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Session 48 PD
The Basics of Long-Term-Care Insurance

Track: Long-Term Care

Moderator: Dawn Helwig

Panelists: Dawn Helwig
Stephen Rowley†
Jesse Slome‡

Summary: Panelists provide an overview of long-term-care insurance. They present basic information relating to how the product works, unique pricing and risk considerations and reserve and capital requirements.

MS. DAWN HELWIG: This session is going to cover the basics of long-term-care (LTC) insurance. We're going to be talking about the product structure, many of the financial aspects of LTC, how it's administered and how it's marketed. I'm covering what the product looks like and the financial aspects.

I'm a consulting actuary with Milliman. Our next speaker is going to be Steve Rowley, who is the vice president of risk management at GenRe. Steve is going to be talking about the administrative aspects of LTC. Here's a little bit of background about Steve. He is in charge of risk management. He works with the critical illness, disability income and the LTC lines of business at GenRe. He also is the author of a book called "The Consumer's Guide to Long Term Care Insurance," so if any of you are thinking about buying it or are interested in it, I'm sure he'd love to talk to you or sell you a copy of the book afterward.

Our last speaker, who's going to be talking about marketing, is Jesse Slome. Jesse

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is the president of Sales Creators, Inc. and publisher of a magazine called *Long-Term Care Insurance Sales Strategies.* Sales Creators provides marketing materials for LTC producers. He has been there for seven years. Jesse has an interesting background. He has marketed a number of different products throughout his lifetime, including the Cabbage Patch dolls back in the 1980s. I view LTC as being the Cabbage Patch doll of the insurance industry. If anybody can get LTC and its message out, it's Jesse.

I'm sure many of you have heard that there have been a lot of issues, concerns and problems with this industry in the past few years, with companies exiting and rates increasing. We will talk about some of those issues; what has been going on that has caused them; some of the solutions; and the new things that are going on in the industry, including the companies that are in and those that have gotten out.

To get into the basics of it, let me give you a little of the history of this product line. It's not an old product line, as you may know. The product started back in the 1970s as nursing-home-only coverage. It was limited. The initial policies covered only nursing home stays that took place after a hospital stay. That requirement was removed in the 1980s. The condition for needing care was changed to "medically necessary." The prior hospital stay was the gatekeeper for getting care under the policy. There were some preliminary coverages where policies started covering home health care only, but it was still primarily a nursing home product.

In the 1990s, the product came into its modern-day state. We started having policies that covered both nursing home and home-health-care stays. Assisted living facilities, as they became popular, began to be covered under the policies. The benefit triggers, or the gatekeepers, also changed in the early 1990s. It used to be that if somebody got care for something that was deemed medically necessary, the care was covered. We went to something called an activity-of-daily-living (ADL) trigger or to cognitive impairment. I'll get into that in more detail later.

The early policies did not have any inflation protection. That was added in the 1990s. Starting in 1996, the Health Insurance Portability and Accountability Act (HIPAA) legislation mandated or created a new class of policies called "the tax-deductible policies." Most of the products being sold today are tax deductible, which means that if the policies meet certain provisions defined in the regulation, the premiums that you paid for the policy can count as an authorized health expense as you're itemizing for federal income tax purposes. You need to have total health expenditures, including your LTC premiums, exceeding 7 percent of your income for this to mean anything.

The other aspect of the tax deductibility was that the benefits coming from a LTC policy were clarified to say that they would not be included as taxable income. The benefits for nontax-qualified policies have never thus been clarified to say that they are included in income, and so that's still a gray area, but tax-qualified benefits clearly are excluded from income.

One of the other important changes that we saw in the 1990s was the dramatic improvement in underwriting and the care management on these products. Steve will talk more about that. Many of the issues that we've seen on LTC policies and the policies that have been needing rate increases have been some of these older generations of the products where the underwriting in particular was not good.

Into 2000, among the changes that we've seen is that a couple of years ago the federal government picked off a LTC program for its employees. The federal government made it clear at the time that LTC was not something that was going to become a publicly funded program, and therefore they were encouraging all of their employees to buy it personally. The federal program has been one of the clearest statements from the government that LTC is not on the ticket. There are a few other things that Jesse will be talking about as far as some public awareness programs that the federal government is attempting right now.

The industry has been hoping and trying for a long time to get full tax deductibility, which means that we've been trying to get the premiums to be fully tax-deductible from the first dollar rather than when you exceed the limits on the health expenses. That particular proposal has been written into several federal laws, and none of them have passed to date. There is still an opportunity for that.

The industry also has been hoping for some federal, state and private insurance partnership programs to be made nationwide. They are in four states right now. The industry is hoping to expand that to where there would be an integration of private-pay LTC policy with Medicaid programs so that a person could fund the first few years of a stay or care under a private long-term-care plan, and then Medicaid would take over at that point.

Let me get into a description of the product and for what it pays. Most of the products are individual, even the employer plans such as federal or state plans, and many of the large employers have LTC plans. They're still fully portable in the sense that even though the group might be the holder of the policy, when people leave that group, they can take the coverage with them. It's different from major medical or group disability insurance (DI), where the coverage terminates when they leave that employer.

Long-term care is issue-age-rated. The premium that people pay when they buy it at age 40 is the premium that they're going to continue to pay for the rest of their lives barring any rate increases. It is designed to be fully portable. If people leave the company, they don't want to have to leave that behind because another policy that they purchase would be at a much higher premium.

It's guaranteed renewable. The carrier cannot cancel the coverage based on people's health history. The carrier can't cancel the coverage for any reason. Rates could be increased, but individuals cannot be singled out for a rate increase because of their health history. The premiums would need to be increased for an

entire class of policyholders.

As I said earlier, most of the policies that are written today have a gatekeeper or a triggering event. One event is a disability. "Functional disability" means that the person can't perform one of the ADLs. Another event is cognitive impairment. The current products tend to cover the full array of possible LTC services. They cover being in a nursing home or an assisted living facility or getting home care. They'll provide coverage whether that care needs to be skilled, on an intermediate level or custodial. Some policies will cover the home health care and maybe the assisted living facility at a different level from the nursing home. In other words, they might say that they pay up to $100 a day for stays in a nursing home but only up to $50 a day for home-health-care visits. But the vast majority of policies pay the same daily benefit up to the same daily maximum for both.

Many of the policies will have a feature in them for an alternative plan of care. Let's say that the policy covers nursing home, assisted living and home health care, and home health care has to be provided through a home-health-care agency. Some of the policies will have an alternate plan of care, which says that if you work out a plan of care with your doctor that covers some of the things that the policy doesn't explicitly lay out (for example, you might want a neighbor to come in a couple of times a week) and this is not coordinated through the home-health-care agency, if that is more cost-effective and everybody agrees that it's a better mode of care for you, the policy may still pay for it.

The policies have benefits paid on what we call a pool-of-money or pot-of-money basis where people will select the given benefit period, a certain elimination period and a daily maximum. The way the benefits are adjudicated, though, is that the benefit period in days is multiplied by the daily maximum to get a pool of money. If people spend less in care or incur less cost than the daily maximum, that pool of money is extended beyond the original three-year benefit period or whatever they bought. For example, if somebody buys three or four years of care at $100 a day but incurs only $75 a day, the pool of money will last longer than the benefit period that was purchased.

Some of the older plans were not like this. They were fixed calendar periods that paid for all the care in three years or all the care in four years. This pool-of-money concept is something that happened in the mid-1990s and is the most common product structure today.

There are two different types of policies that I'm going to come back to in a minute. Most of them are expense-incurred or reimbursements, which say that the actual charges that a person incurs are paid up to the daily maximum. There are some policies, though, that do not require care to be given and pay just a daily benefit. They're more of a disability-style of policy.

I said earlier that most of the older policies had a "medically necessary" trigger.

