LONG-TERM CARE
INSURANCE SECTION

"A KNOWLEDGE COMMUNITY FOR THE SOCIETY OF ACTUARIES"

March 2006, Issue No. 17

Long-Term Care News

contents

In Pursuit of the Truth

by Robert J. LaLonde

Many data warehouse (DW) projects start with the best of intentions, that is, to get at the Truth of what is going on in an organization. However, success has been a mixed bag and popular belief is that many fail. They fail for a number of reasons: the database is nothing but pure data and includes no calculated items for insurance analytical processing, operation and use of the DW become too costly, and users cannot generate adequate useful information. A DW that does not become a true cross-organizational tool serving the executive, financial, actuarial, underwriting, claims, operations and reinsurance units will fail, too. In an insurance oriented DW, significant business knowledge is required. This should be built into the design beforehand rather than relying on users to generate business rules when building reports.

Often the initial objective is to build analysis and reporting to support the sales and marketing function. Not much thought is given to applying the concept to support analytics that relate to policyholders and insureds. This is another recipe for failure.

"Can you explain why we did not make plan?"

The prime question asked at the executive level, which drives straight to the department level is, "Can you explain why we did not make plan?" This one question will send actuarial, accounting, IT and executive resources into an around-the-clock crash-study to answer it. A DW with a database philosophy lacking an insurance business model will not in itself be able to help answer the question.

An insurance business model is not just a single model. It really represents a number of separate models. For example, a source-of-earnings model is needed to analyze actual-experience-to-expected. An underwriting model is needed to analyze the underwriting process. A Long-Term Care (LTC) model is needed to analyze the ins and outs of the LTC business since it has unique multi-status properties.

A data warehouse is a means to an end and it can be the tool that can help in the quest for Truth. Ideally, the end should be a cross-organizational reporting and analysis tool that can be used by all departments in a company, consolidating business rules, easing communication and understanding between functions.

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Long-Term Care News

Issue Number 17 • March 2006
Published by the Long-Term Care Insurance Section Council of the Society of Actuaries
475 N. Martingale Road, Suite 600
Schaumburg, Ill 60173-2226
Phone: 847-706-3500
Fax: 847-706-3599
Web: *www.soa.org*

This newsletter is free to section members. To join the section, SOA members and non-members can locate a membership form on the LTCI Web page at *www.soaltci.org*. Back issues of section newsletters have been placed in the SOA library and on the SOA Web site (*www.soa.org*).

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Brad S. Linder, Newsletter Editor
GenRe | Life Health
695 East Main Street
Stamford, Conn. 06901
Phone: (203) 352-3129
Fax: (203) 328-5886
E-mail: *blinder@genre.com*

Bruce Stahl, Co-Editor
Penn Treaty Network America
146 Lakeview Drive • Suite 203
Gibbsboro, N.J. 08026
Phone: 856-566-1002
Fax: 856-566-5165
E-mail: *bstahl@penntreaty.com*

Joe Adduci, DTP Coordinator
Phone: 847-706-3548
Fax: 847-706-3599
E-mail: *jadduci@soa.org*

Clay Baznik, Director of Publications
E-mail: *cbaznik@soa.org*

O'Shea Gamble, Project Support Specialist
E-mail: *ogamble@soa.org*

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A Word from the Editor

A Bold New World

by Brad S. Linder

Editor
Brad S. Linder

As I write this column, there are quite a number of interesting developments in LTC. First, there is pending legislation in Congress concerning the expansion of LTC partnership programs. Should the Congress act on this measure, we could finally see an important expansion of these programs nationwide.

Many of our readers know about the "Compact" developing in quite a number of states whereby policy form and rate filing requirements for insurance products (including LTC) should be more uniform, hence simplified. But, I wonder how many of our readers know about the New York State Compact for LTC? It happens to be a bold initiative into financing LTC. Many thanks to David Bilson for being the author of this press release style article. I'm including thanks and contact information for Gail Holubinka for her work, too. I believe that enabling legislation should be in both the state Senate and Assembly by the time you read this.

I am pleased to report that we have a Letter to the Editor. Kudos to Dr. Watson for writing us concerning his observations on the underwriting articles appearing in the September 2005 issue. His observations are well said. Although this is not as witty as a response that either Dear Abby or Ann Landers usually offered, it is my hope to encourage full discussions on as many LTC issues as possible.

Lastly, my thanks go to all our authors for their articles. Through them I see a gathering momentum in each of our networking tracks. ❋

LTC Newsletter Publication Schedule

Publication Month	Articles Due
August 2006	June 1, 2006

The Chairman's Corner

Wisdom from Uncle Slats

by Ty S. Wooldridge

First of all, happy New Year to all of you! What an extraordinary opportunity we get every 365 days to start out again with a blank sheet of paper. I'm very excited about the prospects for our industry in 2006 and very honored to be the new Section Chair.

It's never easy to write these things—you want them to be meaningful and make an impact on people, and you want to do it in as few words as possible. The only man I've ever known who had a real talent for that sort of thing didn't publish anything at all.

