- or a 20-day waiting period. You may want to cut back to a 90-day waiting period. Another example would be a degenerative disc

disease where there's been at least one surgery and the person is still taking some medications for it. Maybe you don't want to give unlimited; maybe you don't want to give a 20-day or a zero-day waiting period. There are some types of arthritis as well.

When is the risk just too great to offer substandard? The frail little old lady who's all hunched over, with osteoporosis, who's starting to need some assistance with her finances, who's suddenly not driving anymore, may not be the kind of risk that you want to let into any of your risk pools. Anybody who is ADL or IADL impaired may be too great of a risk. Those with unstable medical conditions may be too great of a risk. When we talk about this, we're talking about the progressive congestive heart failures, anyone with cognitive difficulties, any conditions that pose an immediate risk of needing LTC services, anyone with a high percentage of carotid artery disease in the neck and anybody with recommended surgery. Then those with co-morbid conditions may be too great of a risk: the diabetic who has complications, the diabetic who has had a stroke or a TIA, and osteoporosis that's combined with a history of rheumatoid arthritis, taking chronic steroids to control the condition. The two factors are not favorable together.

The one thing I want to stress from an underwriting perspective is that communication is key. The marketing area needs to communicate with the underwriting area on what the demographics of the sales are going to be—what the average age is going to be. The underwriting area needs to understand the actuarial expectations—the pricing behind it. What do you expect to receive, how many risks should be getting preferred and how many risks should be getting substandard? Actuarial needs to know the demographics of the underwriting criteria or have a good understanding of the underwriting process and tools that we use. Then everybody needs to talk. Underwriting, claims and actuarial need to analyze the business together. You need to look at the claims experience, maybe make some adjustments to your criteria, verify that your assumptions are sound and then data mine. Examine the risks that you've put on the books and make sure that you've classified them appropriately.

MR. TONGSON: That was a lot of information. We covered pricing, we touched on the pricing aspects, and we wanted to allow fairly in-depth aspects with regard to the underwriting process on preferred and substandard. Now we have the "bonus" presentation, as I like to call it. We've got HIPAA to talk about, which is part of what's happening today, and the person who's going to cover that for us is Alison Johnson. She's an R.N. and an M.B.A.. She works for me in the Minneapolis office of Milliman, where she's our compliance officer for HIPAA. Alison is a health care management consultant with over 25 years of experience in the health care industry, having worked in hospital operations, financial management and clinical nursing. She specializes in evaluation and analysis of existing health care management systems and the design and implementation of practical health care management programs.

MS. ALISON JOHNSON: I know that HIPAA is not a subject that everybody is just dying to hear about, and you probably have hit the basics of HIPAA multiple times, especially since in April we had a significant compliance date. I'm going to cover some of the basics of what HIPAA is that you've probably heard 100 times, and then we're going to talk about to whom HIPAA actually applies, what protected health information (PHI) is, what you have to do to comply and then special considerations for LTC.

Of course, with any kind of new legislation, one of the questions always is, exactly how is this going to work out? Exactly what are we required to do? There have been a lot of guesses out there while people are figuring out what is actual compliance and what isn't actual compliance. At Milliman we've struggled with those questions too. Milliman has over 30 offices in the United States, and we have consulted extensively with each other as we sorted out the specifics of compliance. For example, what should we do to secure information in our servers? I will talk about some of those things. One of the other things I want to do today is to ask you three key questions about issues in LTC to find out what you are experiencing in the way of problems right now.

First of all, what is HIPAA? It's the Health Insurance Portability and Accountability Act. It's from 1996, so it has been around for a while. You probably know that insurance portability was the first big issue. That is pretty well behind us in that we've sorted out what to do about portability. The whole point behind this recent discussion of HIPAA is around Title 2, which is the administrative simplification piece. There are three pieces to it. One is the standardization of electronic transactions, the next one is privacy and the last one is security. We'll go into all three of those together. We're not going to talk about all of HIPAA and everything that's in there; we're just going to talk about the administrative simplification that comes under Title 2, because that's the one that's got everyone concerned about compliance right now.

