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Long-Term-Care Insurance Industry Snapshot

Track: Long-Term Care

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Summary: Panelists provide an overview of the current status of the long-term-care (LTC) insurance industry. They cover recent hot topics such as carrier entries and exits, new product trends and distribution/demographic trends.

MR. VINCENT L. BODNAR: I'm currently with Wakely Actuarial Services. I just recently joined the firm from Milliman. I've been involved with LTC for 15 years. This is the second of two back-to-back sessions aimed toward beginners in LTC. The first session was geared toward the basics of the product: how it works, what's involved with administering it and selling it. The second session is meant to give you an idea of what the industry currently looks like, how big the market is and some of the trends that we're seeing. Again, it's meant for people who are considering getting into the market, an actuary looking to change into an LTC line at his or her current company or those just curious about the product.

I'll start off by providing an overview of the current market, its size and some recent growth trends. I'll also get into some hot actuarial topics, and from there I'll turn it over to two non-actuaries. We have with us Lynn Hartung, who is executive

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vice president and chief operating officer of the LTC division of AEGON. She will get into some of the recent trends in administering LTC. After that I'll turn it over to Ron Hagelman, who is an expert in LTC distribution and sales. He is president of Hagelman-Barrie Sales Training Solutions.

We'll talk first about market share and size. Currently the LTC industry has about $7 billion of premium in force. This is just the individual products, by the way. There's another $1.2 billion of group LTC in force, but I will focus strictly on individual. If you want the group statistics, let me know. My statistics all come from the Life Insurance Marketing and Research Association's (LIMRA's) recent survey of the industry. The growth in in-force premium has slowed in the last five years. It was about 19 percent in the year 2000, but if you look at just the last two years, it has trickled down to single-digit growth, just about 7 percent or so. For policies in force, it's the same pattern. There are just over 4 million policies in force (there are another 2 million lives insured on the group side). Growth has slowed from about 16 percent five years ago to about 4 percent now.

New sales are driving this slowdown in in-force growth. New sales have definitely been trending downward. With the exception of 2002, new premium issued has steadily decreased since 2000. We have flirted with about $1 billion of production a year. The blip in 2002 can be attributed to the federal program where the federal government encouraged its employees to buy a sponsored LTC product. Now we're down to about $600 million of production, which, again, is a bit down from where we were a couple years ago. For policies issued, you see the same pattern of an obvious steady decline in new production.

This is all occurring in the face of steady growth in the target market, which is defined as a subset of people age 55 to 69. It has slowly increased since 1999. It has been tracking at approximately 2 to 4 percent increase a year. In contrast, sales growth has averaged –11 percent since 2000. I don't have any history prior to 2000 in my presentation, but prior to 2000, this industry was looking at 20 percent growth. It was easily double digits throughout the 1990s.

A closer look at the target market helps explain part of what's going on. Slowly but surely since 2000, Baby Boomers have been making up a larger and larger proportion of the target market. In 2000, there were no Baby Boomers in this age group. In 2005, a little less than 50 percent of the target market is Baby Boomers. We know that Baby Boomers have different buying patterns. They are different consumers than their parents, and we think that this may be a key reason for the decline in sales, in addition to some other industry factors, which we'll get into later.

The companies selling the product have changed a bit since 2000. Chart 1 is a snapshot of the top 20 writing companies in 2001. This comes from the LTC survey done annually by *Broker World Magazine*. There's only one carrier with over $100 million of production, and that's GE Financial. They're now known as Genworth. You

can see that the premium volume quickly drops off after the seventh carrier.

Chart 1

Top 20 Producers in 2001

Rank	Company	Production ($millions)
1	GE Financial	242.6
2	Bankers L&C	83.3
3	John Hancock	73.5
4	C N A	60.6
5	UnumProvident	54.7
6	Penn Treaty	47.2
7	Allianz	41.7
8	IDS Life	28.4
9	Life Investors	26.2
10	Fortis LTC	26.2
11	Lincoln Benefit	24.6
12	AF&L	22.5
13	State Farm	21.2
14	Mutual of Omaha	19.2
15	AARP	17.9
16	Prudential	17.9
17	MetLife	17.6
18	Conseco	16.0
19	Transamerica Occidental	15.5
20	New York Life	14.3

Contrast that with 2003, as shown in Chart 2. We now have a couple of carriers that are above $100 million. Genworth has shown some decrease, and Hancock has really blown up. LTC Partners is the federal program. Quite a few carriers are missing from this group in 2003. Six carriers have left the market: CNA, Penn Treaty (has not left, but they're not in the top 20 anymore), Fortis Long Term Care, Conseco (sales have dwindled), Transamerica, Occidental and IDS Life. A lot of them came off intentionally. There were capital issues and growing concern over the riskiness of the product. This is very much a capital-hog product; it takes a lot of money to stay in this line. Couple that with the riskiness of the product, and it's enough to scare a lot of carriers.

However, on the flip side, we have six carriers that are new to the list: the federal program, MassMutual, State Life, Northwestern Mutual, Monumental and Med America. We have a big increase in production again from Hancock, Lincoln Benefit, MetLife and AARP. The decreasers are Bankers, UnumProvident, Life Investors and Allianz.

Chart 2

Top 20 Producers in 2003

Rank	Company	Production ($millions)
1	Genworth	230.4
2	John Hancock	197.7
3	LTC Partners	181.6
4	Bankers L&C	63.2
5	Lincoln Benefit	40.7
6	MetLife	40.6
7	UnumProvident	40.4
8	AARP	30.8
9	AF&L	30.0
10	Prudential	27.1
11	State Farm	23.4
12	MassMutual	19.9
13	Mutual of Omaha	19.6
14	New York Life	18.7
15	State Life	18.4
16	Northwestern Mutual	17.0
17	Monumental	15.4
18	Med America	14.7
19	Life Investors	12.0
20	Allianz	11.8

Let's talk about pricing and financial issues. Now that we've seen what the market looks like and how it's trending, one of the things that struck me in reviewing recent trends is that average premiums in force have increased considerably in the last five years. They were about $1,400 per policy in 1999. They're up over $1,600 per policy today. This has occurred at the same time that the average issue age has dropped. For anybody not familiar with LTC, the younger you are, the cheaper the product. The average issue age has dropped probably five to 10 years over this period of time, so there are other forces at work here. Some of this is due to rate increases on the in-force blocks of business, but most of this is due to new business premium rates increasing dramatically in this time period. There were some modest increases in new business premiums from 2000 to 2002, generally 1 to 3 percent. However, in the last two years, we've seen some considerably larger increases in average new business premium, more in the 5 percent range. Some of this is due to premium rate stabilization regulation, which I'll get into a little later.