I was born in the southern panhandle of Texas and although I've lived more years outside of the state than in it, you never truly get over being from there. In any event, one of the great influences from my childhood was a larger-than-life character that I would come to know only as my Uncle Slats. His unusual nickname came from the fact that he was an exceptionally thin cowboy whose tales were the only thing taller than he was. Every day he rode his horse until he was well into his 90s and he was known in the region to be a bit of a front-porch philosopher. Almost any day of the week you could find him with a hand-rolled cigarette, sharing the wit and wisdom of an entire lifetime in his humorous, Will Rogers sort of way. People would make their way from all over the county to listen to the old guy, and believe me, you had to come to him because one of his favorite sayings was that he'd go anywhere in the world so long he could be home in time for supper. He meant it.

Every now and then, Slats would call us kids into his living room and lay a story or a saying on us that reflected the lessons of his mostly very simple life. I recall on more than one occasion that I'd be thinking something like, "I'm five years old … I have no idea what you're talking about." But, as I've aged and recalled some of the things he said to me, they've begun to make more sense, especially as I think about my own career in long-term care.

"Boys, the more you run over a dead polecat, the flatter it gets."

At the time, I was sure he was talking about a genuine animal carcass—to the point where my cousins and I looked everywhere on his farm for that thing. He was, of course, talking about the importance of change. Even though most people would probably think of his life as being very much the same day in and day out, those who knew him best understood that for him every day was constantly new and different. He had, after all, lived a life that began in the presidency of Grover Cleveland and lasted until Ronald Reagan.

On my way to becoming an FSA, I took the demography exam administered by the Society of Actuaries. I enjoyed that thing so much that at their suggestion, I took it again—and two very important things from the experience remain with me to this day. One was that the textbook was exactly the right size to level the kitchen table in my first apartment. The second was that the baby boomer generation is the largest demographic group in recorded history and they are living longer and longer lives. In fact, someone told me once that two-thirds of all of the people who have ever lived to age 65 in the history of the world are alive right

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Boys, in the beginning there was nothing. Then the Lord came and created light and there was still nothing ...

now. The problem is that while the oldest baby boomer has by now been in our product's "strike zone" for about five years, and while you would think that just the sheer size of the peer group would guarantee unprecedented growth for our industry, sales have been steadily declining for some time now.

Whatever else this means, what it says to me is that the time has come for us to think about our industry in brand new ways. In an industry that's frankly not old enough to have much "convention wisdom" yet, I think it makes a lot of sense to challenge everything we think we know. Who says you have to do things the way we've done them so far? I've resolved in 2006 to try harder to get to at least a "let's give it a try," if not all the way to "yes," when fresh ideas are thrown my way.

> *"Boys, in the beginning there was nothing. Then the Lord came and created light and there was still nothing … but by golly you could see it."*

I've thought for some time that this one might be meant for the actuaries among us because it is very much our job to substitute facts for appearances and demonstrations for impressions. When I think about the long-term care industry, I think this responsibility has at least two dimensions to it.

First of all, there are few people better able to evaluate the financial consequences of life's uncertainties than actuaries. Helping to translate the mathematics into powerful but simple calls to action is essential because for millions of Americans, long-term care will become an expensive reality.

Secondly, not only can we help people conclude that no financial plan should be considered complete until it contemplates a strategy to pay for long-term care, but it is also the actuary who can help shape the strategy itself. For example, it is not enough to simply educate people on what percentage of 65-year-olds are expected to need care at some point in their future, but how many might need that care for two years or five years or ten years. And, how much money could that care divert from their retirement savings if it's needed?

I can tell you that this committee is determined to place that kind of information into appropriate hands during 2006.

> *"So you boys want to be pro football players when you grow up? Well, you should know that there are several kinds of players. There's the kind that you knock him down and he just stays down. Then there's the kind that you knock him down once and he'll get right back up, but if you knock him down again, this time he'll stay down. And then there's that guy that you knock him down and he gets back up, and you knock him down again and he gets back up, and it really doesn't matter how many times you knock him down, he always gets back up. Most everybody wants to be that guy. …Personally, I put my money on the kid that's knocking everybody down."*

This was always one of my favorite Uncle Slats stories. I think the message to us is pretty simple. We don't have the luxury anymore of simply absorbing bad news year after year, dusting ourselves off and coming back for more. This is the time to re-invigorate your new product agenda, to aggressively support the industry's government relations efforts, and to do all you can to foster public awareness and education. The time has come for us to play a lot more offense and a lot less defense.

You'll hear more in the coming months about the kinds of things we want to do on this front during the year, things like sponsoring research, building on the very successful Think Tank, developing education-oriented pieces for national publications and study notes, and so much more.

At the end of his life, Uncle Slats was as unprepared for his long-term care expenses as most Americans. But he left me with one final piece of wisdom that I think is apropos:

> *"I used to wonder if ignorance and apathy were really the greatest enemies of progress … but I've decided that I don't know and I don't care."*

See you all at the LTCI meeting in Anaheim! ❋

Tyree S. Wooldridge, FSA, MAAA, is senior vice president and chief actuary with Genworth Financial in Richmond, Va. He can be reached at *Ty.Wooldridge@genworth.com.*

Letter to the Editor

Your September [2005] issue featured promotional articles for three cognitive testing modalities, in which each author presented information in support of an assertion that his test has a high degree of accuracy in screening for dementia and/or mild cognitive impairment.