First of all, "covered entities" must comply with Title 2 of HIPAA. So what is a "covered entity"? A covered entity is a health plan. Now, it does not mean a workers compensation plan, disability, sickness fund or liability coverage. It does mean a health plan. LTC insurance is covered as part of a health plan, so you are a covered entity. Health-care providers are also covered, so this means all the hospitals, doctors, chiropractors, physical therapists, nursing homes and any LTC facility that you can think of. They're all covered entities, which means HIPAA applies to them. Health-care clearinghouses are also covered entities. As a part of the administrative simplification, there's a standardized way in which claims need to be submitted and processed, and it has to be done electronically. The options around submitting paper claims are virtually gone now, unless you're very tiny. So, for example, an individual physician's office may send its paper claims to a clearinghouse that then posts them and sends them in. So, clearinghouses are covered entities also. I'm on a trail here, so you have to follow along. First of all, who is a covered entity and whom does HIPAA apply to? There are three

categories: health plans, providers and the clearinghouses that make it possible for them to submit claims electronically.

What if you're not a covered entity, but you're working with somebody who is a covered entity? This is a situation that Milliman has had to deal with. You say, "Okay, I'm not a provider and I'm not actually directly working for an insurance company," or "I'm an insurance company and I'm going to be sharing information with someone else who isn't an insurance company," or "I'm certainly not a clearinghouse, but I work with somebody who is a covered entity." What do you have to do there? You have to enter into a contract, called a "business associate agreement," whereby you agree to provide the privacy and security that's necessary for information that's shared with you.

The fact that you aren't a covered entity doesn't get you off the hook. If you're not a covered entity yourself, you may want to develop a business associate agreement form that you automatically sign with your clients that says you agree to comply with HIPAA. Milliman has such an agreement that we use all the time with people. Any time we enter into a consulting agreement with someone where we know we will be looking at protected health information, we sign a business associate agreement and send it to the client. The agreement says Milliman has certain things set up that will protect the privacy and security of this PHI. It's becoming common that you need to develop and sign business associate agreements, and that means now, of course, that you need to be compliant with HIPAA.

Comply with what? There are two things that you need to evaluate to decide if the information you are receiving needs to be protected. Only certain kinds of health information that is identifiable is protected. What are those certain kinds and what makes the information identifiable? Of course, you can't protect the universe, but there is certain information that we know about that needs to be protected. It is any individually identifiable health information that is either created or received by a covered entity, and it has to be related to either your past, present or future physical or mental health conditions, or the provision of health care that you actually receive or the payment surrounding that. The information is in any medium: written, verbal or electronic. It pretty well covers everything: the conversations that you have, as well as the written documents that you receive, as well as the e-mails that you send out, as well as any of that kind of information. So "health information" is defined very broadly. It's very broad at this point, but people wind up having to put in systems that protect both the procedures and the services that you receive, as well as information about your health, as well as payment for that.

There are data elements that make it identifiable, and this list is quite broad: the name, if it's associated with a claim or with some information that you receive about an individual; the address, including the city, county and the zip code (with fewer than a certain number of people living in a zip code, the zip code alone is

considered identifiable. For example, if you have a health record from a physician, and the only identifier on it is the zip code, but there aren't very many people in that zip code, you now have PHI on your hands.); dates, including dates of any kind, not just your birth date, but the fact that you have the date of the hospitalization and the hospitalization could be considered identifiable health information because maybe they can track back and find out who that person is; and obvious things like Social Security numbers and medical record numbers. Other things included are not quite so obvious, like photographic images, finger or voiceprints that might have been taken, especially when you're evaluating health conditions. Sometimes you'll get a photograph of a lesion or of a joint or something like that to look at, and that's considered identifiable health information, even though no other distinguishing features of the person's body, like face or hands, are in the photo. That's considered PHI. The account number—anything that you do that can be traced back to the person—makes it identifiable health information. The bad news is that this is very broad, both what's considered protective health information and what format it may come to you in.

