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Session 52 PD
Long-Term Care Lessons for Disability Insurers

Track: Health Disability Income, Long-Term Care

Moderator: Amy Pahl

Panelists: Guy Bertsch
Amy Pahl

Summary: Disability insurers are showing an increasing interest in benefits that tie closely to long-term care. Several insurers have developed disability products that offer additional disability benefits based on the loss of activities of daily living, while others offer options to convert disability policies into long-term care policies.

MS. AMY PAHL: This is long-term care lessons for disability insurers. And I think it's kind of a tables-turned topic, at least the title, because I don't know if the long-term care folks have a lot of lessons to teach the disability insurance (DI) folks yet. We still consider ourselves learning from DI, but what I think we're really trying to accomplish with this session is exposure to how the two interplay in some products that are currently in the market, and then I will address some of the risk elements and the basics, if you will, relative to long-term care and how it might be similar or dissimilar from DI. So that's a more accurate description of what we're going to try and accomplish. And if you go away thinking it's a new lesson learned, then that's great.

Guy Bertsch is going to start. He is a vice president of product development at UnumProvident. He has been in long-term care for 10 years, holding various positions in product management, market development and underwriting. He did ask me to emphasize that he's a non-actuary so keep that in mind, I guess. In his current role, he's responsible for product development of all the company's DI and LTC products.

MR. GUY BERTSCH: I'm asking you again to remember that I'm not an actuary. I want to spend a little time talking about the idea of long-term care and life products and provisions and how they may or may not begin to further infiltrate the traditional DI world. I've worked with some of you over the years; others are new faces. I think in the course of this time we should have a pretty good discussion of what is not happening in the industry, but also what I assume from my perspective. I will admit right now a lot of it scopes a little bit more heavily, and I'll shift specifically to some of the experience that UnumProvident and the new side of that merger company went through really in the early mid-'90s, too, with the disability and long-term care lines. So I'll admit that it is a little biased, but I think I'm going to share some of those experiences.

We're going to talk about the product side and then some of the risk elements and then shift to more of an interactive discussion. The thing that as the marketing guy I'm often asked to explain is: Why would you want to do anything on a combined product basis? It's simpler when it's just LTC or just DI or just life insurance or just critical illness. Yes, but that's boring, let's admit it. That's hard enough to do. They do it well. There are challenges, but from a marketing perspective they're involved with a bit of sizzle that you like to throw out in the market. You hope that it's business value at the same time, but some of the reasons that we're doing it as an industry are to obviously differentiate our products relative to the companies that we compete against; basic business strategy. So this is no different here. Over time, some of the things that we'll talk about today might have been viewed as differentiation plays three, four, 10years ago and now they're becoming a little bit more mainstream and eventually they'll be in the category of not anything more than must-haves. So I think that's an indication of how the market is developing.

The other thing I like to look at is if we're going to spend a lot of time, effort and money trying to acquire a customer, whether it's for a life policy or disability through their working years, I'd love to keep them around as long as they're alive. We obviously know that not everybody's insurance risks will stop when they stop working. Obviously, their income replacement needs drop, but elements like long-term care and life insurance continue. We like to look at it from a marketing perspective as trying to get that customer to be with you in your company even if various product forms go there for life versus the life span of the product they're buying. So as you think about the products we'll talk about and how they may evolve. The design should evolve with the needs of somebody during their lifetime so that we don't have to go out and resell a product at some future time, or have to find another customer when that primary customer is trimming their coverage at retirement.

From a customer perspective, we've done loads of research on this from the UnumProvident side, specifically with the LTC and the DI products and how they shift and work together. As you talk to a customer in a research environment, it's pretty clear that they, when they spend time on it, say, "Gee, it would be nice to have one product that does it all." Well, these same people don't necessarily have

one policy that covers auto and homeowners. They make those buying decisions separately. But there are opportunities to have certain products packaged together. Sometimes what you get through a research mechanism is a little more pie in the sky than actually building the product to go to market and the idea that somebody fully understands that their needs will change over their lifetime and that they should buy this fairly unique product.

In terms of sales, because it's a continuous education on the carrier's part to make sure that people understand that I'm selling a product today that looks a little different than the rest of the world is selling, but it's designed to shift with you and alleviate the risks that develop later in life and evolve over time. But I'll acknowledge that the experience we've had is one that looks good in the research environment or on the drawing board. When you play it out in real life for a broker or an enrollment meeting or a one-on-one sale, it takes a lot more to explain and, typically, there's a price tag attached to it. So while it's unique to have a product that evolves over time and may be a one-size-fits-all, yes, that's nice, but that's also going to serve you differently, and you may feel some short-term sales pressure because of that.

Obviously, we're not doing this to simply meet the needs of the customer. This is a revenue opportunity both for us on the carrier side as well as for anybody in the agent or broker world. They, too, want to have customer relationships for as long as they can and if they can have products that will evolve over time and they continue to generate commissions to them, that's a win for them and a win for us on the carrier side as premium continues to flow in. When you think about this, we all try to lay it against the backdrop of what it is that I do as a company in terms of direction, future growth and brand recognition. If you have a product that is differentiated and is meeting multiple needs, hopefully that resonates as a brand element and a brand attribute for your company around innovation and things that cascade more broadly in building your brand value.

The long-term issue is very, very real. You see that as the plan is formed because LTC sales are increasing. But if you look at statistics around who needs care, the aging of America, the greatest thing that comes from this is awareness among the buying public, the key driver behind long-term care sales. But it makes the discussion of products that have an LTC element in them more appropriate. Five or 10years ago, that awareness was not where it is today and 10 years down the road it will be much higher. So it seems statistics have really winged in our sales as an industry to promote the idea of long-term care type products whether they're stand-alone or embedded with disability products.

I'm going to get right into what we're talking about from a product perspective. There will be two categories that we'll get into, one of which is catastrophic coverage. It's an extension of basic disability. The second part is more in the conversion in the future purchase option environment. It's shifting that disability policy into a true LTC policy. Let me just spend a few minutes talking about the

catastrophic world within the disability arena. We're really looking at covering more severe disabilities. Those are the catastrophic. And when I'm talking about catastrophic, I'm talking about either a cognitive impairment or a loss of activities of daily living (ADL); very similar measures of disability that we use all the time in the long-term care world. So the definition of disability or the best of the triggers are exactly the same.

But we're also looking at a way to do this tied to a disability policy so that we're paying essentially a higher level of income replacement. Some of you would think, “Gee, why would you want to replace higher levels of income?” You have issue when it's on DI for a reason; you don't want to overinsure. While there's a difference between the overinsurance that you have, the definition is purely based on occupational loss, and with that you have probably the more severe catastrophic trigger, which you have with ADLs, the cognitive impairments. So in a lot of ways you see a blending here. This is the first step of personal DI and talk about occupational risk shifting to the LTC arena. So we're still looking at this as an overall disability topic. While it's similar to LTC, it is still replacing income. If I'm catastrophically disabled, I'm not getting $100 a day, I'm getting a higher percentage of my income replaced. Again, I’m still tied to that income replacement type of discussion.

