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Session 62 PD
Long-Term-Care Insurance Industry Snapshot

Track: Long-Term Care

Moderator: Dawn E. Helwig

Panelists: Stephen Rowley†
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Summary: Panelists provide an overview of the current status of the long-term-care insurance industry. They cover recent hot topics such as carrier entries and exits, new product trends and distribution/demographic trends, focusing on the current direction of the long-term-care insurance industry and how carriers are positioning themselves for the future.

MS. DAWN E. HELWIG: In this session, we are going to talk about what the long-term-care industry looks like today, what is happening in terms of growth, the number of companies that are in it, who's in it, what some of the recent changes in regulations have been and what companies are actually doing in the way of underwriting and claims.

I'm going to start out talking about the market size, who's in it and what the market looks like, using results from the Life Insurance Marketing and Research Association (LIMRA) survey on individual long-term care. They also have a survey

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on group long-term care, but the individual one is a little more reflective of the market. It's obviously the biggest portion of the market. On the group side, you see some huge swings in the results because of the federal program that came into play in 2002. In the individual market, there has been a steady growth in the premiums in force as well as in the number of policies in force. But this is where it gets interesting. Comparing the new premium issued in the last few years, 2004 was not a very good year. There was a major decrease in both the number of new policies and the amount of new premium issued in 2004.

I'm not sure we can attribute that to one single reason. We may all have a lot of different reasons for why that happened. There are definitely some changes that are taking place. Much of that big decline in 2004 was due to the exit of a couple of companies that had been very big in this market, namely CNA and AEGON. While AEGON gradually went out throughout the year, their sales were really cutting back. The distribution systems that were selling those products are looking for replacement companies for them, but because they were so big in selling those two companies' products, that accounted for a lot of the decline in 2004. Some of the decrease is from the general market perception of the rate increases and some of the concerns that have resulted. Some of it was the fact that we had the rate stability regulation and, as a result, new premiums per policy are going up. We really do have a higher-priced product than we had two or three years ago.

I don't think the agents have fully adjusted. The agencies will learn how to "right-size the sales" to sell people what they need, rather than saying that everybody has to have the Cadillac product. Doing that may bring the size of the product back to the point where the premium is not as high as it is. There have definitely been some challenges in terms of sales of the product in the last couple of years.

We need to define the target market for this product. Of course, we've got the baby boomers in this range, so it's going to be steadily increasing in size. This is the prime target market for long-term care right now. It's a steadily increasing market. The baby boomers are going to explode onto the long-term-care scene in the next 10 years, so the market growth potential is definitely there.

The target market is considered to be the age 55-69 group. If you plot that alongside what has happened with the sales, it becomes even more dramatic. Only in 2002 did the growth in that target market come close to meeting the growth in long-term-care sales. In 2003 and 2004, we haven't kept up the long-term-care sales with what should be the target market.

There are a lot of studies about the boomers and their attitudes toward self-funding their long-term care. The boomers are getting to be a bigger and bigger proportion of this target market and obviously are going to be the major component of that market in the next few years. As you go out 10 years, they are going to be nearly the entire market for the long-term-care services.

Broker World Magazine published a survey that showed some of the shifts that have taken place in this market in the last three or four years. In 2001, GE Financial, which is now Genworth, was far and away the largest producer, followed by Bankers Life & Casualty, then John Hancock, then CNA and UnumProvident. That rounded out the top five of companies in this market. In 2003, Genworth was still up there, but John Hancock made a great leap up into the number two spot. Long Term Care Partners, which was the product of John Hancock and MetLife joining together, is the company that is insuring the federal program. That was a huge production and became a huge piece of the total long-term-care market in 2003, ranking at number three. Bankers L&C dropped to the number four position. Lincoln Benefit moved up to number five. A couple of the companies that were in that top five in 2001, specifically CNA and UnumProvident, are totally gone out of the 2003 top-five list. UnumProvident is still in the top seven, but CNA got out of the market and is off the list altogether.

From 2001 to 2003, the total group of top 20 has changed radically. CNA left the market. Fortis sold its business to John Hancock. Conseco Senior left the market. Transamerica Occidental was one of the AEGON companies that exited. IDS Life exited. Penn Treaty is still in the market, but it didn't appear in the top 20 in 2003. There were a few newcomers. In addition to the Long Term Care Partners that I mentioned, MassMutual, State Life, Northwestern Mutual, Monumental (another AEGON company, so it will be out of there for 2005) and MedAmerica were newcomers. There have been a lot of changes. Some of the top producers have remained. Genworth, John Hancock, Met and some of Bankers Life & Casualty have continued to be in that top group, but there has been a lot of turmoil in this industry. We could go down the list of the ones that have left, and every single one of that five would have a different reason as to why they did. It is not a consistent story as to what happened with those.

There were other notable changes, some of which I've already pointed out. Again, John Hancock made a big leap in moving up to that second position. Lincoln Benefit has become a major player. MetLife had always traditionally been in the group long-term-care market, and they developed an individual product five years or so ago. They repriced that product a couple of years ago and then again this last year, but they've made a big movement into the individual market. AARP, who sells a Met product, too, but under their individual name, has had a big increase. Bankers, UnumProvident and Allianz are selling, but those three companies have moved down in the rankings a little bit.

I want to talk about some of the pricing changes, particularly about what has happened to the average new premium being sold. The average annualized premium per in-force policy has increased steadily over the years, but the average premium per policy issued has increased even more dramatically. There are a number of reasons for this. By the way, this increase in the average premium per policy issued comes at the same time that the average issue age is going down, so if you age-adjusted this average premium, it would be an even bigger increase.