Now that I have you totally stressed, let's talk about what can you do. There are two basic compliance strategies that people put in place for HIPAA. One of them is to avoid getting protective health information, and the other one is to have some automatic systems that let you secure it as soon as it comes in. Milliman has pursued both of those. First of all, you want to avoid getting PHI, so if there's any way that you can operate without PHI, do it. Don't request huge data files that have all kinds of information in them that is identifiable. You can ask your client to de-identify that information. Take the identifiers off and keep only what you actually need from it. I can see the skepticism right away. I'm talking to actuaries who are thinking that they need those data elements. Of course, there are many times when you do need those data elements. Especially in LTC, where you're dealing with a lot of individuals and when you're assessing insurance risk, there's no way around getting PHI. You simply have to have it, so the next strategy is make sure that you have it protected. But the avoidance of PHI is a primary strategy for when you're dealing with large databases. You just want to be sure that when you're getting a lot of information to do some sort of analysis for someone, you do everything that you can to keep from getting identifiable information, because you have to protect it not just now, but off into the future. One other point is that it doesn't start from the middle of April forward, but there's actually a requirement that you go back and protect all the PHI that you may currently have.

Let's talk about securing PHI. First of all, you need to sign business associate agreements with everybody so that you are sure that you're protecting their information, or if you're on the other side, you have a signed agreement that says, "If I give this PHI to you, you will secure it, and you will treat it confidentially." So, first of all, get those signed agreements in place. Having a standard form that your lawyers have looked through and that everybody is in agreement with makes it very easy for you to simply sign and send. On the business associate agreements, it's not necessary for the person that you contract with; the person who's not the

covered entity has to be the signer, so it doesn't have to be signed by both parties.

Next of all, a key strategy a lot of people pursue is training for your staff. I call this the "avert your eyes" policy. You're saying to people, "Listen, we have a certain amount of information, forms come in from individuals, faxes come in, and when we deliver the mail, we're going to deliver it upside down, so that people can't just walk by and see someone's PHI." Train your people so that if you're working on claims or something at your desk, a general policy in your office says, "We don't look at the stuff that's on people's desks. It's all right for people to leave things out on their desks, because we're not going to read over people's shoulders." Now, at the end of the day we have to secure everything, but a key strategy can be just training your people to treat the confidentiality of things. Sometimes this also involves the signing of an agreement, so you might ask employees to sign an agreement that says, for example, "I solemnly swear I will not reveal any of this information." You develop a form so that people agree that they are going to comply with those kinds of policies. Staff training around handling PHI is an excellent strategy. The other thing to think about is the administrative staff, because they frequently handle the files, the mail, the faxes and all that kind of information that comes in. Training for them on treating things confidentially is an important aspect of staff training.

Something that is a little more difficult is securing your computers, your servers, and your back-up tapes. The back-up tapes can be a particularly difficult to secure. There's no definitive thing out there for HIPAA that says your servers have to be behind two locked doors or your servers have to be in a 900-pound cabinet. But you need to have some way that you can secure your computers, secure the servers and then secure the back-up tapes that you use, provided that the PHI is on those areas. Now, if you have an entirely paper system, you have nothing to worry about, but, of course, that's not much of a solution either. Security for all those areas is important.

Some common things that people do is have a locked area inside the office where they keep all their servers, or they'll have an automatic password-protected screen saver that comes up, so if they leave their computer for 15 minutes during the day, it automatically comes up with a screen saver that's password protected. That's a very effective mechanism. If you walk away from your desk at the end of the day, the cleaning people that come by in the evening couldn't look up anything on your computer without being able to enter your password.

Here's something else to think about. How many people brought their laptops with today? Might you have PHI on your laptop? You have to think about securing your laptop in the hotel room or in the airport, and so you have to think about where you're carrying this information.