The current ones have ADLs or cognitive. There are seven ADLs, but the six that end up being used for tax-qualified purposes are: bathing, eating, dressing, transferring (being able to move from a chair to a bed or vice versa), continence and toileting. The most common standard in most policies says that people need to be impaired in two or more of those ADLs to qualify for benefits or that they are cognitively impaired, which means that they have Alzheimer's or some other debilitating cognitive illness.

To be considered impaired in one of these ADLs, typically the policies require that the person needs some "standby assistance," which is the common term. I think Steve may address that later. "Standby assistance" doesn't necessarily mean that somebody has to be physically dressing or feeding the person every single time, but it does mean that somebody has to be within arm's reach and supervising, helping out as needed or making sure that the person isn't having problems.

When you get to cognitive impairment, somebody could be cognitively impaired and not have any ADL limitations and still qualify under the benefits of the policy. Cognitive impairment would mean that the person needs to have constant supervision so as to not be in any danger.

Many of the current products have a feature that has been a positive addition for LTC in that it requires or allows people to use a company's care coordinator. People can come to the company, which will help them find the most appropriate type of care, be it a home health aid or home health agency in their community that can assist them. The company can prepare a complete plan of care for them. It's a little different from what many people view as managed care under a major medical, which mandates that a certain type or level of care be done. Here it's usually more of an instructional or helpful type of thing.

It is mandated that all long-term-care policies offer an insured two different optional benefits. One is the 5 percent compound inflation rider, and the other is a shortened-benefit-period nonforfeiture rider.

Again, these are issue-age policies, so when people buy the 5 percent compound inflation rider, they are still buying it at one level premium. The premium is not going up every year. As you can imagine, the premiums for the compound inflation are significantly higher than the noninflationary policy, particularly at the younger ages. But that has become encouraged strongly in the sales process, and reasonably so, because otherwise you could have a situation where people buy this at age 40, and then at age 80, when they need the benefits, the benefits are worthless because of inflation.

On the other hand, the shortened-benefit-period nonforfeiture option was developed back in the early 1990s as a result of consumer advocacy. I think less than 1 percent of LTC policyholders have purchased that option. It's unpopular and in many respects unnecessary because of where the lapse rates on LTC policies

have ended up. We'll come back to that later.

I said earlier that there are two types of policies available: the reimbursement policy or the disability policy. The reimbursement policy pays actual expenses up to the maximum, which can be defined on a daily, weekly or monthly basis. A person has to be getting paid care through a nursing home, home health agency or assisted living facility to get paid under the reimbursement policy.

On the other hand, the disability policy pays an indemnity payment just when people meet the ADL or cognitive impairment trigger. They don't need to be getting care. The disability model is a lot simpler to understand and in some respects simpler to administer, but obviously it's a lot more expensive because not only do you cover pay for care seven days week instead of the three or four that you may be getting, but you pay it at the daily maximum. Often on the reimbursement policy there is an inherent savings in that people will have a certain pool of money that they know has to last them throughout their lifetime, and they'll delay starting the claim as long as they can. They'll have a family member take care of them. They'll find community services so that they can preserve that pool of money as long as possible. There is not any incentive like that with the disability policy. There's no reason not to start that payment the day it first meets the trigger. The policy is a lot more expensive, but it's simpler and gives people more flexibility because they can have a spouse quit a job or have a neighbor come in and care for them and still be paid.

Broker World Magazine publishes a survey every year on LTC policies. It shows the premiums that are being collected and gives additional information about the types of coverage that are being sold. While the rest of these results are going to come from the *Broker World* survey, the first one comes from some surveys or studies that the Health Insurance Association of America, now known as America's Health Insurance Plans (AHIP), conducts. It does them only every five years, so we're about due for one again. It's interesting that the policies that pay for full comprehensive benefits—nursing home and home health care—were only 37 percent of sales in 1990. Most of the policies being sold 15 years ago were nursing-home-only policies. That went up to 61 percent in 1995 and up to 77 percent in 2000. When we see the survey results come out at the end of this year, I strongly suspect that we're going to be in the 90 percent range. We don't see many companies offering nursing-home-only policies anymore.

There also used to be a number of companies that would sell home-health-care-only policies. They were problematic in terms of antiselection, particularly because most of them were sold in Florida, which had bad experience and a lot of fraud problems. The stand-alone policies—the nursing home and home health care—have somewhat gone by the wayside; mostly comprehensive policies are being sold these days. Ninety-six percent of policies being sold are the tax-qualified ones. Some companies still are selling nontax-qualified. Usually the benefit triggers are a little looser and would incorporate back in that "medically necessary" trigger, but

again, few sales are being made on that product type these days.

The vast majority of policies are the pool-of-money, the reimbursement type of concept as opposed to the disability income, although a few companies have interest again lately in at least offering the disability product as an alternative for those policyholders who like that more flexible style. There has been a lot more bunching of the production, where we've got a base majority of the sales being sold to the top ten or so companies. A lot of the smaller companies have gotten out (for reasons that we will discuss later), and the market has been dominated by a few of the company leaders.

As far as the types of benefits that companies or individuals are choosing, the most predominant benefit period being sold right now is the lifetime benefit period, where there is not this limited pool of money equivalent to three or five years. Thirty percent of people have chosen lifetime benefit periods where it's unlimited. It's obviously a lot more expensive because not only do you extend the coverage out, but you have antiselection for the most part on the people who choose that option. Because they don't have a limited pool of money, they're not efficient about their care usage. They don't worry too much about whether they have a nurse come in three, four or seven days because they know that there are no limits on their policy. They don't have to try to preserve or extend their pool of money.

One of the things that is interesting is that a few years ago, I think we would have seen the statistic of those choosing the 90-day elimination period being a lot lower. In effect, a lot more people were buying as low of an elimination period as they could buy. They were getting zero days or 20 days, if they could, but 90-day has become a lot more popular. Some of that is because the group plans, including the federal plan, have been 90-day plans, and it has been to save money on the premium side. There has definitely been a movement toward the longer elimination period.

I've gone through the most recent *Broker World* survey, from 2004, which gives the characteristics and premiums of 41 products that are on the market. I'm going to delineate some of them, including miscellaneous benefits that can appear in the policies. The numbers that I give you are the number of products out of those 41 that are offering that benefit.

First is issue age. At one point in time, this product was heavily an elderly product. The average issue age was about 70. It has been steadily dropping. Companies, in fact, have expanded downward the ages to whom they sell it. It used to be common that you'd see the premiums for LTC policies starting at age 50, and they'd sell through age 84. We now see premiums going all the way down into the 20s and 30s because companies have started marketing more heavily at the younger ages. The current average issue age is 60 or 62, somewhere in there. On the group market, it's only about 42. It has become a product predominantly for the working age and the younger ages as opposed to just a senior product.

We've also seen a proliferation in the number of benefit periods and elimination periods that are being offered. Thirty-three out of the 41 companies offer this alternate plan of care, which says the doctor and the company can work together to create a plan of care that isn't specifically covered by the policy, and if it's cost-efficient and effective, they will still pay it. Thirty-four policies have a care management feature, where care advisors at the company help a person put together a plan of care and find the appropriate providers. Thirty-six companies give caregiver training, which means that if you have a family member that you want to have helping you with your ADL, this family member wouldn't be paid, but they will pay that family member to be trained in how to take care of you.

Twenty-five of the policies have endorsed group discounts, which means that if it gets sold to the worksite or the association, they will give a discount. Often it comes at the expense of the commissions. The commissions are lower in those cases. Almost all the policies (39) have what's called the "bed reservation" benefit, which says that if people need to leave the nursing home and go to the hospital for a couple of days, they continue paying that nursing home bed benefit or that nursing home stay so that the bed is reserved for them. Most of the policies (37) waive the premium when people are either in the nursing home or getting home health care.