What's causing it? There are a number of things. One is that more and more people are buying compound inflation; that's a big factor. The compound inflation adds anywhere from 30 percent to 300 percent—maybe 400 percent at the youngest ages—to the premium. In the past, the industry sold maybe 40 to 50 percent of the policies with compound inflation. You now have some companies that are selling 70 to 80 percent of their business with compound inflation, so that's causing this average premium to go up. More people are buying lifetime. We can question whether that's necessary, but that has produced an increase in trend. Probably equally important is the fact that the average premiums, even for the same set of benefits, have gone up to reflect the lower lapse rates, to reflect the lower investment earnings assumption and because of the change in the model regulation that says we have to include provisions for adverse deviation. So the premiums per policy for the exact same coverage have been going steadily up over the last couple of years.

The fact that there are fewer companies in it and that just about everyone else is raising rates is giving companies more flexibility to be a little more conservative on their rates, too. Some companies are possibly increasing their new business rates to try to subsidize or give some stability to their overall block of business. They don't want to go in and take rate increases on existing insureds. I don't think that there's a lot of that going on, but it would be a possibility now that the loss ratio requirement has been removed.

The rate stabilization requirement requires higher profit margins. On the flip side, there is the risk-based capital (RBC) formula. Hopefully that will help going forward in keeping prices down, because it will relieve the surplus strain issue a little bit. It is very key that over the last 10 years we've seen underwriting and claims practices improve dramatically. Many of the rate increases that have taken place have been on older blocks of business that were not underwritten properly. For a lot of older business, we did not have the cognitive test and we weren't doing regular face-to-face assessments, so there was not a lot of consistency in the underwriting rules or the practices. We have seen great improvement there, though it has definitely not been enough to offset the low lapse rates, the low investment earnings and all the other factors that are causing the rates to go up. Consequently, the average premium is increasing.

The rate stabilization regulations went into place in 2001. In the past, the regulation for long-term care consisted of a loss ratio standard. We had to price the policies to have a 60 percent lifetime loss ratio. That was the present value of claims divided by the present value of premiums. The rate stabilization regulation was enacted to encourage companies to put more margin into the rates and to be more conservative with the pricing. The loss ratio requirement was eliminated, so you could price your policy for a 40 percent loss ratio if you wanted. Ultimately, that drives the rate way up and there might be competitive pressures not to do that, but the regulation now allowed you to do it. The regulators were trying to get a more consistent premium pattern and get rid of the large rate increases that they

were seeing. This put the burden on the pricing actuary to certify that they had put enough margin into the rates up front and didn't expect any rate increases down the road. The regulators were asking the actuary to certify that the anticipated costs under some moderately adverse experience would be sufficient, so that you could reasonably expect that there wouldn't be any rate increases over the lifetime of the business.

One of the side effects of this regulation was that before a lot of companies felt comfortable signing this certification, they went back and took a harder look at their experience to determine how that experience was tracking against what they expected. Quite honestly, there wasn't a lot of credibility in some of the experience. It's a hard exercise to go through for some companies, and some of them may have taken their first hard look at their experience after this regulation went into place. That may have led to some of the rate increases that we saw, as well as some of the increases in new business rates.

Again, the actuary now has to certify that he or she has included provisions for moderately adverse deviation. Actuaries also have to certify that they've reviewed the underwriting process and the claims process and think that they are consistent with what they priced. It puts more burden on the pricing actuary in the initial certification to sign his or her name on it and say that he or she feels comfortable that those rates are appropriate and adequate.

The term "moderately adverse" was never defined or addressed. There is a manual that tries to give additional examples of what it could mean, but those examples are all over the board. Ultimately, it's the individual company's decision and the individual actuary's decision as far as what they would consider a reasonable margin for moderately adverse deviation. A company may say that its profit margin is its margin and it's willing to go through most of that profit margin without taking a rate increase. I'd say that most companies would not be willing to take a full profit margin, but they may be willing to take some portion of it. Or they may specifically want to put in a 10 percent pad on the claim costs or one pad on the claim costs and another pad on the lapse rates. Companies are very different on how they determine this margin, but the important point is that the company has to think about it. The pricing actuary has to think about it. Management has to be in agreement that they are viewing that as a margin. It should probably be put in the filing. Otherwise, five years later when you go in for a rate increase, if all you've done is certify that the rates had provision for "moderately adverse," the regulator doesn't know what that means. It could make it a difficult battle to get an increase approved.

The point of the rate stabilization was to encourage companies to not underprice and to penalize them if they did. The penalty was enforced if a company needed to take a rate increase; then a loss ratio standard would come into play. Up until then, you could price it for a 40 percent lifetime loss ratio if you wanted. But if you go in and take a rate increase, then you're going to have to certify to a 58 percent

lifetime and an 85 percent future loss ratio standard. The loss ratio standard will kick in if you have to take a rate increase, though there's some relief on that for exceptional increases.

The risk-based capital standards have changed, and the active life reserve standards have changed. The active life reserve standards have become more stringent; the risk-based capital standard has become slightly less stringent. Overall, the two of them are balancing out. The reserve standard might add a little more to the claim. But if both of these things are inactive, then you could say that you haven't gotten a lot of relief for the companies that are coming into play. But the timing of things is a little different. That reserve standard is a little more stringent, but the RBC is more back-ended. If you're doing an internal rate of return (IRR) calculation, you might actually get a bit better cash flow in the early durations, which will help the IRR a little more.