Probably the easier part of it is securing paper files, faxes and other kinds of documents. One thing to think about is cold storage. Most places sign a business

associate agreement with whomever does cold storage for them. You have an agreement with them that they will secure all of your information, and you make an assumption that all your past files contain PHI. It's a nice way to go because then you don't have to sort through your cold storage; you just sign an agreement with them that says they will protect all of it. Of course, now this means when you go retrieve a box from storage, you've now labeled it as PHI, and so you have to treat it securely in your office also.

Most people use a locking cabinet system. You can lock information in your desk drawer. I took an informal survey among people, and it's surprising the number of people who have no single locked drawer in their entire office. Their office drawer doesn't lock, they don't have a cabinet and they don't even have a pencil drawer that locks on their desk. That means they have to go to some sort of central filing system where they honestly can lock things up. At Milliman we had a couple of file cabinets drilled for locks so that we had a place where we could put things. At the end of the day, you do need to put things in that locked cabinet, lock them up and then get them out again at the beginning of the day. It's not acceptable to leave any of that kind of information lying on your desk.

Think about the security of the office itself. Do you allow people to come in, talk to the receptionist, and then go back and find whomever they're looking for? If that's the case, then you are at risk for someone to walk by somebody's desk and see PHI. Do your faxes and mail come in, get opened, and then sit in an open area so someone could come up to the receptionist's desk while they're waiting to talk to someone and glance over at your fax machine and see something? We taped a piece of paper on the tray for the fax machine so, as the faxes come in, you can't just glance down and see them; they come in underneath the piece of paper. There are a variety of simple things you can do, but you have to think through the process.

Milliman's choice has been to have everyone sign in at the front desk, and then they have to be escorted when they're going to any place within the office suite. When people come to visit the office, you have to go out and get them, even if it's your husband or your child or somebody like that.

Think about your conference rooms. If you ever work in big conference rooms, you pull out all the data, you spread it all out on the table and then you decide to go for lunch before you finish up. You have all the PHI that you've been sorting through lying on the table. You have to have some way of securing that. The receptionist may be sitting right outside that room. You tell the receptionist you're shutting the door and not to let anybody in there. Do you have to put everything away and lock it up? Just think through those kinds of issues around securing paper files, faxes and other documents.

Now, remember that not all health information is PHI. This is the other thing that we got very wrapped up in. We had to stop ourselves at one point and say, "Wait,

we only need to protect PHI. We don't need to protect everything. So let's just calm down here and sort out where we have PHI and where we don't, because there are things that we don't need to secure." If you have de-identified records, so you have health information but it's not associated with any individual and there's no way to trace it back to any individual, it's not PHI. I get a lot of that kind of information because I do a lot of chart review information, but as soon as I remove the identifiers, it could be anybody's medical records.

Let's talk about health information that you purchase from a non-covered entity. For example, if you're buying pharmaceutical information, you're buying benchmark information. It's health information, but it's not identifiable with anybody, so it's not PHI and it doesn't need to be protected. Then if you have records and databases that don't include PHI that's been created or maintained by covered entities, for example some of the government databases and some research databases, that is also not PHI. Think about whether or not the health information is really PHI. I suspect you deal with a lot of PHI because of the individual underwriting situation where you evaluate one individual's information, and it's important that you retain the identifier with that kind of information, so that does mean you need to be sure that information is secured.

There are some considerations for LTC, and I have some questions for you. I'm wondering if people are experiencing trouble with obtaining an APS because the physician is a covered entity, and I wonder if people are experiencing physicians balking at sending over the APS. Is anybody running into that problem?

FROM THE FLOOR: They sign a release form, so that's no problem. They want two forms instead of one form, that kind of thing.