I will point out that there are several that are typically not governed by LTC regulations. The LTC regulatory environment is challenging, and that's because of its complexity and how dynamic it is. It's a burden for the industry right now. I think it's done for the right reasons; for the protection of the customers. But to the degree that you can alleviate LTC type issues and still work in an environment that has more stable regulatory issues, which I think DI has much more so than long-term care, that's a good thing. So if you're a company that's thinking about getting into the LTC world, this is a nice step because it allows you to dabble in that risk element without having to formally build a long-term care operation and deal with some of the regulatory hurdles that we face when we're in the LTC business. We have seen this on both individual and group disability plans across the industry in terms of the catastrophic coverage. You might have a 60 percent base and then you might get up to 80 or 100 percent depending on whether you're ADL or cognitive impaired. Most of the coverage that I have seen sold in the industry has been on the individual side of the disability market. I think that happens for a couple of reasons. The biggest one, though, is when you're selling individual coverage, even if it's through an employer, you typically have more time for the conversation to take place between the agent, the enrollee and the buyer.

This is a pretty sophisticated discussion. It's not just check the box, do you want LTD this year or check the box and let me talk to you about why this product is may be more expensive, but it’s also about providing more coverage. So over time, I think we've always seen that product innovation typically starts out on the individual side and then maybe the group side of the world gets up to speed. Then they simplify things, but it's still a challenge to put certain concepts across in a

group enrollment. But today, right now, a lot of the catastrophic writers that we're seeing in the market really have most of their success on the individual side versus group.

We talked about income replacement ratios. That, again, can scare some people, especially on the underwriting side, but it becomes less of an issue when you start thinking about the fact that the incidence of the severe disabilities is going to be much, much less and it's hard to fake an injury, loss or a cognitive impairment.

You can see these as optional or embedded. I think for the most part these are optional, although most carriers that sell these with standard quote the catastrophic coverage when they issue a quote for disability. People have the right to remove that, but typically they don't. It's a small portion of the overall premium so carriers are saying, "Yes, it's optional, but let me at least propose it versus asking you what you want." You wouldn't want to say, "Here it is. Tell us that you don't want it." And for the most part, at least from UnumProvident's side, we've seen the vast majority of people elect to buy it because it's additional coverage and it's also a pretty good value when you think about the relatively small amount of additional premium.

Now we think of it as being in a typical DI world. It's an extension of what we cover; higher income replacement ratios, but it's still replacing income. But what happens as you get older and you really want true long-term care? Do you have a disability policy that allows you to buy long-term care at some point in the future? Let me go through a couple of different product types and give you an idea of some of the opportunities, advantages and disadvantages that we may face; one of which is the future purchase option.

UnumProvident actually developed the long-term care policy and thought, "Gee, well, it's not really selling so we have to find a way to entice people who are buying DI to go ahead and buy long-term care."

We came up with the idea of future purchase option. It is no different than buying an option to buy a stop. You're paying a premium with the right to buy a policy or a line of coverage at some point in the future. This is in addition to the disability coverage that you have. So while the rider, the option rider is in addition to the disability coverage, you can go ahead and exercise that rider and buy the long-term care and have both the long-term care and the DI at the same time. So it does not directly impact the DI coverage.

The other option that you have in this arena is one that says it's not the option to buy long-term care in addition to the DI, it's when the DI becomes less valuable to the insured in their late 50s, early 60s, when income replacement is not as great a need, is there a way to have that convert or be exchanged for long-term care? So there you actually require somebody to turn in their ID policy and it shifts the risk from the ID risk to long-term care.

With that said, I guess the challenging part is on either of these you, as a carrier, are required to have a long-term care product to give to somebody when they exercise the SDL or they exchange their ID policy. So this type of provision will automatically put you in the long-term care market officially. This brings with it the regulatory challenges as well as some of the administrative burdens that you have with long-term care. It's managed a little bit differently than DI. It's certainly not life insurance. It's not medical. And I think if you go to some of the other LTC sessions today you'll hear that one of the things that LTC carriers have struggled with has been finding the right systems to manage this business. It's a more challenging business. The capital requirements are much greater than we might have thought. The risk is a little different than what we had expected. So if you think about an ID product that may convert into LTC, you really have to ask yourself how much of a stomach you have to be in the LTC market. That's really where the rubber is going to hit the road.

When somebody moves their ID policy into long-term care, whether it's with a future purchase option or whether it converts, you're going to have a certain level of first-year expenses all over again because you are selling and installing and issuing a brand-new policy. There might be first-year commissions or policy issue expenses. You might save a little bit on the underwriting because a lot of these provisions allow you to get the LTC on a guarantee issue, a modified underwriting basis. But there are going to be some first-year expenses all over again. Even now they're still dealing with that same customer.

The idea is that a lot of these things come initially on the individual side and then shift to group. I have seen a little bit of the future purchase options done in the long-term disability (LTD) world, but you can imagine some of the administrative issues in trying to deal with an insured who has LTD who is retired at, say, age 65. The employer typically isn't too actively involved with helping that person make decisions about long-term care, so today it has had no significant success on the individual side, again, where you typically have a broker involved to manage that relationship.

If I sell an option to somebody, I need to know what I'm guaranteeing that you can buy. Am I guaranteeing that you can buy a very specific and defined long-term care plan, or is it something a little bit more flexible? Because if you're buying an FPO, let's say 40 or 45 with the intention of exercising it in the late 50s or early 60s, you may not know what you want to buy in terms of long-term care. So do I force you to say this is the LTC plan I would buy in 20 years, or do I say you have the option to buy certain units of long-term care? That's a choice, but obviously the more flexibility you provide in the form of the option rider, the harder it is to measure the risk that you'll have when somebody chooses to exercise that in the future.

The FPO that you sold at Unum in the early to mid '90s was one that if you bought it, I think it was a great deal. I wish I had bought it at the time. It allowed you to buy a certain number of units of benefit amount. So let's talk about it in terms of

maybe $10 a day of benefits. The FPO could allow you to have $100 of long-term care benefits at some point in the future, but it left wide open the opportunity for you to buy that $100 a day on a lifetime basis with or without cost of living adjustments (COLA). Do you have home care? Do you not? Obviously, when you exercise this option, you have to take the LTC premium that is the going rate in the market, but there's a big difference between $100 a day for a nursing home only policy with no COLA and one that has more comprehensive coverage, yet the FPO is designed to allow people to buy an amount and then decide in the future what the other plan provisions were, so it's very customer friendly. It's a little tougher for us to measure the risk, but as an interest strategy we needed to do something that was a little bit more innovative and flexible.