There has been a lot of pressure on pricing actuaries to increase premium rates. Interest rates have fallen considerably during the same time period, and you know that interest rates are a key assumption in pricing. Companies have also recognized very low lapse rates, often in the 1 percent range ultimately. There's less competition, and when that happens, there's less pressure to keep rates down. There's also, I think, some subsidization of the existing business; instead of taking rate increases on older, poorly performing blocks, some companies are intentionally pricing a little higher on their new rates. Rate stabilization, which is a new regulation becoming more widely adopted, is another factor driving up new business premium rates.

At the same time, there are some good things happening that try to keep premium rates down. Companies are getting much better at underwriting and claims management. From the actuarial side, I think that there are clear trends emerging. The risk-based capital (RBC) formula changed, effective this year, to relieve a lot of the early strain. It's a little too soon to see that effect, but it is in place starting this year. However, these two aren't enough to offset the effect of increasing premium rates or these other upward pressures.

Rate stabilization is probably the most significant thing that has happened in the last couple of years. The purpose here was to protect policyholders from unexpected rate increases. This guaranteed-issue product wasn't sold as a noncancellable (noncan) product. However, no one likes to get rate increases because experience has deteriorated. That's what has happened, and that's what companies are doing. As a result of some pricing assumption misses and these other external factors such as interest rates, we've gotten some pervasive rate increases on this product line. These rate increases have come from the whole spectrum of carriers, from large, well-established carriers to the smaller-to-mid-size carriers that were aggressively pricing this product 10 and 15 years ago.

This is how rate stabilization works. It removes a loss ratio requirement. Previously, actuaries had to certify that benefits were expected to be typically 60 percent of premiums on a lifetime present value basis. That has now been removed. Actuaries now have to certify that the premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the rate schedule is reasonably expected to be sustainable over the life of the form with no premium increases anticipated. That's a pretty tall order; it's just shy of noncan. Obviously, actuaries are now putting some margins in their rates. The actuary also certifies that he or she has reviewed claims and underwriting processes and taken them into consideration in developing premium rates. The meaning of "moderately adverse" is left purposely vague. However, the actuary should keep good notes and state what is meant by "moderately adverse" in putting his or her opinion together.

A company gets penalized heavily if it does need rate increases under a rate-stabilized product. The minimum loss ratio standard is 58 percent of the initial premium plus 85 percent of the rate increase premium. The rate increase premium is meant, hopefully, to just cover administrative expenses. There's some relief for "exceptional" rate increases, and that would be some major demographic shift or collapse in bond rates or something along those lines. Hopefully we don't see anything like that, but the penalties are less severe in that case.

As I mentioned, RBC requirements have gotten a little easier for new entrants. The old C2 provision at company action level was 25 percent of your first $50 million of earned premium and 15 percent of your earned premium in excess of $50 million, plus 5 percent of your claim reserve. This is just the C2 component, and this is just company action level. A lot of companies like to work at something like two to two-and-a-half times this. This will give you a good feel for how much money it costs to

write a dollar of LTC premium. It was prohibitive for new entrants and new business. Companies needed some kind of financial reinsurance if they didn't have enough capital to get into the business. It also had the negative effect of releasing your RBC as your business matured, when you actually needed the capital.

The new C2 provision accomplishes this to some degree. First of all, the absolute level is decreased a little, but your going-in RBC requirements are a lot less. It's now based a lot on your incurred claims as opposed to strictly premium, so your RBC should actually track with your need for the capital down the road. It's friendlier to new entrants, and, again, it matches better with the risk of the business.

Last, but not least, the reinsurance market has definitely dried up quite a bit. Back in the mid-1990s or even in the early 1990s, you had a lot of turnkey programs, where a reinsurer would hold you by the hand get you into the business and might also help you with financial reinsurance. You don't see that anymore. It's hard to find a reinsurer who will get into this business with you. Some will, but they want you to adhere to their underwriting standards and their claims protocols. They will follow you closely. It's very rare for a reinsurer to come in and take on an existing block of business. Reinsurers will only take on the new business, and only if you let them dictate the underwriting and claims protocols. I know there are some reinsurers in here, so I'd welcome any comments or corrections to that during the Q&A session.

That's the market and actuarial overview. Lynn will now cover the administrative trends.

MS. LYNN HARTUNG: I'm going to cover some of the nuts and bolts of how LTC is administered. More importantly, I'm going to talk about some of the things that we're anticipating or seeing now as trends for the future. I'm going to cover trends in underwriting, the importance of claims management, some contract language changes, technology, lessons learned and what might be some of the next big hurdles with which we're going to have to grapple in this area.

As far as trends in underwriting, we clearly have seen evidence of increased requirements at lower ages than we have in the past. Face-to-faces have gone down in age from being required around age 75 to, in most cases, age 70. In some cases we're seeing cognitive screens even younger than that, which is a significant departure from 1995 or even the late 1990s. We're lowering the maximum issue age. Several companies were issuing as old as 99 years old. As you can imagine, with an average claim age of about 78, age 99 is kind of a push. Of course, not many were approved. In fact, in my company, we typically only approved about 50 percent of those people over age 75. People that are a much older age have to be extremely healthy for a company to pick them up, and companies are dropping that maximum issue age down to age 85. I suspect age 80 is probably where it's headed.