As far as the reinsurance markets are concerned, the TPAs have been very active participants in this market. If we drive home only one point, it should be that this is a complex business. It's not the kind of thing that somebody from claims or underwriting or pricing or marketing can just jump into without any expertise. The TPAs have been very helpful in helping companies get through that process, and the reinsurers have been very helpful, as well. The reinsurance market has definitely contracted from where it was a few years ago. Reinsurers would tell you that this is a market about which they've become much more cautious. If there are small players who just want to do this on their own, but without a lot of experience, the reinsurers would be very concerned about taking on a group like that. Most of the reinsurers have very active underwriting and claims departments who help companies in setting up their protocols. But the reinsurance market has changed dramatically, as has the rest of the industry, with the contraction lately.

With that, I will turn it over to our reinsurer.

MR. STEPHEN ROWLEY: I'm going to talk about trends in underwriting, the importance of claims management and contract language. I'll touch on some lessons learned. I'll also use this as my soapbox to talk about what I think is the next big issue that we're facing as an industry. The trend in underwriting is trust but verify. It's where underwriting has gone in the last few years and where claims are starting to go.

First, there are increased requirements at lower ages. Nearly every company is doing telephone interviews on everyone that they're not visiting in person, though there are a couple of minor exceptions to that. They require more attending physician's statements (APS) than ever and more face-to-face assessments than ever at the ages of 70 to 72 plus. In general, we're getting many more requirements, and we're getting them at lower ages.

We've lowered our maximum issue ages. When I started in long-term care (LTC) seven-and-a-half years ago, there were a number of clients we had that, unfortunately, were writing up to age 99. That seemed like a bad bet. Generally speaking, age 80 is the maximum issue age now. If there are companies going beyond age 80, there are very few. They're probably very small and probably don't have reinsurance. But within that, we're also seeing lower and lower issue ages.

The cognitive screening tests that have come out in recent years have improved. None of the vendors or the creators are saying that these things are perfect, but they seem to be getting better. They're trying to pick up the people that are not yet cognitively impaired but have what we call "mild cognitive impairment" (MCI). Our old way was that if you don't qualify for a claim today, we'd give you a policy. We're trying to perform tests that are going to stop the people who will qualify for claims in two or three years because they're starting to show the early signs. The applications have come a long way and are much more detailed.

The mistake that this industry made early on is that it evolved from one of two markets. It evolved from the life market. They ask very different questions in the life market that may or may not pertain to long-term care, but they've always worked. But for them, adding a new question to the application is a problem. Or it came from the Medicare supplement market. TPAs had a lot of experience there but didn't have to ask a lot of questions. So the industry evolved from two different philosophies. I wish it had come from the disability market, where we've been repeatedly stomped and kicked for some of the mistakes we've made in the past in products along this line.

The face-to-face interviews have gotten better by getting into a lot of lifestyle questions—what people are doing, what are their daily routines, are they active in social groups, do they travel. Things like that can tell us a lot about the individual, whereas the old phone history interviews (PHIs) were simply asking questions that were on the application, or, to paraphrase, if we issue this policy, will you claim in the next 24 hours? No? We'll give you a policy. But that means that both face-to-faces interviews and PHIs have gotten more expensive.

Image technology has helped to speed underwriting. What has amazed me is that, despite the fact that we're underwriting more thoroughly, we're declining more cases and average issue age is down (which means we're looking at a longer risk), our time service as an industry has improved about 30 percent over two years ago. The only thing to which I can credit that is the image technology of getting material to the underwriter quickly. I've been amazed at the improvement, even with the increase in decline rate, which is double from what it was two years ago, according to our survey. It takes time to decline a case; not many cases are declined off the application. So there are a lot of requirements, yet we've sped up time service. I give imaging technology big kudos there.

There does seem to be an increase in counteroffers as well. The industry has gone back and forth. With some companies, since you applied for it, you can have it. But with others, there are counteroffers, substandard ratings and maybe a two-year benefit. For a while, we were offering nursing home only. Just to touch on this issue, if you took a map of the United States and drew a V through the center of it, inside the V you're going to have problems if you issue nursing home only; outside the V you're going to have problems if you only issue home health care. In Minnesota, there's not a lot of access to home health. If you live in places where there aren't a lot of home health-care providers, people go into nursing homes.

One good thing that surprised me with our survey is that even with these increases in counteroffers, they are being placed at almost the same rate as the as-applied-fors are being placed. So the industry seems to be maturing, and I think you can plan the counteroffer market. Another trend in underwriting is that insurers are now starting to manage their TPA relationships. They're saying what they want done, and they're auditing and checking to see that it's done.

Claims management is becoming much more important. In early claims management, when these came from nursing-home-only policies that required three days prior hospitalization, you didn't need a huge gatekeeper. Most old people say that they would rather kill themselves than go into a nursing home, so it was reasonably safe, and the product evolved more quickly than our claims philosophies did. Some of these benefits are fairly attractive. No one wants to have a home health aide, but it's far more attractive than going into a nursing home. With adult day care, you want your mom or dad to come and live with you so that you can take care of them, but you've got a day job. Adult day care allows you to take care of mom or dad, but they have some place to go during the day. These are great benefits, but you've got to manage them differently. They become more attractive, therefore there is more utilization.

As benefits become more attractive, we're starting to see that if it's attractive to use, it's attractive to misuse. Insurers have to start separating "want" from "need." I talked about the "just-in-case" claims before: I might fall, or, I want somebody in here watching my mother. That's fine, and you can do that with your own money. But we're insuring people who need care—at least that was our intention—and it's a difficult job. The claims operations often give me a hard time, but I don't think it's easy. I think it's extremely hard to separate want from need.