One of the features that 36 of the 41 policies have, which happens to be one of my least favorite features, is what's known as the restoration-of-benefits feature. It says that if people have a three-year benefit period policy and use up the full three-year benefit period, the wording on the policy says that they then need to fully return to normal activities. They have to, in other words, have recovered for a period of six months, at which point the benefit period will be restored back to the three years. If they have another illness, another accident or something else that causes them to need LTC, they have another full three-year benefit period available to them.

As you can probably imagine, the reason I don't like it is because it has been subject to abuse. If a company is not carefully checking, it's easy for people to get to the end of or close to the end of that three-year benefit period, leave the nursing home, stay with a family member for six months and not have recovered and then get their benefit period restored. It's something that the insurance companies have to stay on top of and check to make sure that people have recovered.

Twenty-two of the policies have a return-of-premium-on-death provision. It's not life insurance; the percentage of the premium that's returned on death usually is 100 percent of the premium up through age 65. It then declines by 10 percent a year through age 75, so there is no death benefit after age 75. It gets a little expensive, although 11 of the 41 companies do offer a full return-of-premium-on-death provision. Some of that has a nonforfeiture option with it.

Twenty-eight of them will pay what they call an equipment benefit, where they pay

for installation of ramps or some equipment in the home to make it easier for the person to stay at home. One of the other trends that we've seen in recent years is a proliferation of the number of inflationary options that exist. The 5 percent compound inflation is the one that's mandated and that companies have to offer to the policyholder. Companies have a number of other provisions. Some have gone to 3 percent; some have gone to 5 percent simple; and some have a guaranteed purchase option, which says that every two or three years, people are given the option of buying additional insurance and that they're then attained age without evidence of insurability.

All but one of the policies have a spouse discount. There is justification in the actuarial experience results, which say that couples who buy a LTC policy are much better morbidity than singles. I think the reason for it is obvious; couples tend to take care of each other for a long period of time. That's recognized in the premium structure of these policies where the spouse discounts are given if both people purchase. Those discounts are all over the place in the market right now. We see them from as low as 10 percent to as high as 50 percent or 60 percent. I think something around 30 percent could be justified actuarially based on the data that we see. That is taking into consideration the fact that a married couple is 50/50 male/female usually. The males have much lower morbidity on LTC than the females do. When you get to the single policies, it's predominantly a single-female policy, so that also drives some of the cost difference.

Joint waivers means that if one person is in the nursing home, the premium on the spouse is waived. That happens in 27 of the policies. Twenty-eight of them have some limited payment options, where you can pay for 10 years, single pay or pay up at 65. Some of them have a survivorship benefit, which means that if the spouse dies, the remaining spouse has the premium paid up—the premium on the remaining spouse is waived at that point. Some of them (11) have rate guarantees, which isn't common in the market right now. It's much more common on the group insurance side. There are some shared-benefit-period policies out there (17), which say that one married couple will buy one policy and share the pool of money. They are a lot cheaper. Some of them (11) are paying monthly instead of daily.

Let's get into some of the economics or the pricing considerations of LTC. The policy in the past, from a regulator standpoint, has had a lifetime loss ratio requirement of 60 percent. That has changed recently with the new revision to the NAIC model regulation that has been enacted in a little over half the states that did away with the loss ratio regulation and went to a requirement that the actuary has to certify that there's a provision for moderately adverse provisions. As a result, the premiums have gone up, and the expected loss ratios have come down. Expected loss ratios for most companies now are somewhere in the 50 percent to 60 percent range.

The morbidity curve for LTC is steep. In fact, it's even steeper than what a mortality curve looks like. When you have issue-age premiums with an extremely

steep claim cost or morbidity curve, a number of things become important, including the lapse rates and the investment income assumption. The reserves that you're setting up are funding that complete difference between the claim costs and the premium in those early durations and paying for that difference in the later durations. The economics and the pricing of this are different from a lot of health products because most health products are major medical and attained-age-based, and the premiums step rate up every year. It's more similar to disability income, but there are a lot of similarities with life insurance and how life insurance is priced.

The commissions right now tend to be heaped. The first-year commission is high. For some companies, the total first-year compensation can be around 100 percent of the first-year premium. We have significant first-year cash-flow strain. There's significant cash-flow strain in the second year, too, because that's when the active life reserves are set up. There's a one-year preliminary term method being used. I'll show some examples of what that looks like in a minute.

The lapse rates on this product are extremely low, and we'll come back to that, too. The statutory reserve standards are probably appropriately conservative and have become more conservative in the past year. The reserve standard was just modified in 2004; it's being implemented in states right now. There have not been many that have passed it so far, but it is being rolled in. There are required margins for conservatism. You can incorporate both the lapse rate and the selection factors in the calculation of the reserves, but you have to be conservative in the lapse rate that you use. The past standard has always said that you can use only 80 percent of the assumed lapse rate for years one through four. Starting in 2004, one of the new things that was added or changed was that the regulation says you cannot use a lapse rate higher than 2 percent ultimately in creating your active life reserve standards. Even if your own experience says that it's much higher than that, you're limited to the 2 percent. It's a little higher on group, but 2 percent is the individual standard.

We use a one-year preliminary term method. The past provision would use a 1983 Group Annuity Mortality (GAM) table. That has been updated to the 1994 GAM table, starting in 2004. The other change that was made in 2004 was that the regulation expressly says you cannot assume that the morbidity will improve over time. We have seen LTC morbidity improving steadily for the past 20 years, ever since we starting measuring it in the population, at least. Some research has been done at Duke University that would indicate that the improvement has probably been around 1 percent per year. Some companies were building that into their pricing and therefore into the reserve assumption. This change in the reserve assumption for 2004 expressly said that you can't build it into the reserves, so even if you think that it's going to happen, you have to keep that out of your reserve standard and get some more conservatism in.

There is a lot of capital strain on this product. It's a capital-intensive product, which has scared many companies away from it. I mentioned earlier that commissions are

high the first year. The active life reserves are steep due to the steep morbidity curve, particularly when you add inflation coverage because not only do you have the steep morbidity curve, but then you're also adding 5 percent of the benefit every year, which steepens it even more. The active life reserves that you have to put up in the early years are high. The risk-based capital (RBC) requirements have been high. In the past, the minimal RBC level on the C-2 risk has been to establish 5 percent of claim reserves, plus 25 percent on the first $50 million of premium and 15 percent of anything beyond that. In many respects, that type of RBC standard was turned around from where the real risk was on LTC, and that was recognized recently. An Academy committee did a significant amount of work in studying what the right RBC pattern should be for LTC and ended up recommending something that would be totally claim-driven instead of premium-driven, so that you're holding more RBC in the later years when the claims become high.

The regulators weren't completely enamored with that. They still wanted some premium component, so we ended up with a compromise that kept in the 5 percent of the claim reserves, kept a component that was related to premium but down from 25 percent to the 10 percent and then added in a component that was related to the claims. This is less stringent. It's not as bad as the prior RBC in terms of the capital strain, but it's still significant.

I want to briefly show a couple of pricing examples of what some of the impacts of the pricing assumptions can be. Because this is a new product, there has been a fair amount of riskiness or experimental nature of this product in terms of the claim cost assumptions in the past. When this product was first priced, we had only population information available, such as National Nursing Home surveys and National Long-Term Care surveys. It has only been in recent years that we've started having some good insured data to look at. With the insured data that we have, we have some good credible data now, but we still don't have the tail of that claim cost; we don't have a lot of experience out in the 1990s. The experience that we have shows the claim costs starting to come down if you apply the claim costs to a total exposure basis, because so many of the people are already in the nursing home that there are fewer of them to expose or to be exposed to the claims. It's not looking like the tail is that bad at this point, but there is not a lot of insured experience.

We can get some different premiums on this product depending on what profit standard or profit measure a company uses. Again, it's because this is a level premium product, and there is so much prefunding going on at the younger ages.