Some people are trying to use the product in a different financial way that maybe Ron can explain better than I. They will sell to an older policyholder even though the premiums are exorbitant, as you might imagine. The annual premium for an 85-year-old is about $12,000. You would have to be very confident that they're extremely healthy because if they claimed, it would be very hard to recoup the claim expense that could be related to it. An annual claim on an average nursing home claim that we pay today that we're selling at about $120 daily benefit, on average in the industry, times 365 is about $40,000 per year in annual benefit. So one year of benefit today is about $40,000 in claims dollars paid out. That's why big premiums are associated with it.

We definitely have improved the cognitive screening. There used to be just a simple 10-word delayed-recall test in the early 1990s when it started to emerge in the marketplace. There were a few early adopters back then. By the mid-1990s, we saw almost everybody adopting some kind of cognitive screening because of the obvious anti-selection related to Alzheimer's and the like. The tests have become very sophisticated. There are a number of different tests available from various vendors that are much improved even beyond that. There are some excellent products that appear to be doing a much better job of determining whether or not someone has a cognitive impairment of some sort or is headed in that direction, which, of course, is what you want to know at the time of underwriting.

We've significantly improved the applications across the industry. We are asking more detailed and more relevant questions regarding medical conditions. Early on, as a new industry, we sort of ripped off a lot of different types of insurance products, such as life insurance and medical supplement, which was a big one. However, there are different questions we need to ask about LTC. In LTC you're not so concerned about when the person is going to die, though you want to know that the product is going to be in force for a long period of time. You want to know whether or not the person is going to live a long, healthy life. You want to know how the person is going to decline, or whether they're going to decline, in his or her old age. You're asking a very different question than you do in almost any other kind of insurance. In light of that, we've learned that certain medical conditions are more critical to that. There has been much improvement in that area in terms of the questions that we are asking.

We followed up that application with verification by phone and face-to-face interviews. We're looping back around to the policyholder and asking questions not just once but twice. We're making sure that the applications that we have developed, which we think are so much more effective today, are being completed the way they should be completed. That makes a big difference. "Trust but verify" is a great test.

In face-to-face interviews we've made an interesting improvement at my company. We actually instituted what they call a "get-up-and-go" test that is a timed test to measure someone's mobility. There were instances in the old days when an agent

would come in, and Mom would sit at the kitchen table the entire time, happy as she could be. There was no problem. We wrote the whole application. We then discovered on the back end in her medical records that she was in a wheelchair. We did get tripped up by some of these scenarios. It was possible to hide some medical conditions, so we're trying to find other tests. We're implementing other tests in these face-to-face interviews that try to uncover some of those extraneous issues. Mobility is kind of hard to measure. How long it takes the person to get across the living room and back is a pretty good way to measure mobility.

There are evidence improvements. The pharmaceutical databases, of course, are being introduced in life insurance and some other places as well. They're getting to the point where they're providing some good information. There are still some big holes. I hear about 30 percent of the people are missing, but having the other two-thirds is not bad. That could really help us to speed the issuance of these policies. Hopefully it will find a place in the very near future with some of the bigger carriers, because it makes a lot of sense. The Medical Information Bureau (MIB) is available now for LTC insurance. There has been some minimal adoption in the industry, but I suspect that there will be more.

We are seeing an increase in counteroffers and declines. As I said, we were seeing about 50 percent declines in people over the age of 70. That's pretty high. On average, we're seeing decline rates between 20 percent and 30 percent now, but that's way over what it was in the 1990s, when we were often seeing an average around 10 percent to 15 percent (maybe 20 percent). That's a big difference in the decline rate, which I think speaks to improved underwriting for the most part. That's not necessarily a good thing, because obviously that's very expensive. I think agent training is going to be related to that, so that agents can try to weed out some of these people. Agents don't want declines any more than home offices do. They're wasting their time. They're upsetting a potential client to whom they might sell a different product. Nobody is happy in that situation. At some point we have to improve each other's understanding of what can be issued.

Regarding image technology, we're getting requirements directly from the vendors and straight into home offices, which speeds things up. Also, insurers are more proactively managing third-party administrators (TPAs) and other related vendors. There's a great deal of opportunity here to speed the requirements into the home office, through providing contractual issues and providing follow-up on requirements that have been ordered. In the actual TPA world, if people are making your underwriting decisions and making claim decisions on your behalf or gathering all of the evidence, it's important that you're doing some audits and verifying that the underwriting program and the claims program to which you've agreed are the ones being executed. That's extremely important.

There are some interesting worksite programs that are emerging in the underwriting world. There's some modified guaranteed issue (MGI) out there. In worksite, typically there are participation requirements that a certain number of

people in a worksite group need to enroll in order for them to have the advantage of the MGI-type underwriting. Going back to the kinds of evidence that we collect, that means in some cases there will be just the application, as long as they've answered "no" to a series of questions the policy will issue. In some cases for some older ages, you might do something a little different, but generally, the more the penetration, the easier the underwriting might be. In some cases, it has been as low as the greater of 15 people or 10 percent of the group that you're trying to enroll in order to be qualified for that MGI-type underwriting, which makes a big difference. In all cases it's important to trust but verify what's coming into the organization.

Let's talk about the importance of claims management. Claims management is probably the biggest change in the industry that we're seeing. In the past, typically we were helping people settle into the kind of care that they wanted and maybe helping them find a lower-cost carrier or provider or something like that. We're waking up to the fact that it's important that we manage our claims. Part of that is because some of our products are so attractive to policyholders. Assisted living coverage is very attractive. Custodial homemaker-type care is very attractive. Some of the ways that payment is done, like indemnity programs, are very attractive when really you just have to qualify and then you start collecting the benefits in terms of cash benefits. Insureds have had a great deal of difficulty separating “wants” from what he or she really “needs” in care, which was what most people were buying the policy to provide. Informal caregiver plans and, more importantly, indemnity plans provide the insureds the financial incentive to initiate earlier claims or prolong the claims.