In informal caregiver and indemnity plans, the trained informal caregiver is usually not a member of your own family. However, that's not always clear, so it could be a neighbor or any number of people. The theory was to pay to train them so that we don't have to pay the claim. But then there are products that pay to train them and then pay them as a caregiver, which is an oversight, but the informal caregiver benefit makes it more attractive. I've actually seen claims where a claimant's spouse is being paid by the insurance company to care of the spouse, which just

doesn't seem right to me. It's poor policy wording. When you have better wording, you need to stand by it. Indemnity lends itself to abuse.

If you're using a TPA, make sure there's an appropriate alignment of interest. They have to have something. If they can't take reinsurance, which most don't, they have to have fees at risk or something. You can't reward them for denying claims—that's going to the other extreme—but you can have incentives for proper managing of claims. If you set up metrics—certain things to be done at certain points in the claim—and they're not done, they're not going to be paid.

From a historical perspective, initially we started out looking for low-cost care: somebody who is paid $9 an hour in Dade-Broward County, Florida, as opposed to somebody who is paid $15. The TPAs did a great job of finding the discounted providers. The problem is the term "plan of service" versus "plan of care." We believe claims should be a plan of care with recovery as the outcome whenever possible, not a plan of service where you get a certain number of hours for a certain number of days and we'll come back and visit you again in six to eight years to see what's happening. There's a big difference between plan of service and plan of care. Whether you're doing your claims in-house or out-of-house, think of plan of care—not just what they call it but what they do.

Are the claims people enablers or motivators? Historically, they're enablers. There are caregivers versus contract administrators. At some of the claims shops, we've asked them, especially the TPAs, who is their customer. Interestingly, because most of them are nurses, they are either "customers" or "patients." However, I don't have "patients"; I have "claimants." That tells you that we have a difference in thinking when they're calling the claimants "patients." In addition, they generally don't identify the insurer that's paying them as their "customer." A little of both is probably right.

Going back five or six years, it was an industry of "can't" versus "can." We can't start asking people to confirm this. If someone is going on claim, I can't ask them to get up and demonstrate to me why they can't walk across the room. But when you send a caregiver in, that's what they're going to help them do, so why can't you ask that when you're assessing the claim? We can't, because that's the way it has been.

The first fraud investigation I ever saw, about a year and a half ago, was a minimal exercising of the contestability provision. These are tools that were designed to make the product a little safer and to keep rates down, and they are fair tools to use, not maliciously, but to use. The current movement is just starting. There are more occupational therapists (Ots) and physical therapists (PTs), people whose training is focused on getting people back to independence or closer to independence. There are fewer registered nurses (RNs). RNs have a great background, and the right RNs can be terrific, but some of them can be enablers. There are more "insurance types." We're seeing long-term-care operations hire

more people from the disability background. Those who have a disability background know that some people will abuse these benefits; they think differently, and they think recovery. They are less clinical. There is some coordination with Medicare. I don't mean offset coordination, but now that we're using OTs and PTs, we're getting in there on a claim and setting things up. The OT works with the doctor to get treatments in place, and Medicare pays for it. So we're not having to pay for the treatment that is going to help these people recover, but we're able to send somebody in to get the ball rolling on that treatment and get Medicare to actually pay for it. There is minimal cost and big savings there.

We now have better workups of the claims on an ongoing basis and less approval of the "just-in-case" claims. It used to be a claim if somebody said, "I'm afraid of falling." Today, the person is asked, "Why are you afraid of falling? Did you just have surgery? Have you been getting generally frail? Do you have throw rugs all over the house that you trip on? Have you ever fallen?" If someone fell six years ago, the person probably doesn't have a claim. But if someone has fallen three times in the last six months, that person might be a very valid claim. The issue is trying to dig down and find the right ones. It's not black and white. I wish I could write down on paper specifically to pay this and don't pay that. Fortunately, people are starting to ask the right questions to decide whether something is an appropriate claim or not.

There is beginning to be minimal consideration of exercising the fraud clause. There is improved contestability, where we're finally seeing claims people sending the files back to underwriting asking if they had known something specific, would they have issued the policy? There is the very beginning of applying common sense to claims. As an example, say you have two spouses. Do you need two care providers if they're both on claim? Do you need them both for the same eight hours? Maybe they do need it, but could you use one care provider for eight hours and another for the next eight and provide better service for them? Can you get the homemaker benefit, which is usually a lower-cost person, to do the shopping and the meal preparation, and separate the homemaker from the skilled care? They're starting to coordinate the benefits at claim time, thereby preserving benefits as well. If they're on a limited benefit period, we're saving that money for them to use in the future.

Like everything else with insurance, contract language is a result of R&D, or rather insurance R&D, which is different from the rest of the industry. We tend to "rob and duplicate" and even photocopy a policy and put our name on it. I've actually had prospects send us another company's policy during the process for reinsurance. Of course, the company that is copied is a company with 87 underwriters, 230 claims examiners and field reps in every state, and this company has one underwriter and hasn't had a claim yet, so the "rob and duplicate" doesn't always work.

Regarding contract language, stand-by assistance is one of my soapbox issues. What does it mean? If you're going to be stand-by (not actually doing or helping the person do it, but just be there in case the person needs your help), is that

being priced ? There are a lot more stand-bys than there are hands-on, which is something to think about.