Chart 1
Effect of Various Profit Criteria (No Inflation)

Profit Criterion	Annual Premium—No Inflation* Issue Age				
	42	**52**	**62**	**72**	**82**
10% pretax (6% discount)	$222	$422	$847	$2,308	$6,707
5% posttax** (6% discount)	$220	$419	$841	$2,292	$6,655
60% loss ratio - excluding reserves (4.5% discount)	$301	$539	$989	$2,511	$6,639
15% IRR**	$280	$493	$938	$2,410	$6,582

* 90-day, 4-year option, $100/day NH, $100/day HHC; composite of risk classes & marital status
** Uses 2.0 * RBC of: 2% of claims liability + 15% of premium
Reserve Standard: 4.5% discount, '83 GAM

In Chart 1 above, for age 42, for example, some of the common profit targets that might be used by companies would be to go for a certain 10 percent pretax profit margin. That is close to being equivalent to a 5 percent posttax profit margin. You get a different result if you price for a 60 percent loss ratio. You can see back before the change in the loss ratio standards that a company that had to meet a 60 percent loss ratio standard could get a different premium from one that was going for a certain profit margin. A 15 percent internal risk of return (IRR) standard also is different from the 10 percent profit standard here. Those differences that the table showed were if you looked at the premium for a policy that did not have that 5 percent compound inflation option.

Chart 2
Effect of Various Profit Criteria (With Inflation)

Profit Criterion	Annual Premium—With Inflation* Issue Age				
	42	**52**	**62**	**72**	**82**
10% pretax (6% discount)	$1,092	$1,480	$2,089	$3,973	$9,165
5% posttax** (6% discount)	$1,076	$1,465	$2,072	$3,946	$9,095
60% loss ratio - excluding reserves (4.5% discount)	$1,714	$2,064	$2,595	$4,479	$9,196
15% IRR**	$1,525	$1,869	$2,428	$4,298	$9,168

* 90-day, 4-year option, $100/day NH, $100/day HHC; composite of risk classes & marital status
** Uses 2.0 * RBC of: 2% of claims liability + 15% of premium
Reserve Standard: 4.5% discount, '83 GAM

Chart 2 above shows the premiums for the same policy, which I'm pricing to be a 90-day elimination period for your benefit period policy with the old RBC and old reserve standards. The premium for the inflation option is much higher, about five times the premium for the noninflationary policy at the younger ages and about 30 percent higher at the older ages. There's a lot more potential variability that goes on at the younger ages with the different criteria.

Chart 3
Expected Policy Year Financials (Noninflationary)

	Noninflationary					
	Year 1	**Year 2**	**Year 5**	**Year 10**	**Year 20**	**Lifetime***
Premium	100%	100%	100%	100%	100%	100%
Investment Income	-1.0	3.2	16.5	42.3	123.1	40.9
Total Income	99.0%	103.2%	116.5%	142.3%	223.1%	140.9%
Claims Incurred	7.5%	11.9%	28.5%	57.7%	162.4%	60.8%
Active Life Reserves	0.0	63.5	59.2	50.1	.4	34.8
Expenses	126.5	25.0	25.6	23.0	23.3	35.3
Total Outgo	134.0%	100.4%	113.3%	130.7%	186.1%	130.9%
Pretax Profit	-34.9%	2.9%	3.2%	11.6%	37.0%	10.0%
*Discounted at 6%						

Chart 3 above gives you an idea of what the expected policy year financials would look like on this product. I've put in the 10 percent pretaxed profit premiums in doing this calculation, 10 percent by age, so when you get over to the lifetime column, the lifetime-discounted results are 10 percent. In the first year, there's a significant strain. You're losing about 35 cents per dollar because of the high commissions and high expenses that are being paid. The second year is barely breaking even. The loss ratios are low in the early years—7.5 percent in the first year—but the expenses are high. In the second year, the reserves being established are high.

Chart 4
Expected Policy Year Financials (Inflationary)

	Inflationary					
	Year 1	**Year 2**	**Year 5**	**Year 10**	**Year 20**	**Lifetime***
Premium	100%	100%	100%	100%	100%	100%
Investment Income	-.6	3.1	20.3	57.8	191.7	75.7
Total Income	99.4%	103.1%	120.3%	157.8%	291.7%	175.7%
Claims Incurred	3.3%	5.4%	14.3%	34.9%	136.4%	62.8%
Active Life Reserves	0.0	84.2	90.4	99.1	95.2	69.0
Expenses	122.6	25.1	25.4	22.3	21.9	34.0
Total Outgo	125.9%	114.7%	130.1%	156.3%	253.5%	165.8%
Pretax Profit	-26.5%	-11.6%	-9.8%	1.5%	38.2%	10.0%
*Discounted at 6%						

It gets even worse when you look at the inflationary policy (see Chart 4 above). In terms of what the reserve standards are in the second year, the loss ratio is lower, but the reserves are even worse.

Chart 5
Broker World Survey (2004; 42 Products)

$100/Day; Single Preferred; 100% HHC; 90-Day EP				
Age	**Range Min.**	**Range Ave.**	**Range Max.**	**Max./Min**
3-Year Benefit, No Inflation				
55	$348	$452	$642	184%
60	$468	$609	$862	184$
65	$668	$904	$1,322	198%
70	$1,078	$1,476	$2,333	216%
3-Year Benefit, With Inflation				
55	$730	$1,059	$1,904	261%
60	$861	$1,306	$2,215	257%
65	$1,002	$1,735	$2,915	291%
70	$1,563	$2,522	$4,660	298%

There is significant variability in the market on what the premiums are that companies are charging. Chart 5 above goes back to the *Broker World* survey and looks at a three-year benefit period, 90-day elimination period product, and looks at what were the lowest and highest premiums in that survey. It's about a 2:1

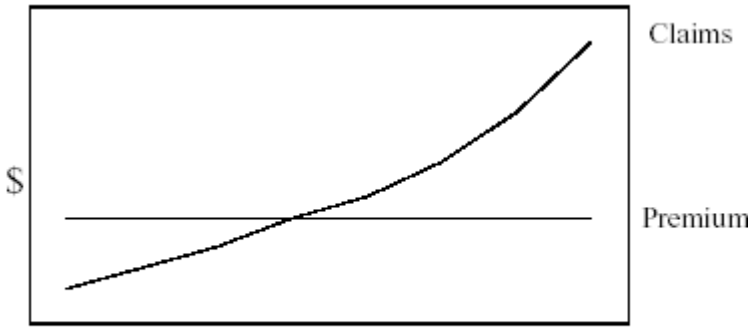
difference between the lowest and the highest companies out there in terms of the premiums. There are some major differences. When you add in inflation, it's even worse.

Chart 6
Broker World Survey (2004; 42 Products)

Age	$100/Day; Single Preferred; 100% HHC; 90-Day EP Range Min.	Range Ave.	Range Max.	Max./Min
	Unlimited Benefit, No Inflation			
55	$540	$741	$1,032	191%
60	$720	$1,006	$1,428	198%
65	$1,075	$1,488	$2,273	211%
70	$1,782	$2,416	$3,641	204%
	Unlimited Benefit, With Inflation			
55	$1,103	$1,722	$3,176	288%
60	$1,374	$2,200	$4,070	296%
65	$1,612	$2,931	$5,581	346%
70	$2,584	$4,215	$7,676	297%

It's similar when you look at the lifetime benefit period in Chart 6 above, where there are significant swings and differences in the premiums being charged.

Chart 7
Importance of Lapse Rates



PV of Premiums = PV of claims + PV of expenses

(All with lapse assumption)

Regarding lapse rates, Chart 7 above shows you the results of a couple of the key assumptions on the premiums. I commented earlier that because this is such a steep claim cost curve, the lapse rates and the investment income are key to the pricing of this product. There's a squiggly line, but it shows you the level premium concept in the high curve on the claims, so you can visualize what the effect of the lapse is going to be.