It's set up so they're exercised with certain ages. When they are exercised, this is typically done on a guaranteed-issue basis. You're giving people the right to buy today the guarantee that you can get LTC in the future regardless of their health condition. It does require, though, that the insured, the broker or the carrier take action. If not, when the ID policy expires and you haven't exercised the FPO, you miss out on your chance to buy the long-term care. So while you may sell it today when somebody's 40 or 45, in 20 or 30 years somebody has got to actually remember to try to facilitate the sale of the LTC.

Carriers may have motivation to do more or less about it depending on any selection risk. Brokers certainly would be motivated, but the broker may not be in the picture anymore. And the customer may or may not remember that they have this, or they may decide to shop around. So there's no guarantee that somebody is likely to exercise this. I know our finance folks spend a lot of time trying to model out how many and when people would exercise because that really is going to impact what the final risk is. You do collect a little premium in the short run for the FPO rider, but the real risk is how many people will exercise that and get the guaranteed issue of LTC in the future.

I think a simpler approach is one that deals with conversion. You know exactly that at some point in time you can simply turn in your ID policy and get long-term care. There are two approaches and one is designed around equivalent premium. If I was paying $1,000 dollars a year for my ID coverage, I could buy any long-term care policy provided that the LTC premium for that plan was equal to the $1,000 that I was paying for the ID. From a buyer's perspective, it's simple because whatever I was paying before, I know that's my cost going forward. What it may buy in the future in terms of LTC protection may be too much, not enough or just right in terms of LTC protection. But from a cost perspective to the buyer, it's much easier to plan for.

The other one deals with a standard plan where if I buy an ID policy today, that guarantees me the right to buy a certain plan that would be defined maybe as a three-year plan, $100 day, 90-day earned premium (EP) with confidence of coverage and certain COLA. Now I have to pay the rate that's equivalent to the age

that I am when I go ahead and convert. It might be in the early 60s, and we don't know what the rates will be, but at least I know what coverage I can get. The premium may be too much or something that I can't afford. But I think we're shifting more to the standard plan approach and I just want to know what I'm getting versus what I would actually be spending on that.

I think it's important to make the point that these are typically convertible. At defined ages we have this formula of FPO, but typically you're not receiving disability benefits. So if I'm unable to work, I can't suddenly say, “Oh, I want to convert to long-term care.” I don't know why you would because the protection may not be as great. But if you are in claim, you actually have to wait for the benefit carrier to expire on the disability. If it's at 65, you would wait till you're 65 and then exchange it for the LTC.

Whether it's the catastrophic extension of disability or the products that morph into long-term care, there are a lot of things you’ve got to consider. One of which I keyed up earlier is, are you in the LTC market anyway, and if you are, does this help you or does it cannibalize the LTC business that you're trying to pursue? I don't know that I have an answer for that, but it's something to be thinking about. If you run businesses as a single unit within your company, maybe you all play nicely, and that's okay. What's good for the company is good for the lives. If you operate on more similar models, the LTC folks may say, you know what? I don't want these disability policies to begin to infringe upon the LTC market that we're trying to stake out; something to think about.

There are more operational elements. When it comes to benefits management, if you have somebody that has disability with a catastrophic rider attached to it, if they're unable to work, they submit the claim. You all know how to do that. It's pretty easy to manage. What happens to that person outside the severe disability who has an ADL loss, a cognitive impairment? Do you have the same claims manager handle that part? Or if you have an LTC cooperation, do you throw that claim over and say, “Hey, I handled the occupational piece, but my LTC counterpart in benefits helped me with the ADL component.” It’s not a big deal, but it's an operational issue that will impact how you attack this and may actually impact how the customer interfaces with your company. Do they view it as one claim or two claims?

In some cases, the catastrophic riders only pay if you're also collecting the occupational part of the disability policy. Intuitively, if you are, that's not a big deal because if you're severely disabled, you probably can't work. Not always, but right now most of the catastrophic riders are set up to pay only if you are also unable to work. But there are situations where somebody could actually go back to work, but they may need help with their ADLs. With the constant impact of ADLs, more and more people are able to come to work and be very productive, but they need help bathing, dressing or getting to work. And if that's the case, maybe this catastrophic

rider should pay those people some benefit even when they're not collecting on the occupational benefit.

One of the challenges I face is how to explain our risks to sales reps and brokers that might have a very strong knowledge of the disability market. Yes, this puts money in their pockets, but it's a new concept, and any time you have that, that represents a challenge in terms of how to explain it. There are a host of other issues here, but I don't want us to go through them all. The fundamental question is, while it may seem like a no-brainer to jump into this type of product form that shifts into catastrophic and LTC coverage down the road, you've got to think through the long-term implications. What does it mean to your overall operation?

Chart 1 is something that we use a lot and I'll show how we stack these products. The bottom piece is what you typically see with a basic LTD policy. So if you were to layer on top of that some type of supplemental individual income protection of DI, you bring the people up to a higher level of income replacement. And the purple part at the top represents the catastrophic coverage. So you could have 100 percent income replacement. The box up at the right talks about this lifetime continuation asset protection rider. That's a whole lot of marketing mumbo-jumbo to me. That's the LTC conversion option that you can have. So while you've got very high levels of income replacement, at the same time, off to the side, you also have tried to get to long-term care at some point in the future. And when you show this to a customer, in some way you can begin to understand it's more coverage and it's more flexible down the road.

Well, I touched on some of the UnumProvident stuff, and let's see if I get some challenges from people in the audience that listened to this along with me. We developed the LTC product in 1991 and we, obviously, had a very large block of DI at that point. In the early '90s, I believe it was early '92, I said, "Well, let's add that FPO type product to our ID portfolio and see how that goes." That worked all right. We didn't sell a lot of it. That's okay. We eventually went to more of the conversion approach. So we don't sell the FPO anymore, but we sell products, and we started doing this in the mid '90s, that embedded in the disability is the right to convert to a long-term care plan. And right now we have a program that converts not to the equivalent premium model, but to defined LTC plan. We've done a lot of tracking in the market and we're not just seeing high levels of LTC sales, but where it's there it just helps. We think we've done fairly well with the image of the disability sales at the same time.

Right now, we've got about a 150,000 covered lives when you think about the FPO or conversion options. And with that said, we have very few people that have hit the ages where they can trigger this and convert it into LTC. Most of that is because they simply haven't aged enough to hit the trigger. We don't have a true sense right now of how many people will take advantage of the right to buy LTC in the future. Hopefully, it's enough to spread the risk, but hopefully it's not too many in a sense that it's more than what we priced for.

I mentioned before that you have to think about how this may or may not impact your long-term care business. We have a long-term care business at UnumProvident. That's group and individual. We've got over 600,000 insureds and are approaching half a billion dollars of premium. So we've grown that very, very nicely despite the fact that we offered LTC type products within our disability world.