Alternative plan of care is a great feature, though I think it needs to be better defined. If a client had a choice of a comprehensive policy, either a home health plan or nursing home plan, they might have bought the nursing home policy. Then they go on claim and say that they're going into a nursing home at $230 a day, but if we'll pay for home health care, they can do it for just $20 or $50 a day. That was not the intention of the alternative plan of care. It was intended to be things like building a ramp or making modifications so the person doesn't need to be on claim or so that you could substantially decrease the cost of claim. That's all alternative plan of care should be and was intended to be, but we just don't administer it.

If we believe that something benefits the claimant, the doctor believes it benefits the claimant and we believe it benefits us, we'll consider it. We don't have to do it, but if it makes sense, we're open to it. But who makes the final decision: the insurer, the doctor or some third party? These are not easy decisions to make. Most companies interpret the "medical necessity" trigger as a doctor saying that a person needs care 24/7, so you've got to give 24/7 care. I think medical necessity could be challenged. We're not seeing nurses pick up the phone, call the doctor and ask why. Nurses learn in an environment where it's not considered good manners to question the doctor. Many nurses feel like second-class citizens to doctors. When it comes to insurance, they don't see the claimant, and the doctor says, "I don't have time to deal with this, so give her 24/7." Is this person someone who is trained to call and challenge the doctor when their entire background hung on what the doctor said? These are things that make a lot of sense when you step back from it.

Defining "cognitive impairment" is essential. I wish I could simply say that if you define it a certain way, you're safe. I'm not sure what the right definition is for that. It's very hard to come up with what is fair to the claimant but safe for us to prevent abuse. We must work at it, constantly rework it and change it.

International coverage is another pet peeve in contract language that I think is disappearing again. It was on the rise for a while. Somebody thought it was a great idea not to limit claimants to the United States. That didn't strike me as wise, and it isn't priced right, either. I tell our clients that if they want to insure people who go to other countries, that's fine, and I don't have a problem with that. But how are they going to manage the claim? They are going to use a TPA. They sent me a claim in the Philippines. By the way, $200 a day is pretty good cash in the Philippines. The TPA looked very diligently to find somebody who spoke Philippino, called the Philippines and spoke to the claimant's spouse. They asked if the claimant was impaired and would they like us to continue sending $200 a day? She confirmed that she would, and they paid the claim. We won't reinsure that. The company pulled it off the table after we addressed the claim. When it's abused, we're not going to bring that claim under control. There is a one-time—not annual—charge of $25. I don't know the right price for that benefit, but I know that that is

the wrong price. It doesn't take a whole lot of claims to get that back. I think that this is on the decrease now.

Some other companies will cover this country but not that country. It strikes me, based on my experience in disability insurance, that it generally is not a good idea to say that if you're from a white, English-speaking country, we'll cover you, but not if you go elsewhere. That can get you in a lot of trouble. We like to say that if you're going to go outside of the United States and insure other countries, it's got to be generally across the board. Yes, it makes more sense in my opinion to insure somebody who might go to Canada rather than Uruguay, but I don't know if that's fair or how the regulators would look at it.

The language about restoration of benefits is also an issue. There are a lot of contracts out there that simply say that you no longer receive care under this policy. If you're still sick and you receive care under someone else's policy and your daughter stepped in for six months so that she can get another five years of payment, it doesn't matter how well you try and manage it. If that's what the contract reads, that's it. We have advocated to our clients that the contract reads that they not only have to be fully recovered, but at the close of claim they send a face-to-face assessor to confirm that the person is independent and capable of activities of daily living (ADLs).

Sometimes I think we've learned some lessons, but other times I'm not sure. Trust but verify, pay attention to detail and everything has a price. Claims do need to be better managed, and insurers must control their own destiny. You've got to think things through if you're going to do them. You've got to manage your TPA relationship. The next big hurdle that I think we're facing as an industry, especially in cognitive screening, is genetic testing. This is something of which everyone is afraid. There are all sorts of different legislation that apply to some products and not to other products. But as insurers, I only want to know what you know when you decide to buy the insurance.

There are Alzheimer's tests that show if you're highly predisposed to Alzheimer's. Some states may allow us to ask that question on the application. I don't know how valuable it is, because if you tested that you're predisposed to Alzheimer's or to breast cancer or to prostate cancer, it means that you're predisposed at some point in the future, probably not in the next two years. It is a big concern. We don't know the answer in our company. I don't know if anyone does. I know the regulators are very concerned that we're going to start declining people. I don't know if that's a wrong thing to do if you had a test that said you are predisposed to Alzheimer's and the next day you contact an agent for LTC. It's probably going to be four or five years until it's resolved, but I urge everyone in this room—whether you're talking life insurance, LTC, especially critical illness insurance—to be thinking through genetic testing, what it means and what you can do. It's the next big hurdle. We're either going to address it, or we're going to lose a lot of money if we don't address it properly and in a way that the states can live with.

MR. JESSE SLOME: I would like to talk about where things are, where I perceive they are headed and why. A lot of this is my personal opinion. It's interesting how the numbers overall are made to look negative and how you can spin numbers to do that and totally blind yourself to where the rays of sunshine are within this. I'm going to keep my attitude positive, even though I'm probably one of the most pessimistic, negative people out there. I keep seeing these positive things out there, but why aren't they plain? I've been helping insurance companies market long-term-care insurance since 1987, but I've been focusing on it exclusively for about the last seven or eight years. But in the end, from a marketing perspective, I believe that somewhere during 2005 to 2006, this industry is going to hit a critical mass that will explode it to the next level.