Chart 8
Lapse Rate Trends (Pricing Assumptions — Age 65-69)

Early Policy Generations			
Policy Year	**Company A**	**Company B**	**Company C**
1	18%	20%	40%
2	14	15	20
3	10	10	8
4	7	8	8
5+	7	6	8

This product was mispriced, but I think that when we started out with this product back in the 1970s and 1980s, the only other product being sold at the senior market was either some senior life insurance sales or Medicare supplement. Those products all have lapse rates that look something like Chart 8 above. They were high in the early years, coming down to ultimate lapse or voluntary lapse rates of 7 percent or 8 percent. It was assumed that since the premium level on this product was similar, and they were sold to the same type of people, it would have the same lapse structure.

Chart 9
Recent Lapse Experience

Policy Year	Company D	Company E	Company F	Company G
1	2.0%	4.0%	7.0%	6.5%
2	1.5	2.5	4.2	4.5
3	1.0	2.0	2.7	3.5
4	1.0	1.5	2.1	2.5
5	1.0	1.5	2.0	1.5
6+	1.0	1.0	1.5	1.5

Chart 9 above shows what we've seen recently. Oops is right. The actual lapse rates have been extremely low in the ultimate durations, which means that we're getting a lot more people to that point on the curve where the claims are high. It's had a significant impact on the premiums that have been charged.

Chart 10
Effect of Lower Lapse Rates

	Priced Lapses	Revised Lapses
Year 1	5%	4%
Year 2	4	3
Year 3	3	2
Year 4+	2	1

Item	Age 42	Age 62	Age 82	TOTAL
Pretax Profit (No Inflation)	-1.5	5.1	9.5	5.1
Premium Change Needed	17.9	8.0	0.9	8.1
Pretax Profit (with Inflation)	-7.8	2.9	9.2	0.5
Premium Change Needed	27.8	11.6	1.5	15.3

If I take that premium example that I developed earlier, if I had priced that originally as a set of lapse rates of 5, 4, 3 and 2, and if I bring those lapse rates down by one point (again, this was the set of premiums that produced a 10 percent pretax profit margin), the first line of Chart 10 above shows what happened to that profit margin after I brought the lapse rate down just one point. My 10 percent profit went down to 5.1 percent. The second line shows what I would have had to do to that premium to get it back up to my 10 percent profitability. The age-42 premium would need to have been increased by 18 percent with just the one-point drop in the lapses. The bottom half of the table shows the same thing, but with the inflationary policy. Because I've just deepened my claim cost curve that much more, it's that much worse. My age-42 premiums should have been 28 percent higher on the inflationary policy with the one-point drop in lapse. Going back to when that policy was first priced in the 1970s and 1980s, assuming an ultimate of a 7 percent or 8 percent lapse rate but it's coming in somewhere between 1 percent and 2 percent, you can imagine what has happened to the premiums over the years as a result.

The saving grace is that the claims morbidity for companies that have done a good job of underwriting has come in a lot better than what everybody expected. There have been notable exceptions, and those have been the ones that have not done a good job of underwriting. For the ones that did, the claims experience has been good, though probably not good enough to offset those extremely low lapse rates.

Chart 11
Effect of Lower Change in Investment Income

Priced Investment Rate = 6% Revised Investment Income Rate = 5%				
Item	**Age 42**	**Age 62**	**Age 82**	**TOTAL**
Pretax Profit (No Inflation)	-1.8	4.2	8.6	4.4
Premium Change Needed	18.5	9.4	2.7	9.4
Pretax Profit (with Inflation)	-7.5	2.1	8.3	0.2
Premium Change Needed	27.5	12.9	3.3	16.0

The other factor that's had a material impact on results recently has been what's happening with the investment income rates. Again, that 10 percent pretax profit margin that I assumed earlier was done using an investment rate of 6 percent. If I drop that now to 5 percent, my 10 percent profit goes to 4.4 percent, as shown in Chart 11 above. There's such a heavy buildup in the reserves. It goes all the way down to 0.2 percent on the inflationary policies, and the inflationary policies would have needed a 16 percent increase in premium to account for that one-point drop in investment earnings.

When you hear about the rate increases that have taken place in LTC in recent years, or the increases in the new-business premiums that are being charged, those last two factors that I just mentioned are the two primary reasons. It has not for the most part been the claims experience; it has been the lapse rates and the investment earnings.

There are a lot of other factors that can impact the profitability. There are the spouse discounts that are being used, the percentages of people who are purchasing who are married and what kind of preferred risk discounts you might give. All those things affect profitablity, too.

We have seen a real upsurge in lately in the combination product market, where LTC is combined with universal life (UL) insurance or with annuities. Lincoln National has the MoneyGuard product that is popular. Golden Rule has what's called "Asset-Care." John Hancock and New York Life have products, and those are some of the leading products in the industry right now. It's estimated that the sales on those products in 2004 were about $500 million. Most of the sales right now are single-premium UL.

There are some annuity products being sold. It's a similar target market to the

people who are buying LTC because it's focused on the 50- to 70-year-olds, which is where individual LTC is being sold right now. It's about the same percentage of women who are purchasing the products. The asset base might be a little higher than the ones who are traditionally buying LTC. The key difference is that the combination products are sold by the traditional life producers, who are more comfortable selling a product that will either accelerate the death benefit or accelerate the death benefit and then add some kind of LTC extension of benefits on to that. Then they are picking up a LTC policy and selling it. In a sense it's a way to get LTC coverage to more people through the life insurance sales, because those agents are more comfortable with this product.

There are two ways that the product can be structured. In all cases, there are three variables: the pool of money, which is always equal to the face amount, in this case; a monthly maximum; and a benefit period. One of the models that is out in the market would define the benefit period and then back into the monthly maximum. The other would define the monthly maximum and then back into the benefit period. Either way you get to the same result. There also are a number of different options or designs that combine both annuity and LTC. There's lot more variability in the market on what those could look like.

With that I'm going to turn it over to the administrative side of things for Steve.

MR. STEPHEN ROWLEY: I'm going to start with a little disclaimer. I hate the fact that the SOA records all these sessions. People are starting to use these recordings in court. I'm going to start with a disclaimer saying, "I'm giving my opinions. My opinions change from day to day, and if you use this cassette against me, I'll say that's the mood I was in that day." There goes that, and that's the beginning of any deposition. I'm covered.

I'm going to talk today about underwriting, form language, claims management, a little bit on technology and partner versus build.

Regarding underwriting, you're going to see a recurring theme throughout this and the next session: trust but verify. That's an important part of underwriting. Few companies truly measure their experience against their underwriting. They think that diabetes *might* be bad, good or otherwise. Most companies did not do a great job of coding at underwriting time or at claim time, and then they look back and say that this stroke stuff is bad. It hasn't been done well in the industry. It's being done better. Some of the TPAs are doing better, and some of the larger companies that have the resources to do this are doing better, but it hasn't been done well, and that's probably from the underwriting side. One of the biggest struggles we have is: Do we know this is right? No. We're taking an educated guess based on research and some statistics.

Among the tools in underwriting, the application has come a long way. The applications for LTC are the worst-completed applications that I've seen in any

insurance industry. Agents, applicants or whoever you want to blame genuinely don't answer the questions correctly or in any degree of detail. The only question that's of any value in my opinion is: What medicines are you on? For some reason people answer that. They'll tell you about their diabetic medication, but they'll check "no" to the diabetes question. The application is not the most productive thing that we have.

We get face-to-face assessments. Those are more valuable in our industry. We want to get somebody out there looking at the person. Can you walk across the room, or are you already waiting to go on claim? That generally is being done between 70 and 72 and above in this industry. A few years ago, it was much higher. There is still one company that doesn't have a mandatory age for that (it's not reinsured by us). But that's coming down. Personal history interviews are required across the board in this industry. Largely there's a poor application completion. We're getting a tremendous amount of information in the interviews. These are not life interviews in three minutes. They can run 15, 20, 30 minutes or longer, and many of them include cognitive testing.