Let's go back to my example of the average $120 daily benefit that pays out about $40,000 per year in claims payments. If you had a 5 percent cost-of-living adjustment (COLA) or benefit increase option attached to that plan, 14 years from now it's going to double. So it's $80,000 per year. Then 14 years after that, so 28 years out, it's going to double again. That's $160,000 per year that someone could collect on an indemnity plan as a result of this. If the person bought a lifetime benefit associated with that, somebody is going to be incented to trigger earlier and collect that money because these are large dollars. That's the reason we're seeing some changes, and that's the reason we have to write our policy language appropriately. We have to manage our claims appropriately and make sure we have the policy language to support that. Of course, TPAs have to have that alignment of interest, as I explained earlier.

Historically in claims management, what we've done is helped people settle in, as I mentioned before. In the early days of my company (before I arrived), we sent flowers to every one of our claimants when they claimed. It was a happy day for them. We were taking care of them. We were meeting the objectives. Our marketers loved it. It had a lot of pizzazz. We'd still like to send flowers, I think, to all of them. We stopped the program to some extent because it was too hard to find them. They were in such flux when they were claiming that we couldn't find out

where they were to deliver their flowers. That was half of our problem. It was run primarily by nurses within the claims department. Their primary job and their training were to make people comfortable. It was a mindset that was very different from what you might have found in a disability claims environment. We're seeing a shift to the realities of what we're trying to manage here and the kind of dollars that we're trying to manage here. In claims management, "can't" versus "can" used to be a bad word in this industry. Your marketers didn't want to hear it, and we just didn't talk about it. But we're going to have to talk about it because the industry is facing the fact that they have to stand behind these products so that we're able to pay everyone the benefit that they purchased.

The way that's being addressed is typically by changing some of the approaches in claims management. We're hiring fewer nurses and more occupational therapists, physical therapists and social workers. These are people whose training has been to move people to independence and to help them address the activities-of-daily-living (ADL) dependencies that they have when we find them or when they file their claim. The objective there is well-aligned with the claimant's. The claimant wants to be independent. To the degree that we're able to provide claimants with services that allow them to do that, everyone is happier. It makes a lot of sense. You're starting to see more claims-examination- and claims-adjudication-type skill sets coming into LTC claims organizations, which are providing a good deal of value in terms of the contract administration function.

You're seeing more coordination with Medicare in the products. We're definitely doing a better job of the trigger evaluation and the qualification for those triggers. The big benefit of this is that we have moved to the tax-qualified (TQ) triggers, which are ADLs or severe cognitive impairment. We're getting better at evaluating those triggers. They're becoming less nebulous. You would think that it would be easy to understand bathing, continence, toileting and eating, but it gets fairly complicated. What is bathing? Bathing as defined in most policies means that you can bathe without assistance or bathe using a sponge bath. We don't usually talk about bathing meaning sponge bath, but in the policy definition, in language that came right out of Health Insurance Portability and Accountability Act of 1996 (HIPAA), that's what bathing means. That makes that definition very important and hard for people to understand because it would be a different definition than what they might think. I don't think this is in the policy to confuse people; I think people just took the language straight out of HIPAA, and that's what they've used and adopted.

When I came into this industry, everybody said, "You know what? These folks are seniors. They're wonderful people, and there's absolutely no need to consider fraud. It doesn't exist in this industry." For the most part, there isn't. It's very small, but it does exist. A vendor recently talked about a program that it ran for a major carrier. The vendor said, "Give us 100 of your claims. Let us go out and visit them. Can we find them?" They're coming up with 1 to 2 percent where there's fraud. They're either not there, or they are no longer qualifying. It costs about $150 or $250 for

us to send a nurse out to do eyes-on type of evaluation. If we're paying benefits of $40,000 a year, it's worth it. We hate to be suspicious. You hate to adopt that kind of mindset, but in reality you have to make sure that you're administering the policy according to its terms.

Contestability was probably underutilized in the past. I think there's more of that, and it's related to the same types of issues. Did we receive all the information? Was it all factual at the time we received an application? If you're getting claims under two years, it's important that you take a close look at what actually occurred there. The underwriting in this business seems to last in the three- to five-year range, so if you're getting a lot of short-term claims, there may be a problem with your underwriting or your evidence collection. Finally, we have the beginning of common sense. There has been common sense for quite a while, but it's becoming a better process.

Contract language comes with a lot of intensive "R&D." That's, of course, insurance "R&D," meaning "rob and duplicate." That's where we got most of our contract language over time; somebody wrote a policy, and then everybody just copied it. But we've gotten better. Companies do a better job now of trimming up their own language. It comes with experience. Again, this product is only 15 years old. There are certainly 30-year-old policies out there, but that was generally a lone rider. In terms of actually becoming an industry, it's only about 15 years old. Everybody is getting better at it as we go, and certainly the language has tightened up quite a bit. We've learned some hard lessons as a result of it. I'll point out a couple of things to think about going forward and things that may happen in the future as a result of some of the lessons learned.

I'm not sure what's going to happen to the alternate plan of care (APC), but I can tell you that it's very difficult to manage at claims time. Everyone loves an APC. The marketers love it because it's easy to sell. It says, "Hey, no matter what kind of providers are out there in the future, you're going to have care." Ten years ago, there weren't many assisted living facilities (ALFs). Everybody just knew about nursing homes. There wasn't a lot of home health care to get. They didn't have all these care agencies like they have today. So who knows what the future is going to hold? Robots may be giving us our care as seniors when we hit our twilight years. The alternate plan of care is that thing that picks that up, but it's difficult to administer at claim time because it turns into a "let's-make-a-deal" situation. People say, "Well, I have this." "Well, you don't really qualify for that kind of benefit." They say, "But I have this APC." What they really want is to turn it into kind of an indemnity payment in many cases. It's difficult at claims time. I think there will be some changes there. I can tell you that my company eliminated it in our last product and replaced it with a one-third cash benefit that was indemnity, but it was only a third of the daily benefit. If they didn't want to follow the policy guidelines for the providers that were available, they could take the cash and go. Whether or not that was the right decision, it's the one that we made. Surely there are other companies out there that are struggling with that.