So I would say that I think we have proven that you can live together and compliment one another without initially cannibalizing each other. But I think, depending on the company, that may work for the better or worse.

MS. PAHL: I failed to mention earlier that I'm with Milliman USA in Minneapolis and I've been working with long-term care for over seven years, so I've got a lot of experience working with stand-alone policies, to a lesser extent the riders and the combination products. I'm going to take a fairly basic approach to speaking about the LTC risk elements.

I'm going to touch on the design issues and the perspective will be primarily from the stand-alone basic, but they will also relate to the kinds of things that you would need to consider if you're doing a DI or a combination type product; underwriting characteristics, which is a differentiating component, than for DI and LTC; claim adjudication of care management; assets of overall long-term care; and the actuarial assumptions, which get into the meat of where the risk lies, what the challenges have been from an actuarial standpoint in the long-term care industry, and then lastly, I'll touch on the regulation, which Guy described, I think, accurately of being a very challenging environment.

You have different kinds of coverages in long-term care. Facility- only and home-care-only policies exist, although they are not as common as the comprehensive policy, which is one that offers coverage regardless of the site or the location of care or the kind of care, but by far it is one of the most common policies or benefits designed today.

The tax status is something that came out of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which clarified when LTC benefits were not taxable. It was silent on what happens to a policy that's just deemed not tax qualified, but if a policy is tax qualified, then the benefits are described as not taxable. So there's a grey area on what happens to the nontax qualified policies. The tax status is based on the benefit trigger and some other provisions that must be in a qualified policy. The vast majority of the policies issued today are qualified. However, there are still some nonqualified policies in the market. They are believed to be easier to access benefits and that's why they still exist. But you have the downside of the unknown, if you will, relative to the taxability of those benefits.

I mentioned the benefit trigger is part of what defines the tax-qualified policy as qualified. And the older policies and policies that are not tax qualified might have a medical assessment trigger, which just means a doctor says that you, for medical

reasons, require some kind of care that would qualify you for long-term care coverage. Those kinds of policies are not common today. The tax-qualified trigger is a two and six ADL impairment or cognitive impairment trigger. And so those ADLs, if I can remember them all, are bathing, dressing, transferring, incontinence, toileting and eating.

It says you have to fail two or six or be cognitively impaired. Now the other requirement with a qualified policy is that your physician or your doctor must be able to certify that you will need that care for 90 days, a 90-day elimination period, but they must say that you'll live for 90 days, which then makes it long-term as opposed to short-term. So if a doctor won't say that, then you would not qualify for coverage. So that's believed to be a somewhat tighter trigger. I think it's debatable amongst the LTC industry participants whether that's been effective or not, but that is the definition within the LTC policy trigger language.

The levels of assistance have varied over time. You might see words like standby assistance, supervisory assistance or substantial assistance. You might have severely impaired or substantially impaired. So there are different definitions in different contracts. I think they have become fairly common today, at least now on the tax-qualified language, which spells that out very specifically. But in older contracts, you will see various levels of levels of assistance in the descriptions.

The different policies can have different payment methods. And what I mean is that if you qualify for coverage and if you fail the ADLs of your cognitive impaired, under reimbursement policy you have to be incurring charges and you have to demonstrate what those charges are and you get reimbursed for those charges up to a daily maximum. Typically, that's the design. An indemnity policy is generally defined as one where you're receiving services so you have to demonstrate that you're getting services, but it does not consider the actual charges. It just pays the maximum daily benefit if you are receiving services.

Then what we have termed the disability model is if you qualify for coverage it doesn't matter if you're getting paid services. You can have an informal caregiver providing you the care you need and you could still receive a benefit. So it's a very liberal benefit relative to what's most common in the industry now, which is reimbursement policies. And reimbursement has been a trend recently because you can manage that claim then. You have some control over the cost on that claim.

Adjudication frequency is something that's been different in policies and changes recently. Here I'm referring to a maximum daily benefit. You will often see now either riders or embedded benefits where you convert your daily benefit to a weekly or a monthly benefit, which is a more generous benefit because if you're receiving intensive home care and it costs$500 in one day, your daily maximum would cap at $100 if you had $100 policy, but on a weekly adjudication it would pay the full $500. So those are things that are different. And I think relative to DI, everything is

adjudicated on a monthly basis so you would have, in the context of long-term care, your most liberal benefit on a monthly basis.

A couple of other things to be cognizant of in the LTC arena are the definitions of these different types of coverages. You have assisted living facilities, skilled nursing facilities and a whole array of things in between that may or may not be qualified as states of care for receiving services. You also have different definitions relative to the community-based services or non-facility services. Some policies cover some and others don't. Meals On Wheels is frequently not covered, but adult day care, hospice and various other community-based services could be.

There's a whole array of ancillary benefits that a lot of industry participants are offering, which include bed reservation. If you're in a facility and you need to go into the hospital for a short time, they reserve your bed. If you're receiving home care and the caregiver who is helping out needs a break, respite care will be coverage for that to provide care when that formal caregiver is taking a two-week vacation. Things like that are commonly included in policies, too.

The stand-alone policies are anything that's issued as long-term care. Regulations require them to have a 5 percent compounded inflation protection offer. So the consumer can certainly decline it, but it must be offered. Likewise, a nonforfeiture benefit period must be offered. So these are things that you must have available in your policy., Compounded inflation protection is quite frequently elected, whereas the shortened benefit period, which incidentally is just a shortened amount of coverage is based on the amount of premium you have paid. You just pay that concept from life insurance with some special conditions, but that's just the easy way of thinking about it.

So generally you're underwriting people who are in their 60s or 70s—more recently the average issue age is coming down to the 50s in this group of business, or lower than that. But the traditional underwriting of long-term care is a combination of medical and lifestyle underwriting. So there's consideration for health conditions and jobs. Generally, sources of information include an attending physician's statement, which obviously has the remarks from the doctors. Lifestyle underwriting considers the home environment and the applicant's social interaction—you know, somebody who is driving and going to senior citizen's monthly and playing cards, even if they're physically as healthy, they're more likely to stay off claims. So those are all considered in the underwriting process.

We mentioned ADLs and there are also instrumental activities of daily living, (IADLs), which are things like the ability to go shopping or manage medication, things that are more day-to-day. And those items are also considered in the underwriting process.

There's an attending physician's statement, which is pulled on different percentages of applicants depending upon the philosophy of the company. That certainly is a key

component to underwriting a lot of insured applicants. There's a telephone interview that at least confirms everything on the application and usually there's some kind of verbal cognitive screening—just things that would alert the underwriter that there's something not right with this person. And then in some cases where there seems to be either more impairment or some kind of red flag in your telephone interview, you might send out somebody to actually talk to this person. You would see them in their own environment. All of this is very costly. All of this very time consuming, but I think it's a pretty big difference from what you have on DI.