The Medical Information Bureau (MIB) is something that in life is a gold standard and in disability is a gold standard. In critical illness, it's starting out that way. We can't get the LTC industry to play seriously with MIB. It has been frustrating because it's a great tool. About one-third of the companies use MIB, and they tend to be the smaller companies. It's a frustrating thing, but I think that will change over time.

Cognitive testing is a huge and important part of underwriting. A lot of claims, such as a fall or fracture, should be a fairly short claim if managed correctly. As Dawn said, we're underwriting people down into their 50s and 40s, and we have cognitive claims on people in those ages. Those are going to last a long time, and we're going to spend a lot of money. There's no cognitive test that's perfect. There are many out there, including the delayed word recall (DWR) and the Enhanced Mental Skills Test (EMST), which has recently come out and is looking pretty good. Time will tell. That's based on a lot of clinical experience. The Minnesota Cognitive Acuity Screen (MCAS) seems to be a strong one. Then there's the Mini-Mental State Exam (MMSE), otherwise known as the Fulstein, among a handful of others. These can be done telephonically or on a face-to-face assessment. Most companies get them above the age of 65, while some get them on all lives. There's an indication for the added cost of getting a cognitive screen on a 40-year-old. It takes only one claim on a cognitive claim to pay for a boatload of these. They are going down in age.

We're moving back to that trust but verify, and we're getting more information and more attending physician statements (APSs). APSs were not common in this industry, which was one of my biggest frustrations when I got into LTC. The applicant is diabetic. Is it well-controlled? Yes, because the applicant told you that the diabetes is well-controlled. He just saw the doctor three short years ago. APS is one of those penny-wise and pound-foolish things. Today we're getting many APSs.

We're getting better now as we're trying to trust but verify.

Let's talk about form language. I'm opinionated, so I'm going to tell you that there's some stupid stuff out there. Dawn talked about indemnity with a limited cash benefit. The indemnity products that are going to pay you regardless of your actual cost of care and counterintuitive to insurance in general are disability, auto, homeowners and medical. You get a tooth pulled, and we're going to give you $5,000. That doesn't make sense. At $100 a day, that might be fine, but we have indemnity paying $500 a day, and one company is advertising no cap. You can buy an $800- or $900-a-day indemnity plan and be receiving $50 a day of care. Who here thinks you have a claims department smart enough to get that person out of claim? Nobody? This is an LTC meeting. Everybody could do that with no problem. Indemnity is a huge concern.

What about medical necessity? It's the same thing. It's in the old nontax-qualified (NTQ) policy. I don't think it fully does this, but to a large degree it is saying that the physician can decide whether you're going to pay benefits or not. I want to go back to other insurances. You don't have garages telling Geico, "I'm going to turn this Hyundai into a Cadillac and bang out every fender. It will look a lot different, and I'm making the decision that that needs to be done." They're protecting themselves. Medical necessity is, in my opinion, a foolish trigger. Stupid is as stupid does; somebody has it, so somebody else has to go and get it.

Some have high daily benefits. We get the agents saying, "We need $500 or $900 a day." No, they don't. The one that they do sell at that level is going to go on claim, but the average sale is still $109 a day, according to our most recent surveys. The high daily benefits are going to change. One thing I always say is, "Money changes people's behavior." That may not be as true in life insurance, but I suspect it is true to a degree. My background is DI, and we know that money changes people's behavior. In LTC, I believe it does also.

There also are soft benefits. I could lump them in with the "just-in-case" claims. Dawn talked about the triggers. You're unable to bathe, dress, eat or toilet. Those aren't our claims. Our claims are the person who says, "I think I might fall, and if I do, I might trigger the policy, so why don't you have someone come in here to make sure I don't fall and become ADL-impaired and go on claim?" To a lot of companies, that seems like it makes sense. I tried that. I called Geico and said that I had a feeling I might get into an accident, so it should replace my car with a Volvo because it's safer. The company didn't think that that was a good idea, but it made a lot of sense to me. I'm sure you life people have people calling and saying, "I think I might die, so could I get my life proceeds now, go on claim and have a vacation?" The LTC industry does that. The "just-in-case" claims are huge. The claims that we're seeing are bathing, dressing and "I think I might fall. Not that I ever have, but I think I might." They're there.

The zero-day elimination period requires nothing out-of-pocket. In life insurance,

that dying thing is a major trigger. Almost every other insurance requires some "skin in the game" by the policyholder, whether it's dental, auto or homeowners'. Get that 90-day elimination period, and a lot of people will not claim because they're on these soft claims, the "just-in-case" claims. They'll have to pay out-of-pocket before you start paying. I think that if they have to pay out-of-pocket, these soft claims at least are going to be deferred.

Let's talk about form language a little more by specifically defining benefit provisions. Cognitive impairment seems clear and simple, but it's not. Most, but not all, policies say that severe cognitive impairment means that you're a threat to yourself or others. I'm not sure what that means. I don't know how to define severe cognitive impairment. Does it mean that you've been a threat to yourself? You have left the stove on; you think you might; or, most likely, you're in Florida, and your daughter in New York thinks that you might leave the stove on. Because you've got a zero-day elimination period for $500 a day, send somebody in to take care of you.

It's hard getting at the ones who are truly cognitively impaired, are becoming cognitively impaired or are a little forgetful. I thought these were black and white from the underwriting side, but try to define that. We just finished having a major discussion with one of our reinsurance clients, who had a nice provision that said, "You have to have clinical evidence of cognitive impairment and fail these standardized tests." They thought "and" meant "or," so we offered them a couple of things. They could pay premium "and pay claims," or maybe "or will pay claims." We gave them a few possibilities to think about what "and" and "or" might mean. Cognitive sounds like the easier trigger, and it's not. What is severe? What is threat? How do you measure it? The more you can do with internal procedures to be consistent and fair, the better.

ADLs also sound clean and clear, but we get into whether it's hands-on or standby. Is it standby at arm's length? But with standby, you've got your home health aide sitting in a room watching Oprah Winfrey while you're on the toilet, and if you fall, all she's going to do is call the ambulance. That's not helping the person. That is not needed. At least with standby at arm's length, you're helping people steady themselves while they're trying to get there or trying to get dressed in the morning.

What about homemaker benefits? Regarding the homemaker ratio, one thing we perceive is that we get the people who are on a bathing-and-dressing claim, and they almost all are because they think that they might fall and that may require a home health aide coming in for an hour or two in the morning to get them up, bathed and dressed. I don't know whether any of you have parents or grandparents in their 80s. These people aren't jumping in the shower every day unless they have LTC, and then we're paying for a bathing visit every day, but they are not bathing. Hopefully they're dressing every day. What we're seeing is eight hours a day given to these people or more, and it appears that they're trying to access the homemaker benefit. That's pretty nice.

For the most part we're not mowing lawns and stuff. We're making the meals, doing a little light housekeeping and going shopping for them. It's fun when you look at some of these care plans and see that the person has to grocery shop every single day for an hour and a half. That's what we're seeing. It's probably not happening. Or the husband and wife are both on claim, and the aide shops an hour and a half each day for each of them. That's probably not happening, either.

One thought that I have is that the homemaker benefits are nice to help people stay in their home if the benefits are tied somehow to the skilled care so, for example, they're receiving two hours of skilled care a day for the homemaker benefits to be 50 percent an hour. So over the course of a week, if it's every day, that's seven hours to do light housekeeping and things like that. Somehow it's a ratio, because what we're seeing is that the homemaker benefit is a majority of claims, and I don't think it was priced that way. I know we weren't thinking about it at underwriting time. These are my opinions.