Regarding the claims trigger, we've certainly changed the decision-maker from being medical necessity. The ADL triggers, the cognitive impairment triggers and the TQ triggers as defined by HIPAA have made a big difference in terms of making that process make a lot more sense. There's a big question about the definition of severe cognitive impairment. We try to break it down into numbers. The mini-mental state exam is a common cognitive impairment test that scores from zero to 30. The test itself says that a score of 10 and below is severe. A score of 10 means pretty severely cognitively impaired, but some people have said, "No, I think it's about 14." We actually had a state dictate to us that it was 23. What is severe? I think that there are going to be some arguments about this with the TQ. I'm hoping that we're going to see some refinements of that language in future policies.

International coverage is interesting. It has its challenges. Who are the providers? How are you going to know that they meet your requirements or that they're even meeting the care needs of the policyholder? How are you going to do the assessment on them? Some have tried to solve this by saying that they'll fly the policyholders home. There are expatriates trying to buy these products, and they're most attracted to the indemnity-type payment plan, for obvious reasons. But, again, it's going to be very difficult to do the claims-eligibility determination simply because they're not here, and there aren't vendors that are worldwide that I know of yet. It could present some problems.

As far as restoration of benefits, this is one area where language has improved over time, which is good. They've limited what that means. Let me explain what restoration of benefits means in LTC, for those of you who weren't in the earlier session. Say I'm in my 40s. I buy the product. I have a car accident, so I use my benefits this decade. Then I heal from that accident, and I go on and live the rest of my life. In my 80s, I become debilitated and want to use the policy then. That's the concept of restoration of benefits; if you use them up, basically the clock just starts over. You would have a full benefit the second time around. In the past, there was no requirement that you were not receiving services for some time between, so you could sort of wait it out. They've fixed that in most policies, which is good.

Let's talk about trends in technology. We're seeing electronic applications coming from the big players. There is a lot more electronic usage by the agents, which is great. They've really adopted some of these tools to which there was a lot of resistance early on. We're seeing some shared-image platforms between some of the big general agents (GAs) and home offices, where they're literally a part of their workflow. That is going to be very interesting to watch. It's becoming very common. Many people are adopting the electronic transmission of evidence from vendors and sharing information electronically between the two so that home offices have access to that kind of information. We can buy LTC administration systems now, which is great news. There were not any off-the-shelf solutions in the 1990s for the most part, and today there are some options from which to choose. That's a big improvement. As people go into the worksite business, they're going to continue to look for some solutions for the worksite administration, especially the

billing issue.

When you're dealing with individual products like this, doing list billing or common-remitter-type work does make it complex because people can change their coverage levels. When there's a rate action and you have to adjust people's billing as a result of that, it's very difficult to move that along. Typically that becomes an issue when you're dealing with the smaller or mid-size groups. If you're doing the big groups and the big true group, that's usually a simpler process because it's more defined as part of a larger common-remitter-type package, but certainly there are some obstacles in that worksite from a billing perspective. I think we will be seeing more Internet enrollment for the worksite. That's what it's going to take to do some of these larger groups. Eventually that technology will roll down to some of the smaller groups as well.

There are lessons learned. Trust and verify. Follow up. Again, it is a unique population with which to work because it's typically seniors, though we do certainly have some young-age claimants. It's important to collect better information and validate what's there. Secondly, pay attention to details. Sometimes there are little benefits in the policy that you might think from a pricing perspective won't make any difference, but in reality they're big benefits. Everything has a price. Survivorship was one that was a surprise. Marketing loved it. It's a great benefit, and it makes a ton of sense, but it comes with a price. It's not free. We're improving some of our pricing assumptions on many other little benefits like that that were thrown in over the years. Claims clearly need to be managed better because that's what's going to take us forward in the future. The process should make more sense. Finally, insurers have to control their own destiny. If you do work with outside vendors, there are some great ones out there, but it's important that you make sure you're managing that business and not delegating that.

One of the next big hurdles is genetic testing. We're getting close to having more access to this kind of information. It's going to be interesting to see where all that goes. I don't even have a prediction. A second big hurdle is unfolding claims litigation. We are dealing with a senior population that is very sympathetic in a jury situation. I don't know of a lot of claims litigation that has unfolded to date, and I certainly hope that we don't see any problems out of that going forward, but there's always that risk. We have seen some irrational decisions made by jurors.

MR. RONALD J. HAGELMAN, JR.: I'm going to tell you the truth, and then I'm going to put a good marketing spin on it. Production in 2004 was abysmal at best. (It was actually the worst year for new sales we've had since we started doing this, if you want to look at it in relation to the prior year.) A number of forces were at play, but I think the best way to describe it is that there was a general loss of faith by companies because of the difficulty of profitability. If you look at the LIMRA numbers, as many companies lose money as make money in this business. Of those that make money, only 20 percent hit their returns on investment (ROIs). It's a tough business in which to make money. Of the 42 companies, we've had 14 give

out in-force rate increases. That leaves a bad taste in everyone's mouth, particularly agents who have to report the bad news and then try to salvage what they can.

One of the things we found is the persistency of this product. The reality is that it's the greatest insurance mystery of our times. Here you have an individual A&H product, the most beloved product ever bought by the American public. They love their policies, and you can't take it away from them even with a rate increase. The problem is how tough it is to get them to write that first check. Something is in there that we still don't understand.

Anyway, I'll put a positive spin on this. In 2004, 362,000 people did buy a new policy. We do have 4.2 million in-force policies. Total premiums are $6.8 billion, and in-force grew at 12 percent compounded between 1999 and 2004. Lifetime premiums represent 90 percent of new premium. New insureds are paying $1,924 for the first year of coverage, which is a 6 percent increase. Premiums will continue to increase. Five out of six carriers' buyers are paying larger premiums than 2003 buyers.