Claim adjudication—you're obviously doing a very different terminology for different sites of care. You know, this is a geriatric environment and generally you have to deal with the disabilities and capabilities of someone who is older, so it's just a different arena in the terminology and in understanding the different situations that your claimant would have. There's a licensure requirement. A big part of claim adjudication is making sure that that facility or that health care agency, or that day care is appropriately licensed.

The service delivery is intensive so the adjudication is ongoing and the services can be as simple as housekeeping or chore services, or as intensive as physical therapy and skilled care in the home. So you have a very wide array of service intensity.

To complicate things further with the reimbursement format, you have to collect the bills. Although I've never seen this, because I don't do a lot of review of claim files, I'm told that you might see handwritten invoices from a health care agency that indicate how many hours they spend and their hourly rate and that's all you get.

MS. PAHL: Care management exists in a wide range of intensity. They're really not keeping it all. They're not doing an independent assessment. They're not trying to steer toward a different side of care. These are things that are reasonable under the policy and this is actually our approach from a patient advocacy perspective. So it's not like they're trying to cheat the claimant from what they really need. It's just the opposite, in fact. They're trying to find them the best care possible.

For example, if you're in North Dakota and they can't find a home care agency to service a certain area, maybe by default you end up in a facility. Well, that care management person will help find community-based services that could keep them in the home, which, of course, is desirable from a claimant's perspective and is desirable from an insurance company's perspective for keeping the cost down.

So that's really what care management means in the LTC arena. So it's not official gatekeeping; it's more of a patient advocacy type of situation. It's still too early to see what kind of impact it really has, but there's a belief that it could have as much as a 10 percent cost savings on your claim costs. Obviously there's a cost for providing it, but there's also a morbidity cost versus the cost savings for them.

Morbidity is the primary actual assumption, and I'm going to address the big ones; morbidity, persistency, expenses and surplus, and there's mortality, which would be part of persistency. Regarding morbidity, the market has only been in existence in its current form for the last 20 years and, arguably, over that period, the policies have changed significantly. Even though some companies might have data that old, they may not be similar enough to what's been issued today to truly use that data. But it is improving, so we're still relying on population data to fill the gaps and trying to make assumptions about how behavior differences are taking place relative to insured behavior versus population behavior.

G.E. Capital has got the most LTC experience of anyone. They have about 20 years of experience. Considering that the average issue age now is about 62 and the average claimant age is well into the upper 70s or lower 80s, you're just now starting to get into the meat of your high claims activities in the company that's been around the longest in long-term care.

So what do you need to know? I think you're going to see a lot of similarities here with DI. You obviously have an incidence probability of going on claim. You obviously have continuous, which is your probability of staying on claim or your claim termination, which is the inverse of the probability of coming off of claim, however you want to state that. You have to consider the mix of services.

For example, I mentioned earlier that your design might only have nursing home coverage. It might only have home care coverage. It might have comprehensive. It could have certain ancillary benefits and not others.

And then there’s service intensity, which means you have home care, and if you have a maximum daily benefit you wouldn't assume you get a daily benefit every day because you're not likely to receive home care every day. The average is four or five days a week, so you have to consider how much coverage you're going to get if you do qualify for claim when you're on a reimbursement model. The product of these items is what becomes your claim cost, so it's your incidence times your amount paid while on claim, times your continuance.

You do have a number of adjustments and those would include your effective selection. There's a lot of debate about what that effect is, and there's a wide array of the level of underwriting everywhere from extremely tight(attending physician's statement on every single life, telephone interviews with very intensive cognitive screening), to one that's much looser (relying largely on the application, maybe a less rigorous telephone interview and more liberal decisions about certain co-morbidities or lifestyle decisions). The selection factors can vary from anything from when you're a first-year selection factor of 10 percent, then you save 90 percent on your selection in the first year when you're tight underwriting, or as little as20 percent reduction if you're underwriting loosely, and it varies by issue age as well. So if you're underwriting somebody who is 70, that selection effect is going to be different from somebody who's 60.

You have to make an adjustment for prior claims. Most claim costs out there are expressed in terms of $100 or $10, or whatever per day of dollar daily benefits, but it's also generally per life; not active life, but per total exposure. So you have to be cognizant of your claim cost definition so you apply it to the right exposure base.

Morbidity improvement—there's debate about whether or not that should be projected. Salvage is consideration for the fact that if you have a maximum daily benefit you may not pay it when they have services in a given day. For example, if you have $200 of coverage and on average the cost in that area is only $150, you have a $50 salvage. You're not going to spend the full $200 at one time. What generally happens is that $50 is left in the pool when it's reimbursement and it extends the benefit period, so you can be very conservative and ignore it, but in today's market you would also not be competitive.

There's risk classification everywhere from accept, reject to three or four different rate classes. Probably most commonly you'll see at least two classes and often times three, sort of like a standard. It looks like a standard preferred and a super preferred. The substandard concept really isn't popular in long-term care.

Regarding persistency, this is one where we have historically been bad estimators. LTC is a lapse-supported product, so lower lapses are bad and lapses have been very low. Products five or 10 years ago might have been priced at an ultimate lapse rate of 4 or 5 percent. Today companies are using 1 percent or less and there's still speculation on how low that will go. That has been a real problem for companies in their performance because people are sticking around. They're there to claim later and experience has been adverse because of it.

They said that mortality is also a big factor. The valuation requirements have specified the 1982 group annuity mortality (GAM) tables as the valuation in the mortality tables until very recently when they changed it to the 1994 GAM table. For purposes of projecting the mortality risk, companies are using very different things, but in general they're moving to longer expected lifetimes within the mortality tables. So then you want to have lower mortality. Assume they're going to stick around and go on claim. It's more conservative and consistent with what we're seeing.

There is an inter-company study that does provide some persistency experience. It also provides some morbidity experience, but like any inter-company study, it has limitations relative to homogeneity and enough detail to really know if it's acting like your own experience. But it's a starting point and you can get some idea of what's happening in the industry.

The last comment here is as the issue ages get younger, more and more inflation protection is being offered and, therefore, consumers are making a bigger investment in their long-term care benefits, which translates into a lower likelihood of loss. So this actually compounds the issue of the persistency risk.

The expense structure is expressed in different ways and commissions and marketing expenses would traditionally be expressed as a percentage of premium, an other item of issue is the per policy. I'm doing an issue that can give you some idea what some of these rates might be. Let me actually back up to commissions. You might see a 75 percent average first-year commission, which would maybe differ by issue age and then a renewal that's perhaps 10, 12, 15 percent. So the commissions are pretty heavy in the first year, not surprisingly. Underwriting an issue will vary by the level and intensity of the underwriting and it will also vary by the issue age because you're going to be doing more intensive underwriting for the older insureds. So you might have an average of $200,000-300,000.