Claims management is not life insurance or medical supplement. How do you manage a life claim? You stick a mirror under their nose, right? If it fogs, you don't pay the claim. Life language is pretty simple. However, I will tell you that I recently found out that even with life, sometimes you don't phrase things as well as you should. We do it all the time. I'm originally from Springfield, Mass., and a Springfield police officer was killed a couple of years ago in the line of duty in a car accident and was resuscitated. His group life policy did not state "permanently dead" or "declared dead by a medical examiner." It just said "dead." The ambulance guy said, "He was dead. I brought him back to life," and the insurance paid. I suggest that if you don't have it, "permanent death" is a good thing. Temporary death is bad.

Our claims are long, ongoing relationships. We have lots of opportunities to make mistakes. In theory, we have a lot of opportunities for success. Look at the initial eligibility. Are you impaired? How severely are you impaired? Do you need two hours a day? Do you need eight hours? Do you need 24/7 live-in care? Do you need home health care? Do you need nursing home care? That might be different three weeks from now. If it's an orthopedic claim, such as you fell and broke your hip, it should be a high front-end claim and then taper down to recovery. If it's a chronic or a cognitive claim, it might start out as a little bit and would ramp up to 24/7. There are a lot of touchpoints along the way, which means that there are a lot of opportunities to manage it right and many opportunities to manage it wrong. This isn't an easy claim to administer.

I like to view the claims staff as a contract administrator, because they love paying claims that are not in the contract. "If it were my mom, I'd want to pay it." Me, too. I want my dad's death benefit paid now, but I can't find a life insurance company to do it. I get all sorts of reasons that claims are paid. "She seemed sick." Did she meet the criteria? "No, but she's not doing that well." If it's in the contract, we'll pay it. If it's not, we're only going to get a rate increase to cover it. Dawn

mentioned that these are priced to stay level, and we all hope for that. I don't know whether *Broker World* has ever done it, but it would be fun to look around and see how many have stayed level. We've had huge rate increases. The part of me that wants good claims management is not to be a jerk; it's to keep prices down. It's unfair. We're jacking the heck out of rates on these seniors on fixed incomes. Some of it is because we're not doing a good job of being gatekeepers and keeping those who shouldn't be on claim, off. This goes across the industry. I don't care how big or how small. This isn't one company that did this; this is a lot of companies.

The focus should be on recovering, not on enabling. The nurse-caregiver model that the industry put out there has had some successes but has also had nurses making the decisions. Nurses are trained in caring for people and being nice to people. "No" usually comes from doctors. "I'd love to take care of you, but Dr. Smith said that I can't give you your OxyContin today." They haven't been focused on recovery.

I'm going to talk later about occupational and physical therapists, They're trained from day one to get people back to work, which means back to recovery. I think recovery is the direction we have to go toward. I don't think that we're doing a bad thing if we get an 85-year-old woman who fell and broke her hip back to independence. Does anyone think that's bad if I can bring people back to their independence? I don't, but when you enable them and give them eight hours a day when they need two, they get used to it. Some of them are lonely and like the person coming.

When deciding whether to partner or to build, there are pros and cons to both. TPAs play a major role in the LTC industry, both big companies and little. I'm surprised. They have a lot of knowledge and a lot of information. They help companies enter it quickly. You don't have to build your systems or your claims staff. Claims staff is never built anyway until claims are out of control. They've got that for when the day comes. They have the underwriting staff, so it's nice.

If you use a TPA, it's still your money. (If any of this sounds obvious, I apologize, but the LTC industry is stupid is as stupid does.) What we've seen is a failure often of the direct writers (and some of these are big companies) to manage their TPAs. I've had large, reputable companies, whose names you know, look at claims and ask, "Why was this claim paid? It didn't make a lot of sense to us, but the TPA said that it should be paid." Whose money are you spending? You're not spending their money; you're spending your own money. Large, monster mutual companies that have called TPAs saying, "We think you should do this," have been told, "No, you're wrong because this is how we do it." It's your money. If you're going to use a TPA, please manage it aggressively and make sure the expectations are clear. If it doesn't deliver, make it pay. If it does, reward it.

Most TPAs, unfortunately, have no vehicle to have skin in the game. Their interests are not always aligned with the insurer's interest. I don't know any that are this malicious, by the way, but you could argue that it's to their benefit to issue a bunch

of policies. They get to put all those policies on the administrative system and get their fees for that. If they all go on claim, they get paid to manage the claims. If you're not minding your Ps & Qs, you could argue that it's there. The worst case I've seen of that is when we had one deal where the TPA was paid X percent of claim dollars paid. To get it to manage the claim down, the TPA is going to have to spend more resources and get paid less to do it. I apologize if I sound as though they're bad, because they're not. There are some knowledgeable people. But you're remiss in your responsibilities if you don't firmly say, "This is what I expect of you, and this is what I'm going to enforce." Trust but verify. Don't be penny-wise and pound-foolish.

We had a company a couple of years ago that was all excited because the marketing organization agreed that it would pick up the total cost of underwriting and do the underwriting for the company. The company thought that was a good idea because it was going to save a lot of money in underwriting. The claims weren't going to come in until the actuary left the business. Manage your business. Trust but verify.

MR. JESSE SLOME: I'll start with my comments, then ask two questions of you, go through some of this quickly and then leave a few minutes for questions and answers, which I think are the best part of any program.

I come from outside of the industry as a true marketer. With any marketing of any product, there is a way. It goes up and down. Every product has it. Typically companies have multiple ways, or any product has multiple ways. We are at an interesting point with LTC. We are at a transition point between Phase One for a product, which is our introduction of a product from a marketing standpoint in terms of consumer awareness, media awareness, government awareness and all of that, and Phase Two. Phase Two will be dramatically different. One can only conjecture what Phase Two is going to look like, but get ready, because over the next several years I believe that you're going to see market differences in products.

I want to ask you two questions because you're a divergent audience. We have some 20-year-olds, and we have some that are older than 20. This gets into the core essence. Only a couple of you raised your hands at the beginning and said that you were interested in bringing LTC insurance to your company, so you're obviously here for other reasons. How many of you have a family member or a loved one who has experienced a need for long-term care? There's the market. The second question is: How many of you have received a solicitation for LTC insurance through the mail or other means? What's interesting is that there are fewer hands on the second question. That is the essence of the marketing of LTC insurance. It's about that word "care." It's about caregiving.

The sale is made in two areas. If you look at the distribution, the companies and the models have been based on people who have directly experienced the caregiving issues and problems. As you heard, why are people out there selling

lifetime policies? Why are they out there selling high benefits? First, it's commission-driven. But second, it's because they've directly experienced that caregiving issue, so the agents who sell this take it personally.

Because you looked around the room and probably 95 percent of the hands went up with the caregiving issue, you now understand what's going on around the country. The statistics clearly show that we are living in an age where we all encounter that caregiving issue. We will be exposed to it first-hand. From the marketing standpoint, we will all—the consumer and the market out there—have the experience. Are sales going to happen? Yes. Why haven't they happened up until now? Because we're still in Phase One. The inevitable question is: When does Phase Two start?

My two minutes are going to be used to get a few more of you to raise your hands and show interest in bringing products out to the market. To help you do that, I would suggest that you contact the Government Accountability Office (GAO), which issued several incredible reports. One was issued April 27, 2005, called "Long-Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets." This is the director of health care for Medicaid and private health insurance issues testifying to Congress.

Here are two of the facts. Spending on LTC services just for the elderly is estimated to increase by more than 2.5 times between 2000 and 2040. I'm not an actuary, but I learned enough working inside insurance companies to know that people can play with numbers and make things grow easily, but when you start talking about constant dollars, it's different. It could nearly quadruple in constant dollars between 2000 and 2050 to $379 billion. A lot of money is going to be spent on it. There's a lot of awareness, a lot of need and a lot of risk.

The second point becomes the key. As the estimated 70 million baby boomers become elderly, Medicare, Medicaid and Social Security will nearly double as a share of the economy by 2035. While the president is making the debate about Social Security, clearly the debate right now, underneath and behind the scenes, is about Medicare and Medicaid. What will inevitably happen is that government can't pay the bill, so you have a market out there of educated, savvy, primed and ready buyers, who understand enough, who are being solicited and who are going to buy. At the same time, you have the government that has paid the bill up until now but can't continue to do so.