The companies that have the best sales growth are the ones that have a fire sale going before their new policy form gets approved. Insurance agents love fire sales. It used to be that the number was fairly even between independent insurance agents, if you will, and career insurance agents. That number is beginning to shift. The most recent numbers look like about 55 percent independent and about 43 percent career. So independent agents are doing a better job selling the product. Although other people are getting into the action, even those people that we traditionally view as order-takers (broker/dealers, accountants and financial planners) have begun to understand that it is, after all, just a piece of money, and perhaps there's a way he or she could get his or her mind around this and do a better job of selling it.

Let's talk about trends in cross-selling. This is important. What's happening is that we're beginning to see the way that this needed to be done in the beginning. For years I've been one of those people who walk to the front of the room and call for a crusade. We need an army of trained, professional LTC insurance specialists. The truth of the matter is that we've sort of created one. Ten years ago, distributors would say to me, "Ron, I want to get in the LTC business. I'll go out and buy a Med Supp agent list." No. You go out and get your certified financial planner (CFP) list. That's what you get because the way this works most effectively is to be sold by your best agents as part of a financial plan. It is part and parcel of an adequate financial plan. In fact, there are those who are beginning to argue that if you don't sell LTC insurance as a professional financial planner, you have an errors-and-omissions (E&O) problem in play.

This is a very complex sale. When you survey agents about the problems with LTC, they say that it's too complicated and that it's too expensive. The only way to make

it less complicated is to go to a disability insurance (DI) model. It doesn't get any simpler than that, and, of course, that raises premiums 30 percent or 50 percent. That never encourages agents. I have two solutions to it being too expensive. Either I decrease benefits or cut commissions. Which would you like me to do? Agents don't like that one, either. How many people make a living selling LTC insurance as their primary objective? The number 10,000 may be a little aggressive, but I'd like to believe that there are that many specialists out there.

There are three kinds of people who sell LTC. There's the specialist who does it. There are the people who dabble in it; they do it because their clients want it. Then there are those who have policies taken away from them. The clients really want it, and they ask, "Do you sell LTC insurance?" Well, of course they do, and of course they don't know what they're doing.

The other thing that's happening is the federal plan. It's done a lot of good, not just because of the applications that were taken to enroll in the federal plan, but because it stirred up a conversation. I would argue that there were many sales made because of the nature of the conversation. Agents spent a year-and-a-half selling against the federal plan. All an insurance agent wants is something to have a conversation about. Remember that what's going on today has nothing to do with what's going on tomorrow.

What's going to happen next? Well, there's your reality, which is whatever you think, and then there are the facts. The fact is that when you live a long life, you're going to need LTC insurance. The vast majority of Americans are going to need it. Baby Boomers are beginning to retire. The largest, fastest-growing demographic in America is the 85+ age range. Sixty percent of those reaching 65 are expected to need care. There are 7 million over the age of 65, and there will be 12 million by 2020. Most are absolutely unprepared for this financially.

Along the Texas coast we fish. I fish religiously, and I fish for red fish. They're called slot fish, for those of you who don't know, because there are fish that are too small and there are fish that are too big. LTC works the same way. There are those whose assets and income are putting them in a situation where they probably shouldn't be buying a policy, and there are those who would argue that they can self-finance this so they don't need a policy either. If the Baby Boomers are the Titanic, then LTC is the iceberg. The government clearly understands. The message coming out from anybody who opens their mouth in Washington these days is, "We can't afford this anymore, folks." Who should pay? The answer is, "Anyone but me." It's the old Marine mentality. "It's not going to happen to me. It's going to happen to that other guy in the foxhole." Medicaid covers two-thirds of New Hampshire nursing home residents, and Medicare pays 13 percent. If you look at total LTC cost, though, the number is a little different. It's about 57 percent Medicaid and about 17 percent Medicare. The truth of that proportion is interesting. In relation to the cost we personally pay out-of-pocket as Americans, Medicaid's share has risen by 20 percent over the last 20 years. The government has continued to pay more,

not less, and that's what has to stop.

The most interesting fact about the federal program is that it's the government's own admission that you need to go take care of yourself because the government is not going to be able to take care of you. Its own people got the message. The highest percentage of those who bought a policy (by the way, nobody talks about this) were the people in Congress. The only way you can fix this is private pay. All the solutions involve private payments. We're the only people that are going to provide those dollars. It's not like the money is not out there. The money is out there. There's $2 trillion in home equity. One of the growth industries finally getting the play it should is reverse mortgages. Also, there's $9 trillion out there in IRAs and private pension funds like 401(k) plans. The money is out there to solve the problem, but you're going to have to feel the risk first.

Public awareness continues to grow. We are getting generally favorable media attention. Anyway, we're getting commitment of major product with the manufacturers. We're getting training in experience distribution. One of the reasons we have a great future is we've just spent 15 years training an army of specialists to go out and sell this product. They demand product. That creates need. The distribution that we built is part of our success. For those of you who are unaware, there's a governor-awareness program. Five states have mailed 4.5 million people a letter and a brochure explaining that they have a problem that they need to solve. You're going to see more and more of that. We have paid $10 billion in claims. We do have 20 years of experience. There are over 7 million policyholders. There's a growing employer-endorsed marketplace. Right now sales are 80 percent individual and 20 percent group. Predictions from anybody that has paid any attention are that those numbers are going to flip-flop within the next five years. I think it will be faster than that. The growth is going to be in small group. There are 3.5 million employers below 50 lives, and that's where the growth is going to come.