MS. JOHNSON: The observation is that it was terribly slow to get APSs before and it's even more so now, but the other observation was that the applicant signs a release, and that sending that release to the physician should break through that kind of problem. I was at the doctor's office a couple weeks ago, and I tell you, the amount of information they gave me about HIPAA and the forms that I had to sign were fairly considerable. I read through this to see what they're saying, and one of the things that they said was that they would not share any information without my knowledge. Even though I signed the release, it sounded like they were going to have to give me a call before they sent any information any place other than to my direct insurance company that already covers me. I'm wondering if obtaining the APS is not going to be an issue going forward for LTC.

Have you thought about what you'll do if you can't get an APS? I'm sorry to say I'm getting a good idea of what you do if that kind of thing happens, because it would be difficult to underwrite without that sort of verification from the physician about what the situation is.

Let me repeat what someone in the audience just said. Life insurance companies

send someone out to do a history and physical, draw a blood sample, and even though they may request an APS, the rapidity with which the policy is issued seems to indicate that they probably never got that statement and issued the policy anyway.

Another interesting factor on that is that life insurance companies are not covered entities, so the PHI situation does not apply to life insurance. Think about what you're going to do about the APS and about whether there are going to be increasing difficulties with that. One thought is the idea of an independent examination that does not rely on the APS but relies more on the physical exam of the patient and a history taken from the patient rather than an APS. That might be one way to get around that. You're still dealing with PHI, you're still collecting PHI, but what you interrupted is that need to sort through the Privacy Act with a variety of individual physicians around obtaining information. You simply obtain the information in another route, and it now becomes your responsibility to protect it.

A second consideration is agent relationships. Can you now discuss individual clients with an agent? Remember that HIPAA applies to conversations as well as written and electronic records. What then do you do to obtain this kind of information? How many people here work with agents? We have only a couple of people working with agents, so it sounds like that's not a real issue for this group, but again, thinking about the discussions that you have can be important. Then if you farm out services such as claims adjustment, medical management, or underwriting kind of things, what business associate agreements do you have to have in place there? How many people are involved with farming out claims utilization management—do any medical management underwriting people have those kind of relationships? Yes, a few more hands here around this. That's the other issue I think that's going to hit LTC, unless you're a totally self-contained shop where you evaluate, issue all the policies, run all the claims yourself, do the medical management yourself and do the whole underwriting cycle yourself. If you farm out any piece of that, then you just have to think about what business associate agreements you have to have in place and make sure that you cover that. You have to set up routine ways to sign agreements and handle information so that you don't slip up. You need a routine way so that things are automatically handled and everything is secured.

Just note that life insurers are notable exceptions. Not all entities are covered entities. However, the group health part is, and if they offer group health and life together, now they're a covered entity for the health reason. But if they're only issuing life policies to some people, then that is not. Even though it's the same information, life insurers are not covered entities.

It's not that clear yet exactly how all this is going to work, especially since the privacy aspects are just a couple of months old as far as what people need to comply with. So people are feeling their way, and I will tell you people are being cautious about what they are doing right now. Freestanding life insurance-only

people consider themselves out of it, but if you do life insurance and LTC, or life insurance and major medical, then those people consider themselves covered.

One of the advantages of offering life insurance with health insurance, or with LTC, is that ability to share a sales force and share information. That means you have to protect that information. People wind up erring on the side of caution and protect it all so that they can use it all, just as people make default decisions about their cold storage. They call it all PHI so they don't have to ask about what's eventually going to happen with this, or if they need to handle it this way or that way. They just develop one system to handle it overall.

MR. TONGSON: I think we will see HIPAA's impact on the cost structure of LTC products in the near term. We have a few minutes now for questions, and we have a fairly diverse group of perspectives with regards to LTC, not only from the pricing impact, but also underwriting and as we've discussed, HIPAA.

FROM THE FLOOR: One of the provisions that you didn't address in HIPAA is—people have always had it—the ability of people to ask their physicians to keep certain information confidential. I don't remember the phrase that they used to call that, but it's highlighted in the new regulations that people can go to their physicians and tell them not to tell anybody anything about such-and-such treatment. The physician has to make a decision on whether or not to black that out of the records. Have either of you, Caroline or Alison, had experience with that yet? Did you have it prior to HIPAA? Do you think you're going to have more with HIPAA? Are you seeing medical records coming with big, blank pieces?