The third aspect is that you have a primed media. In the success of any product, especially in the insurance industry, the media plays a critical role. If you think about what I call the 401(k) analogy (because I used to wholesale and market 401(k) plans), when 401(k) plans were introduced in the mid-1980s, the first articles in the magazines had to describe what they were and why they had this wacky name. It took several years for the media to look and to suddenly say, "This is the greatest thing since sliced bread, and you should be maximizing your

contribution into your 401(k)." You don't see those types of articles anymore. You see articles about how you should diversify and how you should start planning for your retirement. The media has become far more aware and far more educated, and the same thing is happening in LTC.

Dawn and I gave an interview to an insurance reporter at *The Wall Street Journal*. He was sitting there with five policies on his desk that he was reading. I've not read five policies, and here he was dissecting them and looking at them so that he could give consumers good, proper advice. When all three of those things happen together—a consumer marketplace that's ready, a government that can't afford the bill and is primed and ready to tell people that, and a media that's ready to tell people that this is a good thing—you have a marketplace that is going to take off. Toward the end of the report, it says, "We have to do something to encourage people to take personal responsibility with insurance."

I could go through and tell you what people are buying, what they aren't and why they're buying, but all of that is looking back. You read all the bad news, and it is amazing to me how we in the insurance industry do a bad job of countering bad news. You read about declining sales. At the same time, there are companies that are experiencing 20 percent sales growth. So first, I'm telling you that while there's concern and caution looking forward, the market is primed. Two, people are out there experiencing growth. The perspective on marketing is positive.

FROM THE FLOOR: What about poor underwriting in the past?

MR. SLOME: Steve talked about that from a marketing standpoint. That is a real concern because it's hitting people, and it is experience. The issue from a marketing standpoint is that a lot of that is old business, and you get a lot smarter. If you bought a car today that had 1980s technology, it would not be a smart buy. The industry has to do a good job of telling people that we've learned a lot.

MR. ROWLEY: It is a frustrating thing for the industry to realize that and think that we're hitting some real people, and there are lapses happening to people who are going to need this care. The rate increases have been disturbing for everybody. Dawn talked about a lot of the pricing. It seems that we thought Jimmy Carter was going to be re-elected president and would get high investment earnings and all that. Again, there was the thought that everybody was going to lapse these policies the day before they go on claim. Getting back to that 1980s vehicle, the learning and the underwriting have tightened.

I think the next challenge the industry has, though, of trying to keep rates down, is trying to manage claims, and it's one that only in the past two years has even been discussed at industry meetings. That doesn't mean that you don't pay a good claim, but pay only the care that you need to keep the person there. In my opinion, that's where we are today with pricing and underwriting under control. If we're going to keep rates down, we've got to make sure that we pay the care that we should pay

per the contract and that we don't pay more. We're going to have to keep going after rate increases there. If you go back even two years, you could have gone to any LTC industry meeting and there would not be a single claims topic on the agenda. Today you can't go to one where claims isn't a huge topic, so we're getting there. Unfortunately, we're probably still five years away until the industry is corrected in terms of its claims maturity.

FROM THE FLOOR: I have a quick question for Dawn. I think you mentioned that active life reserves use the life valuation rate, which is possibly likely to change to 4 percent. Do you have any indication what the profit margin might be when you use a 4 percent discount rate? Is that a trigger for people to reprice products for 2006?

MS. HELWIG: It does depend on whether a company is pricing the pretax profit margin or an IRR. Most companies are at least looking at both of those measures and probably are doing the pricing more on the basis of the IRR, in which case the active life reserve target will come into play. I'm in the process right now of pricing a new product line where we've incorporated the new regulation, which means that we've updated to the 1994 GAM from the 1983 GAM, and we've gone to the 4 percent discount rate. At the same time, we also threw in the new RBC standard, and it helped enough so that we ended up about the same place that we were at. If you can get those two things in conjunction, they mitigate each other.

It takes a specialist to be able to know the product well and understand it. The LTC specialists like that complexity because it makes them special. They can explain it. They like to pick out the features that they think are important and sell those. But the generalist agents can't sell this product. It's too complicated for them. I think that the theory has been to start looking at ways to simplify the product. We'll get rid of a lot of the frills. We'll have fewer benefit periods and get rid of all of the nursing home, home health care or ADL, and just say that if you meet the trigger, you get cash, and you decide what you do with it. It's more the simplicity of the sale and the ease of understanding. It looks more like a disability product. I think that's the main reason why some companies are at least considering making that an option. It costs, according to our calculations, 50 percent or 60 percent more. It's a lot more expensive. If you don't get away from the management issues, as Steve has pointed out, you still have to do some checking. You have to make sure people still remain qualified for the benefits and that they're not buying $500 a day or something that's going to be so attractive to them that they want to go on claim.

I don't think that the MoneyGuard products have cut into the LTC sales, and I don't think that they have been one of the reasons why the LTC sales have suffered. If John Hancock and New York Life have a stand-alone LTC product, and Golden Rule and Lincoln National do not, they have not detracted from their own LTC sales by having the products available. I don't think Hancock or New York Life feel that they have, either, because a different group of agents is selling it. Part of what I think are the reasons for the decline in sales or why we haven't gotten the market penetration that we hope for is that we are so limited in our distribution capabilities

right now. It is this specialist sale. We need to get it more into the hands of life agents, financial planners, the group market and worksite marketing. All of those other distribution mediums have to happen and happen more frequently for this to take off. Getting a combination product in the hand of the life agents is one way to do it. It's also a riskier product for most companies than a true LTC. Particularly if you're just doing the acceleration-of-benefit feature of this, people view it as their own money. We see the difference in the morbidity experience of the LTC piece of a life rider or life policy versus a stand-alone LTC. The morbidity is significantly lower.

MR. SLOME: Most of it goes back to Phase One and Phase Two. It depends on to whom you talk and how you look at industry sales, whether they're down or up. There are agencies and companies experiencing 20 percent and 30 percent sales increases. It goes back to that immaturity when everybody had high expectations and based everything on that. Then things changed. Rates increased, and a lot of people got hit on the side of the head. At the same time, they had picked the low-hanging fruit from a marketing standpoint. With direct mail, they were skewing one kind of person. Everybody had been inundated and was no longer responding. The answer was to go to younger ages. That doesn't work with the same message. A number of forces all hit at the same time.

I am optimistic that you're getting ready for Phase Two. Indemnity is a simpler product. It's more expensive, but what you're now seeing is that the media and the industry are going to educate people on how to "right size." The agents may still be out there saying, "You need this care. You need to look at this. Look at Christopher Reeve." When *The Wall Street Journal* starts running headlines and Kiplinger starts running headlines saying, "Two- or Three-Year Policy may be Adequate for Most People," you start to see the marketplace turn around. Ultimately I think the great savior, and probably the most likely legislation to happen, is a national partnership program. Four states have partnership plans where LTC insurance integrates with the state Medicaid program, and you have asset protection built into it. It's probably the most likely legislation to happen that they will expand on a national basis. As Dawn said, hopefully they won't muck it up and create products that consumers won't buy and that the industry won't sell. If they do it right, I think you're going to see resurgence unlike anything that you've seen in the past because it will be marketed correctly.

FROM THE FLOOR: Will that be similar to flood insurance?

MR. SLOME: It's not a bad analogy. The analogy from a marketing standpoint is exactly the same. Government is saying to take personal responsibility to protect yourself. It's closer to the Federal Emergency Management Association (FEMA): if you have catastrophic disaster insurance, after your three years of insurance benefits, Medicaid comes in and offers you that continuity of care. It's closer to a FEMA relationship. Right now what you have is Medicaid paying it all. But partnership, if that happens, is the one to watch.