Policy administration—I've seen percentages of premiums as high as10 percent, 15 percent ongoing, per-policy expenses. the maintenance is $40 or $60 a year. It just depends on how the structure is assembled, but you can see a pretty wide array there.

Claims of care management is frequently expressed in terms of incurred claims or paid claims, and I've seen as much as 8 or 9 percent on the high end. Premium taxes are overhead as per compliance; those are going to vary by the company structure and what your internal costs are, but are not to be ignored.

Target surplus is a big ongoing question and issue for LTC carriers. There's been a lot of discussion recently at the Academy level for the NAIC making changes to the current risk-based capital (RBC) formula. You'll commonly see companies holding 200-250 percent of the RBC level with the covariance adjustment. The most relevant risk here is the C-2 risk, which currently is based on a percentage of premium and reserve. It has some problems, though, and you can see here there's a threshold of $50 million of in-force premium and then you get a break on your lower percentage of premium C-2 risk after that.

But there are a number of issues with that—one being that you have limited pay contracts, for which this structure doesn't make sense. There are also varying opinions about whether this is too much or not enough. There was a proposal made to the NAIC last fall at an Academy work group to change it to what I have here as a $75 million threshold with different earned premium percentages. That was actually thrown out. The regulators did not like this proposal. I do know that the work group is going back to the NAIC in June with a second proposal, which is going to be based on a percentage of incurred claims. They're going to throw out the whole earned premium concept altogether, which will be a pretty significant change. There will be the same 5 percent of claim reserves, but now it will be a two-tier incurred claim-based C-2 risk. I don't know the percentage off the top of my head. I also don't even know what the NAIC reaction will be, but the inside word from the work group is that proposal will be made the second time around. In any event, the new proposal, which will be announced next month, is anticipated to reduce the capital requirements. So one might expect the NAIC to have a pushback on that.

The regulatory environment has changed quite a bit. What is long-term care and what is part of HIPAA has been clarified. But subsequent to that there was an actual revision to the model regulation, which was adopted by the NAIC in 2000 or written by them in 2000. It's been adopted slowly by the state since then. But basically, the essence of it is prior to that model. LTC, like DI, was governed by a loss ratio requirement. So if you met the loss ratio requirement, everything else was fine.

The problem, though, is that artificially keeps the premium low, which you would think is what the states want to do, but they found that there was too much rate increase activity in their view. So it was a rate stability effort, which led to the 2000 model regulation, which eliminated the loss ratio requirement. This was a pretty big change for the LTC actuaries. The idea is that market forces will control the premium level along with additional requirements for certification by the LTC pricing actuary. Those certifications are rather specific regarding the fact that the premiums being priced are designed or are going to be sufficient over the lifetime of the business, and there are some very specific words being stated in the certification.

It must be under moderately adverse conditions, which aren't well defined, but it's something that there's been a lot of discussion about. As the actuary, you don't have a loss ratio requirement to look at. You have to be very clear and comfortable with the fact that you're setting assumptions that are intended to be appropriate for the life of the business, i.e., you won't need a rate increase, but you're certified. Then there's another gross premium test in here regarding expenses, which is a way for the regulators to get into a little bit more of what your assumptions are.

The certification itself is nothing like it used to be. It's as short as one or two pages. You say what you need to say and you certify it. You write a memo, a company memo that has to stay on file, that the regulators may or may not ask for, which resembles a lot of the actuarial memorandums of the past. The certifications under the 2000 model regulations are actually pretty straightforward and easy to prepare, but the underlying tone is very assertive.

So that's the regulatory environment for the actuary. There is also a lot of regulation, obviously, for forms and disclosures and marketing materials and those kinds of things. That concludes my formal remarks on the LTC components and the basics of the risk element.

FROM THE FLOOR: There was, I think, for me a very good segue of the issues, the pricing issues for long-term care since I don't really do that much of that. My question is, what kinds of actuarial assumptions do you need to look at related to long-term care when you're developing combo products, say, a DI product and you're looking at options like that? Can you address some of those things?

MS. PAHL: I can try. Guy, I know as a non-actuary you can't answer the actuarial part of it, but you can respond with some of the dynamics of the combination of products.

My general approach is to think about it first as a stand-alone policy. You go through the same mechanics, the same assumption setting that you would if you were pricing a stand-alone policy. Then you back up and layer on the fact that you're probably not doing underwriting. You're not going to be having the same kind of risk profile because you're going to know something about this insured on the DI side. So the exercise isn't that different other than to consider differences in the benefit or differences in the experience.

One place in which it is a little bit different is the stand-alone. It's complicated, but it's pretty straightforward on how you calculate the claim cost because it's generally a daily benefit. You consider those things that I referred to, and then you have to translate all that into the monthly benefit situation, which is generally the way the DI conversion policies work. So you're not concerned about salvage. You're usually going to pay a monthly benefit without any consideration for services costing less than the maximum monthly benefit. So some of the things that we're really meticulous about on the stand-alone policy we need to think differently about because of the structure, and the structure is usually, from a benefit perspective, more like a DI policy, which is not what you usually see on a stand-alone policy.

MR. BERTSCH: That's a great question. I think if you look at the combination of products you can really separate them into two categories, and I talked about those that have an LTC component. But you know what? It's still pretty much DI. It's an additional benefit. I want to minimize the complexity of pricing that, but that's probably simpler. It's when you get into the conversion options and the FPOs that you're really trying to assess the risk of buying long-term care and, obviously, you got the selection component of when you're exercising it, say, at age 60 or 65.

I think that because we haven't had a lot of experience with how many people will actually take advantage of those options to convert, even though a lot of people have those opportunities coming to them in future years, I think the carriers have an opportunity to assume the worst in terms of who will buy and then maybe get a little salvage in the sense that if we do a nice job of marketing them, we'd maybe spread the anti-selection risk.

But I think for any of those people who elect coverage, my nonactuarial opinion would be that those people are probably going to have even lower lapses than people that are buying LTC at different times because these people show a habit of having DI coverage in force for 20 or 30 years, so they're definitely insurance savvy. They're taking the extra step of having bought this conversion option and then they go ahead and exercise it. So if you take that 1 percent ultimate lapse rate that you have for the same amount of LTC buyers, you might squash that down even more, and it's kind a “sky is falling” type of perspective not based on any real

actuarial science. But it seems like you'd have people that are even less likely to give up the policy because of what they would have had to have gone through at that point to go ahead and exercise it.

MS. PAHL: One parallel I can draw is that a lot of long-term care stand-alone policies have a guaranteed purchase option built into them, which operates fairly consistently with what the future purchase option is where you buy the ability to buy more insurance five, 10, 15, 20 years into the future. You're going to pay at a then-attained age rate, so you're just really buying the option to do that without evidence of insurability. Generally, what we see in the market for long-term care for that guaranteed purchase option is a 2-5 percent additional premium. So that might be at least a kind of benchmark or a way to at least think about what that extra cost is, and that's attributed entirely in anti-selection. Potentially, there is a little bit of expense for actually having to issue that additional coverage, but the vast majority is anti-selective.