The Johnson-Pomeroy Long-Term Care insurance bill was just reintroduced last week. That's the one that provides above-the-line deductibility, caregiver tax credits and the ability to take LTC premiums out of Section 125 (cafeteria) plans. There are also conversations about getting money from rollover balances in flexible spending accounts (FSAs), getting money from 401(k)s and getting money from IRAs. There's lots of experimentation going on here in Congress. There's research going on right now in the Budget Office trying to determine the extent of the damage caused by Medicaid planning. When we get a better handle on those numbers—we haven't looked at that since 1991—we're going to find a way to shut that silliness down. There are conversations about a national partnership plan. As you know, there was a successful six-state pilot project, but now there's a conversation that maybe we should do this everywhere. As an industry, we've done a very effective job of selling comprehensive, expensive policies to people with money. That wasn't our total responsibility. We have a bigger job to do than that, and this may be one of the ways to help address that, as well as advances in the worksite.

We need better solutions that address affordability. One of the things we're learning is that perhaps less benefits is effective enough. All LTC insurance sales are good sales. All LTC insurance sales are co-insurance sales because even if you stack three policies, even if you bought every policy they'd allow you to do with a jumbo risk, the truth of the matter is that you're never going to cover 100 percent of the cost of a bad LTC claim. In that context, every sale you make is a good sale. Even that person who has the two-year benefit will be grateful for that money. The vast majority of the claims will be paid.

You're going to see more innovative approaches to product design, but I'm not going to talk about that. It took a long time to get the 401(k) moving. I was one of those people who tried to sell it in the beginning, and I couldn't give it away. I can't tell you how many speeches I gave, yet didn't write much business. Now everyone wants their 401(k) plan.

Why in the world should I pay for something that the government is giving away across the street? That's going to stop, because the government can't give it away anymore. There's no way we can make that math work.

When consumers believe that this is affordable protection for them, sales will increase. Perhaps we should do a better job of selling smaller benefits to more people. When employers offer viable options, that is very much where the game is going to be played, I believe. Employers are going to get more and more involved. They're going to get involved not because they care about benefits and not because they love their employees, but because they want to protect themselves because they have a risk. The risk they have is the giant financial risk that they face when their employees have to leave work to take care of somebody. When the product is sold based on that risk, that's when we're going to make the progress we need to make. We need better media support, which I believe we will get.

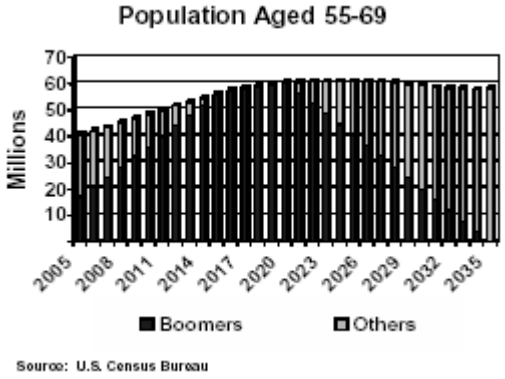
MR. BODNAR: I'm going to close the discussion with my humble views of where I think the market is heading. You'll hear a lot of similarities with what Ron just shared with you. If you hear it from an actuary, you'll know he's not just blowing sales smoke at you.

Let's start off with a reality check. The financial burden is real. The care is costly. The cost of care is increasing faster than inflation. Most people will struggle with financing retirement, let alone LTC. The gap in the coverage is real. The government is not going to step in and pick anything up. Current medical policies don't cover this. Medicaid requires that you deplete your assets before you're eligible for coverage. As we said, there's just not enough tolerance for the federal program, nor room in the budget for it. Private LTC coverage is still, I think, the most viable solution for closing this gap. Even C*onsumer Reports* is quoted in their November 2003 edition as saying that LTCI may be a lousy deal, but right now it's just about the only deal. Even they admit that it's something everybody needs. In spite of the need, there's less than 10 percent market penetration.

I always thought that it was about consumer education. If enough people heard Ron talk, we might solve the problem overnight. Now I think that that's only part of it. The Boomers are becoming a bigger and bigger part of the target market, and they're a different type of sale. Their parents were very risk-averse. They looked for ways to protect their assets first. They were more concerned with what their kids are going to have than with what they were going to have. The Boomers, I think, are the opposite. It's all about what they are going to get out of this. The Boomers are want-versus-need consumers. They like to put decisions off. Many of them are aware of the risk because they put somebody they know through a nursing home or through the system, but, for some reason, they still don't want to buy it. They just don't like the value proposition, which is to pre-fund for a very deferred event, and then there's a good chance you're not going to get anything back from this product. Many prefer to self-insure, which means they save whatever they can for whatever need they may have in the future. Many Boomers are just ignoring it right now.

Chart 3 is a good picture of what the Boomer population is going to look like in the future. Each bar in total represents projected population, from 2005 over the next 35 or 40 years, of everybody between the ages of 55 and 69. About half the people in that age bracket are Baby Boomers. Within the next 10 years or so, it is going to be everybody. Everybody is going to be a Boomer by that time. Eventually it will peter off, and their children will make up this demographic. They're even harder people to whom to sell. The code needs to be cracked. How do we get at the Boomers?

Chart 3



The other issue is that there are a lot of barriers to new carriers getting into this market. It's a niche product, and to be successful in it, you need expertise. You need specialized administration and access to distribution. You also need a lot of money. You need a lot of capital. In the face of all this, you have increased regulation and risk. There's the whole uncertainty as to what care delivery is even going to look like in 10 to 15 years. So it's hard for carriers to justify to their shareholders why they want to get into this. There's too much unknown risk.

Again, carriers are struggling to crack the code to get at the Baby Boomers. I agree with Ron that the future is at the workplace and going after the younger people. We're also looking for new designs for carriers that may reduce the exposure to risk. Part of the answer is to have policyholders have more skin in the game.

We're starting to see some combination products that take sort of a universal-life approach where you can build up an account fund via a universal life (UL) policy and tack a rider onto that where the LTC benefit kicks in if you need to go into a nursing home or you need access to funds before you need access to your life benefit. A rider will accelerate your LTC benefit, usually at a multiple of your death benefit. If you have a $200 face amount, this LTC rider would accelerate, say, two or three times that in the event you need care. This little subsegment of the LTC market is a big grower. There's $500 million in new premium in each of the last couple of years, which is significant. A good example is Lincoln's MoneyGuard product, if you want to go on the Internet and take a look at it. This is a UL policy with an LTC rider.