Here is a sales snapshot. In 2004, more than 300,000 people purchased long-term-care insurance. There are 4.2 million in-force individual policies. When you add the group policies, this is where I believe critical mass is going to happen. By the end of this year, there will be 7 million Americans who either own private long-term-care insurance through an insurer or self-funded long-term-care insurance. That's an awful lot of people out there who've had the experience and own insurance and are talking to others. From a marketing sense, there are 7 million people who own something and are talking to other people and saying that they did it. It's no different than Mercedes. Mercedes didn't sell a lot of cars 20 years ago in the United States. Today, it depends on what state you are in, but in California that's all you see. Why? Because if you hit critical mass, people see it. The positives are there. Half of the carriers in-force grew 10 percent in the last year. Yet why are the sales down? Some companies that were significant players left the market, creating some imbalance within the marketplace. Also, the industry got complacent with just picking the low-hanging fruit. They knew they could send out direct mail, get an 8.8 percent response back, set up appointments and people would buy. Then the marketplace changed under their feet very quickly, and they weren't ready. But they will recover.

There are some trends in premium that, again, make me positive that that critical mass will hit. I don't feel positive about the lifetime premium representing 95 percent of marketplace and sales, except to say that shows that there is an acceptance and an understanding of the issues. We are at the conclusion of Phase 1 of the marketing. Phase 2, in my opinion, is going to be an industry that's marketing right-size products, and right-size products are going to be shorter term. When you look at the same numbers three years from now, you are not going to see 95 percent representing lifetime. I project that you're going to see maybe 40 percent, and you're going to see far higher numbers getting coverage. It is a positive sign that insureds are paying more for coverage across the board. That shows that people see this as having value to them.

Who's selling the product and where is that trend going? In 2003 data from the Life Insurance and Marketing Research Association (LIMRA), there was already a significant and dramatic shift, but at the end of 2003, which was the last year that LIMRA had, 44 percent of the sales were made through career agents, 47 percent

through independent brokers and the rest through a diverse group of stockbrokers, accountants and financial planners. Where is the trend and where is the shift going? Very clearly, it is going toward the independent and toward the non-affiliated sale through stockbrokers, accountants and financial planners. Ultimately, if you're going to have an industry that's going to right-size its product, sell shorter term and have a national partnership program, you're going to see a tremendous increase in the direct sale of these products. It has not happened yet. It is still consistently a face-to-face sale, but there are statistics that show that two-thirds of buyers today do some comparison shopping, meaning that they meet with more than one agent. Traditionally, it's a kitchen table sale. After that, the next way is that they're going to go right on the Internet and start looking. Once they've determined what features they want in what durations, because they read about it in *Money* magazine and in the local paper, they're going to see what it costs and just spreadsheet it and make that determination. You are going to see dramatic changes in the marketing.

In the last year or so, I've seen more companies expanding their marketing efforts and cross-selling their existing clients. Why are they doing that? A couple of years ago, I created a direct mail letter for one of the Blues that wanted to market just to its own clients. They marketed to their own clients that had Medicare supplement policies as well as to the general population. In the general population, because of their name, they got a fairly high response rate, about 1.5 percent. To their own clients, they were pulling a 20 percent response and conversion rate, and they basically continue to do that. They still use the same letter and send it to the same people who now get it for the fifth or sixth time, and they're still having the highest conversion rate. Companies are now realizing that as they get into more simplistic models for products, when customers already own an annuity or a life insurance product, they're going to start buying long-term care.

Is long-term-care insurance a specialist sale? The answer is critical for where the direction of the marketplace has been and where it is going. The answer is both yes and no, because long-term-care insurance is not one size fits all. We do a meeting for producers every fall, and that group of 700 producers would absolutely and adamantly tell you that it's a specialist sale and that nobody but specialists could sell it. Why is that? First, it's a complex sale because they make it a complex sale. To their credit, there are now about 10,000 people who have completed one of the several long-term-care designation programs out there. Everything is oriented to defining the need, the future, the products and all the moving parts, and it becomes a complex sale. By making it a complex sale, they've limited the marketplace, though not intentionally, because their belief is that 100 percent of America should own long-term-care insurance.

The federal plan attempted to make it not a complex sale. It created a recommended prototype of what you should buy. They diminished the number of moving parts, did consumer education and took 260,000 applications over a rather narrow window of time. That proved in my mind that it doesn't need to be a complex sale, and the industry learned an awful lot about it.

From a marketing standpoint, most companies who enter long-term-care insurance get out specialists and use the same training that worked 10 or 15 years ago. But that is clearly not where you see some of the industry leaders. The best analogy I heard was when some agents approached one of the leading companies and said, "We don't understand. We brought you into the business, and now you're turning your back on your career agents." The explanation was very appropriate and gives a picture of the future. Consider a parent who first has one child. They love that child. They dote on that child. The child can do no wrong. They give every gift they can to that child. Then they have a second child. They don't love the first child any less… You can see where the picture goes. We are now in an industry that's having its third and fourth children in terms of distribution, and they're showing that love for each, but the second and third children are probably going to be the more successful ones.