MR. RICHARD LEAVITT: Do people buy paid flat premiums that are fixed for long-term care?

MS. PAHL: Yes, they're level for life. They're guaranteed renewable so they can be increased with regulatory approval, but going in, it's a level premium based on issue age, so the premium scale looks a lot like your morbidity curve. It's quickly increasing with age. Obviously, there are other dynamics going on, but it's designed to be an issue age-based, unisex-level premium.

MR. LEAVITT: Then it's very confusing to me why you possibly could sell the RBC formula that depends upon incurred claims since you could sell a policy to someone who's 50 and have no capital requirement for the next 25 years or something like that.

MS. PAHL: Yes, that's interesting. I'm interested to see the proposal. I've only talked to the chair of that work group. He happens to be a Milliman person, so I picked his brain about that a little bit before this presentation. I don't know a lot of the details, but that is the essence of the proposal, so there's going to be, I'm sure, some pushback and questions on that subject.

MR. LEAVITT: Right. There must be an active life reserve, no?

MS. PAHL: No, not in C-2. You've got your C-1 asset risk. Is that reserve- based or asset-based?

MR. LEAVITT: Finally, this is speaking from the difficulty my parents have had on long-term care. Do any companies offer a product where there's a dollar amount that the claimant will pay out before the long-term care kicks in? It's kind of like a deductible for medical.

MS. PAHL: The dollar deductible?

MR. LEAVITT: Yes, where they figure they can pay a certain amount of their assets up to a point and then if they suffer a condition, which then drains that and they go beyond that, then they may recover it. It seems to me that would be a good product that people would like.

MS. PAHL: I'll let Guy respond as well, but what I would say is in existence relative to that now is the thing that's closest to high elimination periods, which a lot of states don't like, but there can be as many as 365 days. I think that's the maximum elimination period that the states will generally allow.

MR. LEAVITT: Yes.

MS. PAHL: So that's the closest thing to which I think you're describing.

MR. BERTSCH: I think you have to see a dollar deductible presented in the market and over the years we've had filings go out even with two-year earned premiums (EPs), not that we've got anybody who would buy it on a regular basis, but for some people that want to truly self-insure for the short-term, we could do it. But as Amy points out, the regulatory bodies are the same now, and I think that's because the regulatory bodies are focusing on the majority of their populations with an eye toward consumer protection for those that don't know enough to protect themselves. I think as you get into this business you realize that some of the protections in place are burdensome and they almost scare away, I would say, the more sophisticated buyers that would be very comfortable taking on a higher deductible or other type of policy provisions that are maybe more innovative, but unfortunately, the carriers are not allowed to offer because we end up operating at the lowest common denominator.

MR. LEAVITT: That's what I'm saying. I know a lot of people underbuy knowing that they could swing half of it.

MR. BERTSCH: Exactly, and I think even when you get either into a disability-based approach or the indemnity you can do it as well because you're getting the payment on a per-day or per-month basis, which may be in excess of your expenses incurred, and you can sock that away if you wanted to.

MR. LEAVITT: You mentioned early on about the premiums, and I think just as a point of reference, as we go down the market in terms of ages that we're selling to, especially as you get more and more into workplace sales, the preference of accelerated payment options whether it's a one pay or a 10 pay, or even payment schemes that are tied to your birthday or the to 65s, it's a great option when you retire. Those are becoming much more prevalent.

FROM THE FLOOR: I have two questions. One, someone mentioned the conversion option on a DI policy might be worth 2-5 percent of premium. I just wondered if you had any qualitative guidance on how you would reserve any of that amount, and if you did release the ones with the policy converted.

The second question had to do with both catastrophic and long-term care conversion or purchase options in a group setting or whether it's multilife individual disability income (IDI) or actual group insurance. I would think the underwriting issue has become more considerable at older ages as well as with age discrimination under IDI and if there were any special considerations you gave in group settings to handle the older employees.

MS. PAHL: Let me clarify your first question. The 2-5 percent was the load for a guarantee purchase option that somebody would have on an LTC policy. So you've got somebody who owns a stand-alone LTC policy and has the option to buy more. There are some dynamics there that do differ from a DI conversion policy, so I offer that as a way of parallel or another way of thinking about it in terms of something that might be a reasonableness check.

FROM THE FLOOR: Well, whether it's that or the load on a DI policy, do you have any qualitative guidance on how you would reserve, given the option?

MS. PAHL: I think what the industry is doing is not holding an additional reserve for that. That is because it's a guaranteed option, but until they elect it there's no real measurable risk. I think a company could be a little more conservative and not do or hold something by grossing up their morbidity or making some assumptions in that election rate and indirectly load up their morbidity to account for that. I can't say what companies are actually doing with certainty. I don't have a lot of experience in that, but I think it would be an area in which you have to be a little creative because it's not a real known quantity.

MR. BERTSCH: I can't explain exactly how we're mechanically reserving for that risk at UnumProvident, but we do hold that as an additional reserve for that risk. I think it's evolved a little bit over time as we've shifted from an FPO type of model to the conversion type of model where if somebody converts we know we're losing the ID risk and we're picking up the LTC risk, but there is an incremental reserve held and there's been some back and forth on whether you can set that up as an additional ID reserve. Is it some type of LTC reserve? I'm sure there are people in the room that I work with here that can speak to it more intelligently, but I guess the bottom line is that we are setting something additional on the side.

As far as the catastrophic and the LTC conversion mechanisms within employer settings, whether it's group LTD or IIP, yes, we have run into some age discrimination issues and it requires us to either recalibrate what the benefit maxis are on the underwriting disability, which is where the catastrophic benefit would be paid, as well as reset the exercised ages that somebody can trigger in terms of

converting into LTC. Certain states have looked at it differently. In fact, some states have actually said your ADL or catastrophic component of a disability plan is not disability and, therefore, you cannot have it. They said you can have the occupational benefit and you can have the conversion benefit, but that catastrophic benefit for income replacement during the working years we're not really sure what that is, therefore, you can't sell it in our state. So a lot of states have looked at that overall concept of these combined products very, very differently.

FROM THE FLOOR: Are you paying first commissions on the long-term care conversion?

MR. BERTSCH: We pay first-year LTC commissions when somebody exercises either the FPO or they convert into the long-term care to the conversion option.

FROM THE FLOOR: Do you offer conversion credits or discounts on the long-term care policy to entice conversion?

MR. BERTSCH: We do to some degree because we've done a couple of different models over time. I'll give you an example that would be the FPO option that we had. We actually had a series of discounts that were tied to the number of years that you had the disability and were paying FPO premiums. Don't quote me on this, but it might have been something to the effect of if you were paying for those combined provisions for 10 years, you would qualify for the then-available preferred discount on the LTC policy that somebody would get if they were super healthy. You might not be super healthy, but you were essentially given that because of your 10 years of paying the FPO premium. Yes, it is permanent. All the discounts on the LTC are permanent whether it is a health discount, spousal discount, things like that.