MS. JOHNSON: I can say a few words about that. The biggest issue around that is that the medical record isn't even all in one place, and many times the physicians themselves don't know about the other issues. We have a couple of big blank spots when we start trying to tie together medical information. This is terribly frightening to people who aren't clinicians and don't know that this is happening, but we cannot tie together behavioral health claims, medical claims and pharmacy claims. We just can't do it. We can't find the same person. When you go to see your doctor, he often does not know about your behavioral health history, and he also does not know about all the medications you're on unless he personally prescribed them and he kept track of what he prescribed for you. The issue is even worse than the physician's keeping something quiet. I think the place where that issue came up was around HIV and AIDS, where there was tremendous concern about that information not being revealed.

While it's been an issue in behavioral health, it hasn't been as large, because most people don't seek behavioral health services from their primary care physician, but they go outside their primary care physician, and then he has no knowledge of what's going on. So it's even more difficult than that, and then, of course, we can't tie the claims systems together either, because pharmacy exists in a different set of shops than your medical claims information, and because behavioral health is

such a frequent carve-out, it's processed in yet another claims shop. Tying it together and saying, "Yes, this is the same individual" is very difficult, so that doesn't get to the HIPAA protection kind of issues around it. It's more of the realities of even trying to sort the data. Now, from a HIPAA prospective, I would say I am not aware of how people are going to be dealing with physicians not revealing information.

MS. LESTER: I can add something to that. It's definitely a concern that we have, and fortunately it really hasn't happened yet. We haven't found that we are receiving a large number of medical records, or any medical records, where large areas are either blacked out or copied out of the section of the records. I can say maybe in the last year I've seen one record where it was an HIV part that was blacked out, and we just called the doctor's office and asked what was the nature of the information that was blacked out. They said it was information they couldn't disclose to us. You have to make the best decision you can with the information that you have.

MS. JOHNSON: An even graver consideration from that standpoint is that many people don't seek care because of fear of that situation, so people who suspect they may be HIV positive will not be tested. People with behavioral health problems will not seek treatment for fear of being punished by insurance companies later or that information being made public. They may have it and it's going untreated, and you have no way of finding out.

MR. TONGSON: I have a general question for Caroline, and maybe you covered this. You have worked with risk managers and insurers. In terms of the distribution of the business that comes in, how much would you say of the percentage is standard, substandard and preferred? Have you seen a shift in that over the last few years or so?

MS. LESTER: Our substandard business as a whole typically is a very small piece of the total business that's placed on the books. It's typically somewhere between 2 percent and 7 percent, probably closer to 5 percent or less. Our preferred is still a very small piece of the business; maybe about 10 percent or 15 percent of the business is getting a preferred. Everything else that's getting issued is typically a standard rate. Like I said in the presentation, we are finding more and more carriers that want to entertain a preferred rate in their offerings, and fewer carriers for us that want to send out there in substandard categories.

MR. DUPOURQUE: Right now about 80 percent of the business has some preferred discount, 15 percent have no discount and 5 percent have substandard loads. The trend is to fewer discounts.

FROM THE FLOOR: When you say "80 percent with discounts," are you talking just preferred discounts? This doesn't include the marital status?

MR. DUPOURQUE: No, that does not include the marital status, but there would be some discounts. If one of the persons with the joint policy has a risk class discount, then the policy would be included in the 80 percent.

MS. LESTER: That gets into what I was trying to explain in the presentation. It depends on what type of a discount you're talking about. Is it truly a preferred health discount? I would find it very unlikely that 80 percent of the business is getting a true preferred health discount. It's probably something more on the lines of a lifestyle discount. Maybe the person is a nonsmoker or the person's activities meet a certain category level. It would be pretty rare to see 80 percent of the business getting true preferred.