What's likely to happen? When people ask what some of the barriers are to the sale, I tell them that if you've had the experience, then long-term care is a reality to you. If you haven't, then it's really not; it's just an article that you read about in the paper. Each person has their own reality, but then you have to look at the facts. From a marketing standpoint, the facts clearly show where this industry is headed. Two years ago, I would have stood up and said to you that in my personal opinion—and all I do is publish a magazine for long-term-care producers and run a meeting—I was extremely concerned that there would be a government solution to long-term care. Despite everything that we were all doing, if you talked to folks who were within levels of influence in the government, there were enough of them who were saying that we already pay 90 percent between Medicare, Medicaid, Social Security and everything else, so what's a few more percentage points? There needs to be a government solution. Then the tide turned. The federal and state governments have run out of money. That's good news, because that way we provide a solution. If you're looking to show management why we are at the cusp of having government and private sector partnership that has different levels, get copies of the General Accounting Office (GAO) reports. GAO is an arm of Congress that does studies for Congress. They are unbiased: just the facts, the recommendations and the delivered testimony. On their Web site, which is www.GAO.gov, you can request any report that you want. After all, they're our tax dollars. The report GAO 05-564T is the long-term-care report and testimony.

As an illustration of future market direction, we reported two years ago that, for the first time, this industry paid out $1 billion in claims in a year. Checks going out from the insurers equalled $1 billion. That's a lot of people. Seven million people own long-term-care insurance. They haven't been touched yet, but there are people out there who own it and have been touched. The analogy that I draw is that since I live in southern California, I own earthquake insurance on my home. I have never put in a claim, but I can't tell you how many houses I've been in that not only have been rebuilt, but that have been improved, thanks to earthquake insurance. Every year, earthquake insurance doubles the premium for those who are not in

California. It's just an absolutely 100 percent rider on your premium. The deductible is enormously high, but I dream of granite counters in my kitchen one day, and therefore I own it.

You know the demographic facts, and you know the facts about the need. There's going to be a private solution. As I said, I believe that in 2005 to 2006 we're going to hit what I call that critical mass. This is why I believe that's about to happen. A foundation of enormous awareness already exists. You cannot open a magazine today and not read about the importance of thinking about long-term care. But there's the transition between thinking and acting.

There is a second reason why critical mass is going to happen. As an industry, we are extremely hard on ourselves. Consumers are not so hard on us. That's not to say that there are not problems out there that are addressed, but in general, both consumers and the media are actually less hard on us. Every now and then, and rightly so, they report on some of the negatives, but overall, if you weigh the negatives and the positives, the positives far outweigh the negatives. Yes, there have been companies that have exited, but for the first time I don't see that happening with the major players. A year ago, there was talk about who was next, when is the other shoe going to fall and which one of the big four or big three is going to exit next. There is no longer talk like that. I say that I'm positive about that because the big three are aggressively in D.C. lobbying for things that they believe are important. They all have multiple businesses. They would not put their necks on the line saying that they are committed to this, then pull out and embarrass themselves, because they have other businesses that they have to support.

The marketplace is primed. Health and Human Services, which runs Medicare and Medicaid, did a joint program with the governors of five states to increase levels of commitment and awareness. The governors in each of those five states mailed letters to all residents age 50 to 70, encouraging them to plan for their long-term-care needs. The residents could respond to get a Medicare package about planning, including a CD-ROM and booklets, all of which basically said private insurance is absolutely a key component that you should be considering. Response rates have been enormous. They are now looking at expanding that five-state program.

Where is long-term-care insurance headed? I don't believe that we will see tax deductibility or that it is even prudent. Would the industry love tax deductibility? Sure. It would push a lot of product out the door for a relatively short period of time. Is it necessary? There are pros and cons to each. I don't personally think that tax deductibility is the best solution. I do believe that a national partnership plan is the best solution. A partnership plan encourages the individual to buy a baseline of personal protection, and then the government steps in, protects their assets to a degree and takes over should they need care once their benefits have been exhausted. To me, that is the best of all worlds. It's the government sending a very clear signal of personal responsibility, and it protects taxpayers. It also protects the

individual by having high standards. That is likely to happen within that 2005 to 2006 period, and I think that will take that critical mass to the next level.

I believe there will be more innovative approaches. When I talk about better solutions that address affordability, it's basically going to be right-sizing. *Consumer Reports* does an update of long-term-care insurance every couple of years. It is their number one ordered reprint. Trudy Lieberman, who puts it together, said that an intern commented one day that this was their number one selling reprint, and three of the four top companies that they recommended were no longer in the business, so maybe it would be time to redo that. They now do it on a fairly regular basis, but it shows that consumers read. I believe that as they gain more knowledge, because they listen, too, they will be literally recommending what a fair right-size solution is for people. With all of those things hitting together, that critical mass will take off.

I'll end with what I call the 401(k) analogy. In the mid-1980s when I was a 401(k) wholesaler, my first job wholesaling 401(k)s was with Aetna. At that time, Aetna put me out in the field and reminded me that 25 percent of all contributions had to go into life insurance. A 20-year-old today would probably be startled and say that you can't put life insurance in a 401(k). But indeed you could, and you did. That was their whole basis. That's how many insurance companies created the 401(k) marketplace in the beginning. Today, if you walked into an employer and suggested installing 401(k)s and putting 25 percent of the contribution into life insurance, you would be shown the door within 35 seconds. The questions that you would be asked today are dramatically different from what you would have been asked in 1987, even though quantitatively in time it's not that far off. The analogy is the same. Long-term care has just finished that first cycle. When we look back 15 years from now, whatever our life insurance in that plan, it's going to be dramatically different, because the issues are still the same. Government can't be the solution. Consumers are going to perceive that this is an affordable and doable option. Employers are going to step in and offer viable, intelligent options. The media will unanimously support this, because if I did this same session in front of reporters and asked how many of them had experienced a care-giving issue or know somebody who has had that experience, they would say that they have been touched, just as we have, by the issue. When they see that as a solution, they're going to wholeheartedly support it. We are going to hit that critical mass in the next two years.