MR. DANIEL SKWIRE: One aspect of long-term care offerings I always found confusing alludes to the benefit triggers and the parameters for assistance whether it's standby assistance or substantial assistance and so on, as you were talking about. Could you give us a little more detail on that and some insight on what's more conservative? What's more liberal? What seems more appropriate in the contest of, say, a catastrophic benefit on a DI offering where the tax qualification doesn't matter?

MS. PAHL: Right.

FROM THE FLOOR: What are the risk implications?

MS. PAHL: Terminology aside, the actual words used to describe it are less relevant, obviously, than what it actually means. So standby assistance means you might have to have somebody in the room that would need to be there to catch someone, for example, if they're not sturdy on their feet, which is very different than substantial assistance, which would be somebody who actually needs physical help transferring, for example. So to the extent that you can really nail down what

that trigger is, in other words, is it supervisory or standby, which I think are pretty similar? Or is it substantial? Think about what that means to the claim. If it's somebody who just needs to have somebody else in the room to help them, that's obviously a much easier trigger to meet than somebody who needs some significant help in doing whatever that ADL deficiency is. So you really need to drill down and look at the definitions on what you expect that person to need for assistance.

I would say, though, that the trend, and just from the standpoint of keeping your morbidity risk down, would be to keep the terminology tighter. In other words, standby or supervisory is less frequently seen. You're seeing the more high level of care or assistance needed in your triggers. And that's in large part because of the movement to tax qualified, which is now pretty standard language. But that's also the movement I think we would see without tax qualified because it's tightening up the requirement for receiving care.

MR. BERTSCH: I know there were people on disability and the advantage to that is you get away from the tax qualification guidelines. The other thing I would offer up is if you're thinking how you'd approach it on the disability side, are you, as a carrier, or if you're consulting with one of your clients, are they in the LTC business or are they thinking about it? They may want to make sure that they're more in lock step with what they're using on LTC, which would be substantial from a marketplace initiative perspective.

The worst thing that could happen is that somebody actually has a long-term care policy and a disability policy with catastrophic coverage and you're looking at the ADL component a little bit differently. The frequency of that would be very, very rare, but I think consistency for the market is probably worth looking at as well, even if that means being a little bit more liberal on the disability side in order to align with LTC.

MR. ROBERT HARDIN: It's at least my understanding that the long-term care costs or the costs of care are very geographic and, thus, probably the average amounts that you sell on a per-person basis are very geographic at least. I wonder if the group conversion vehicle or any of those kinds of vehicles vary geographically also. How do you respond to the geographic differences?

MR. BERTSCH: You sound like some of our favorite brokers that are always asking for a little bit extra on the conversion amount. Right now, I'm looking specifically at UnumProvident disability policies that I described. If you bought a disability policy, you'd get a certain level of conversion benefit. Let's say it's $3,000 a month, and that's embedded in the plan. We're selling most of our disability policies in a multilife and on a guaranteed issue basis. We give people the option to buy additional amounts on that conversion option through underwriting, so we allow people to, hopefully, accommodate their regional differences and costs knowing that it will never be exact because where you're living when you buy the DI policy may not be where you're living in the future.

The thing we really try to focus on is when you're buying the DI policy with the conversion option, the LTC policy you get will have inflation attached to it. What we're looking at as an industry is the inflation on the LTC component only kicks in once you've exercised it, which may be 20 years down the road. So there's some thought that if I'm buying a conversion, to make sure that the amount that I can convert to inflates prior to my conversion time frame. That doesn't completely address the regional differences, but it deals with the overall escalation of costs issue.

I do know that within our company we may have issue and participation limits that are geographically different—not necessarily at the state level, but in some of the major metropolitan areas. So it's never perfect, but I think it's something that companies are trying to address without just giving away the farm.

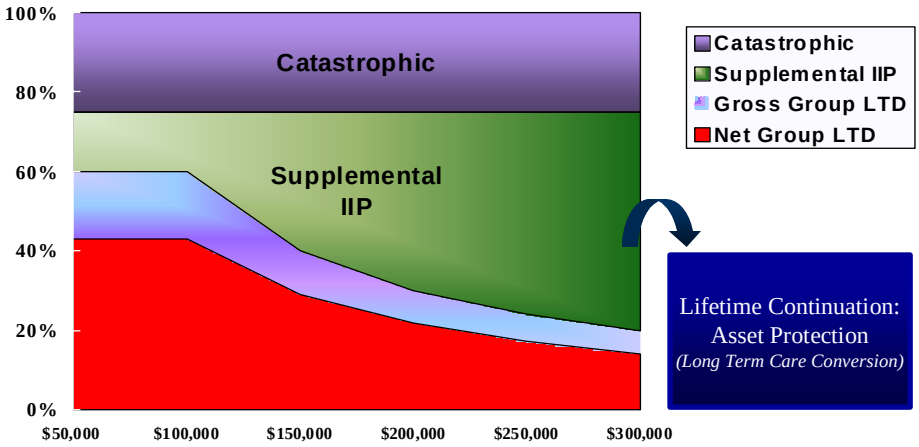
MR. ROBERT A. MOSER: The post-2000 regulations state that an actuary will certify that the rates are accurate and there are moderately adverse conditions. My question is what happens if that is not deemed to be the case? Is the actuary going to be subject to a class-action lawsuit?

MS. PAHL: No. Incidentally, the certification is an individual risk that you're taking. But with that said, that's not generally what the implication or the repercussions are. Just because you're certifying that doesn't mean you can't rate or get a rate increase. So five or 10 years down the line if experience is adverse, you can still request and file for a rate increase from the regulators. The process is very different. You don't demonstrate compliance with your original 60 percent loss ratio and demonstrate the amount of premium you need to get back to it. But rather you have to demonstrate that your experience has been worse than what you define as moderately adverse experience. So you have to pull out that document that you did for the company's file that documented what your assumptions for moderately adverse were or what your tests were, and how you substantiated your certification that you thought premiums would be level.

The fact is this is still considered an experimental product and even though we're moving in the direction of rate stability, there's still a recognition that is guaranteed renewable. We are still going to be wrong, but they're just trying to make sure that the likelihood of our being wrong is reduced, so you wouldn't be faced with a class action lawsuit simply because a rate increase is going to be made in the future, although they've just stacked the deck against you as far as being able to obtain those increases. Certainly there are reasons why you could be subject to a class action lawsuit, but I don't believe that's really a problem here.

Chart 1

Combined Product Solution



Assumptions: Non Contrib 60% to 5K Group LTD, Net = 28% Tax implications

IIP: 75% of Total Comp - GLTD, Cat = 25%

10