Another group of hybrids out there is annuities with LTC riders on them as well. The base product is a single premium deferred annuity. The annuity account would be used to fund any initial LTC cost, and then there's a rider on top of that that would provide some multiple of your account value if you ever need care. An example would be Guaranty Income's Annuicare. That's also on the Internet, and I suggest you take a look at that.

The examples I cited are really single premium products. In both cases you're going after a more upscale, wealthy target market, and you're asking them to dump a lot of money into a product. I'd like to see some kind of level premium product that builds an account value up, some kind of equity-based product that's funded by level premiums. We don't really have that yet, and I'd like to see some products come out with that feature. Right now, regulation restricts this. It restricts this and other areas of creativity. Issue age rating limits how policies can fund this equity-based product. Also, HIPAA prohibits cash values. Complexity is an issue. LTC is already hard enough to sell. After you have someone like Ron convince you that you need the coverage, you need another half an hour with the policyholder or applicant to explain how the coverage works. Then you layer on top of that some kind of equity-based product, and you're in someone's house for a couple of hours. Complexity is an issue not just for the policyholders but for agents and in training distribution systems as well.

As far as where the market is going, I think that the product fundamentally has to change in order for it to make the penetration that it's capable of making. Clearly there's a need. Today's product is not meeting that need. We need some creativity. We need some regulations to change in order to get it to that next level. There's a market here. New entrants can be successful with this with access to a lot of capital. Either build or hire the expertise. You need to be able to manage your block of business. Even if you're using a TPA, as Lynn said, you need this trust-but-verify

relationship. You still need the expertise back in the home office, and you need access to specialized distribution. Most importantly, you'll need some creativity and awareness that this product has to change in the near future.

FROM THE FLOOR: You mentioned cash value. Would that make the annual outlay even more than it is?

MR. BODNAR: Yes, it would. The point was that with cash values, the premiums would go up. However, if people think that they could get something back when they die or lapse the policies, that would help. There used to be a feature called "return of premium." It's not very popular anymore, mostly because companies mispriced it. For a considerable increase in premiums, policyholders could pay into a policy and get all their money back if they were claim-free after 10 years. That was fairly popular, particularly as you get into the younger ages where the premiums aren't quite so high anyway. It's an attractive possibility.

FROM THE FLOOR: I think the New York Department of Insurance has put LTC riders on life policies on their to-do list. Do you have any idea what that is about?

MR. BODNAR: No, I don't. LTC riders on life policies have been around for 15 years, and they currently are regulated by the NAIC model. Maybe New York is just getting around to what they typically do, which is to come up with specialized rules to standard regulation.

FROM THE FLOOR: Are commission levels changing along with the changing sales patterns? Are those commission levels coming down?

MR. HAGELMAN: No, there's no dramatic shift in commissions. There has always been a conversation about levelizing commissions, and that's also true in LTC. There are three or four states that have paid differently, if you will, and tried to levelize the transaction and enforce it. But for the most part, no, there's no change. This is a very difficult product to sell. You need those first-year allowances. The reality is that the reinsurance allowances on a product are generally the same among the three reinsurers left in the market. What I'm saying is that everyone pays the same commission. It just depends on their distribution and how they funnel that out. I'm going to say that the average first-year commissions out there, gross to distribution, are around 80-85 percent, and you'd need those dollars to make the sale. If you think about what the agent makes on those cases where we talked about the average premiums, how many of them does he have to sell in order to make a living? These are not easy sales to make, regardless of how good you are. Some of the best agents in the country only sell 30 to 40 policies a year. It's hard to make a living doing this.

FROM THE FLOOR: You mentioned that premiums for new business have been increasing.

MR. BODNAR: Yes, they are. The new business premiums are increasing even as average ages are decreasing. You're also seeing less and less rich benefits as companies are not emphasizing them as much. They have lifetime benefits. What that means is, yes, the cost per unit is increasing.

MR. HAGELMAN: It depends on where the company has chosen its market. If you're in the executive corporate market because of the tax issues involved, you know you're there because the client says to you, "Do you have any more riders?" If you're in the senior market, the client says to you, "Can you make this thing any cheaper?" They are two different markets.

FROM THE FLOOR: Pursuing that line, we've been saying that less rich benefits may make the product more viable and materially more viable. If the savings are material, are we not saying that we're postponing a problem but not really solving it if you can save huge amounts of money by making it two years instead of lifetime? The mere fact that savings are material may indicate that a lot of claims would have come beyond two years, and they will not be covered now.

MR. BODNAR: Yes, but you're at least taking some bite out of the LTC crisis.

MR. HAGELMAN: No matter what product or policy you sold, you're not covering 100 percent of the risk. The client is always involved in part of the payment of the claim. It's only a question of degree.

FROM THE FLOOR: Those are things like deductibles. Now we're talking about the other end of the tail.

MR. HAGELMAN: No one wants to have a client that runs out of money, but it happens. Hopefully you've had an LTC refusal form signed so the client knew he could run out of money.

MR. BODNAR: It would be a real sin if you go in and say, "Hey, buy this two-year policy. It's going to cover you no matter what." But it's okay to go in and say, "Hey, buy the two-year policy just because it's what you can afford. Later on, if you want, and if you're still healthy enough, buy the rest of it a couple of years from now."

MR. HAGELMAN: God bless Lyndon Johnson, my fellow Texan. His intentions were correct. There needed to be a social safety net for people in this country. What we had before was not healthy. The purpose of Medicaid was to provide help to those people who needed it. As long as that's its purpose, I'm in favor of it, as are most people. The problem is it has been abused, and that has to stop.

MR. BODNAR: You have a whole industry of lawyers right now that specialize in Medicaid planning. They're planning to get you on Medicaid.