How will the health savings accounts (HSAs) impact? Do you want to address that, Dawn?

MS. HELWIG: I don't know. At this point, I don't know if anybody knows. I do think that it's a positive impact. But I don't think it has been focused on in the marketing area as a possibility. It's going to take some time for those funds to build up and to be significant enough to pay for the premiums of a long-term-care policy, but I do think that it's a positive feature that we can start to emphasize a little more in marketing them down the road.

MR. SLOME: From a marketing standpoint, I do believe that we're at its infancy. People are still selling this as if it's that nursing home protection and you have to have it and it starts with that first dollar. The marketplace is going to be more mature. The media are going to make us more mature. As with retirement planning, where you no longer have to have all of your money saved for retirement in your 401(k) because you're going to get Social Security and your house is going to have value, we're going to see the whole picture. Ultimately, the HSA will play a part, because if you started your HSA, by the time you get to be age 70 and need it, you're going to have a certain amount of money in there. Now, Dawn is a real proponent for high-deductible/long-elimination, and there is a marketplace for that. It hasn't happened yet because there are regulatory issues there and the consciousness isn't there yet. But in my mind, there is a prime mix, where products of the future combine your HSA with your long-term care because you've built up $100,000 that you can spend for that. Right now, it's being looked at only as that you can deduct a premium out of that. That's a short-term solution, but we're not there yet.

FROM THE FLOOR: What are companies specifically doing today to attract more independent agents and more life agents to this market?

MR. SLOME: Those are two questions. The underlying question to that is, are they doing it? It's a tough one. It varies from company to company. Some of them are still recruiting. Genworth is still recruiting career agents, though I would think with greater difficulty than in the past. For the most part, many of the companies are trying to push the problem out to their distribution, typically to the brokerage. They're saying, "We manufacture a product. Here it is. We pay you a commission. You go figure out how to market it." The marketers out there are really the distribution force, who are all doing their own thing, and they're all scrambling. Right now you have, in my opinion, the worst of all scenarios. The distribution is trying to cherry-pick each other. They're looking for a top producer and saying, "Come to us. We'll take care of you. We'll give you one point more. We'll give you some leads." That's a very short-term solution. On the positive side, some of the bigger carriers are starting to realize that and rethink what they're doing. They're investing in training. They're investing in trying to get the word out. If you're General Motors, you don't just say to your distributors, "Here you go. Go figure out how to sell cars." You create ads; you do the marketing. They're starting to realize that they have to be involved, though not enough. To a degree, a lot of the companies are starting to focus a lot of attention on alternate distribution. They have set up bank channels. That is where many of them are spending a fair amount of money. They're supporting what they call "alternate" distribution, but that is becoming mainstream distribution.

MR. ROWLEY: We're now seeing commercials about long-term care. I think it started with Conseco a couple of years ago, who obviously isn't doing commercials anymore. Mutual of Omaha commercials talk about long-term care, as do New York

Life commercials, and I'm pretty sure that one of the Genworth commercials talks about long-term care. So we're finally starting to see it going out, and it benefits all of us when a few start advertising. It's becoming more of a mainstream product. Prior to the Conseco commercials, which were probably only three years ago, there wasn't any regular advertising about long-term care that I recall. It will also attract producers to the organizations that advertise, which then should create more advertising in the end.

FROM THE FLOOR: Many companies now have accelerated death benefit features in their universal life products. Have you sensed any impact at all in the long-term-care market from having those features in the life insurance products?

MS. HELWIG: I would not say that the success of those products has affected the individual long-term-care market directly, because they are sold through totally different agents. The life combination products or the universal life combination or the annuity combination products have been designed primarily to expand the long-term-care market and to get long-term-care sales in the hands of some additional producers. The life producers have not been comfortable selling long-term care, and long-term-care sales have not taken off with the life producers. Those that get trained on it maybe sell one a year. So this has been the life companies' attempt to expand long-term-care production and get it in the hands of more agents. It's usually a totally different group of agents selling the two products.

MR. SLOME: But there is a trend, and it depends on the distributor. There is definite trend to helping agents offer what they are now calling "long-term-care solutions." It's a slower process than I would have anticipated, but when we do our producer summit this year, where we'll have 700 or 800 of the top producers, there will be an entire track dedicated to these nontraditional products to orient and train the producers. Many of those dedicated producers now realize that they need it to keep their income up there. Through underwriting, they're getting anywhere from 20 to 60 percent declines, so it's marketed at balancing it. Last year, I tried something like that at our producer summit, and the sessions were not well-attended. It was interesting that the carriers were actually not discouraged. They came back and said that even though they only had nine people in the room, they're not giving up. It's just going to take longer than we had all hoped. I project that this year those rooms will be filled, certainly with more than nine people. More and more of the distributors are now realizing that it's no longer just long-term-care insurance; it's long-term-care solutions.

MS. HELWIG: I would like to add to that. To the extent that you can use a consulting firm as the barometer of what's happening in the industry, we've seen a lot of interest in the last couple of years with developing combination products for new companies that are not in long-term care. It's a way for some of the life carriers to dip their toes in the water, try long-term care out a bit and get comfortable with it before they take the step of doing a stand-alone product. That's great, because it works. The one caution I would make is that the experience on

the combination products is better than stand-alone long-term care, so you can't take your combination product experience and develop long-term care off of it.