To best serve your readership, I would like to offer the suggestion that, in the future, all articles of this type be accompanied by straightforward disclosure of the extent of financial interest that an author has in the test being promoted as well as an accompanying analysis of the data presented by an independent expert. Such an approach is mandatory in major reputable medical journals. Unfortunately, initial reports of accuracy and efficacy of tests and drugs are frequently proven to be unfounded by independent researchers who attempt to replicate the findings. This problem is particularly common in situations where the researcher or promoter of a particular result has a direct financial interest in a study's outcome. One noteworthy example can be found in the recently published review of genetic test studies by Joel Hirschhorn, a geneticist at the Broad Institute in Boston, who reported that "only six of the 166 initially reported associations of genes with a disease or trait had been replicated consistently." This astonishingly high failure rate of primary research findings demands a healthy skepticism when approaching any test that has not been unequivocally confirmed for accuracy on follow-up testing by financially disinterested third party research.

It is also highly advisable to cast a critical eye upon the quality of the evidence presented in every medical study that is provided in support of any finding. The saying that a statistician can get a study to say anything he or she wants it to say is not far from the truth, which explains why so many initial findings—even in the gene studies noted above that were published in peer-reviewed journals—turn out to be complete busts.

Without commenting directly on the specific assertions presented in the three articles in question, I would offer these general considerations to aid decision makers at LTC companies who may desire to best interpret and utilize the information regarding cognitive screening tools provided in such articles:

1. Take a close look at the population that was studied and at what relationship it has to a prospective population of LTC insurance applicants. Studies involving participants or participants that are drawn from memory impairment clinics may produce skewed results that are irreproducible when the same test is done on a population of likely LTC insurance applicants. Screening tests that show a high sensitivity and specificity when tested in a group of subjects with moderate or severe Alzheimer's Disease may yield a very low sensitivity and specificity when used to screen a group of insurance applicants having a low prevalence of severe Alzheimer's Disease.

2. Look at the outcome that was studied. Was it dementia? Established Alzheimer's Disease? MCI alone? A screening test that has good sensitivity for Alzheimer's Disease should not be considered to be effective for screening MCI until proven so.

3. Look at how the existence of the impairment in the study subjects was measured. For example, if the Clinical Dementia Rating Scale (CDR) was being used, it is important

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to understand that a CDR of 0.5 can encompass a wide range of severity of short-term memory loss. Theoretically, an individual can have virtually no short-term memory function and still qualify as a CDR 0.5 if other functionality is reasonably intact. Therefore, test results in subjects with CDRs of 0.5 can be quite different depending on which end of the spectrum of memory loss subjects are selected from, and these results may not be readily applicable to a screening setting for insurance applicants.

4. Examine the quality of the methodology used to conduct the study. For example, the average ages of the control group and the impaired subjects should be the same. Also, studies involving small numbers of participants with MCI can easily produce skewed results that are irreproducible when the same test is done on a population of likely LTC insurance applicants.

Approach with care any assertion that a particular test has been proven effective on the basis of its use in an insurance industry setting.

5. Approach with care any assertion that a particular test has been proven effective on the basis of its use in an insurance industry setting. Such an accomplishment is difficult, if not impossible, to achieve because it is usually unknowable in most cases if an applicant who has a positive test for MCI truly has that problem in the absence of the complete follow-up neuropsychological testing that is effectively never available.

6. The assertion that the occurrence of dementia claims is lower in a group of policyholders who have been screened with a particular test as compared to the incidence of the dementia in the general population may mean little, if anything, given that the incidence of dementia claims in a group of applicants who are screened with commonplace modalities, such as filling out an application and participating in a PHI, can be expected to be much lower than in the general population. For a test to be proven effective in such a setting, it needs to be demonstrated that the incidence of claims in insureds who have been screened with the tool is significantly lower than the incidence of claims in a group of insureds who were not screened with the tool, but in whom all other processes were carried out in substantially the same way.

These are just some of the considerations that decision makers may find helpful when evaluating the suitability of a cognitive impairment screening tool or other testing modality for insurance applicant screening.

One final point with regard to MCI that is worthy of mention: The great weight of the medical literature supports the position that the clinical features of MCI overlap age-associated memory loss to such a large degree that it is virtually impossible to distinguish between the two in most cases with any type of testing done at a single point in time. That is not to say that an effective test has not been developed that can accomplish that task, it is just to say that the burden of proof rests squarely on the shoulders of anyone who claims to have done it. ❋

- Robert Watson, MD, FLMI

Editors Note:

One purpose of the newsletter is to address current issues facing our industry. The newsletter editors sought articles from competitors who market cognitive screens in order to avoid promotion of a specific screen.

Dr. Watson's response serves another purpose of the newsletter, to provide a vehicle for experts to express their perspectives on current issues.

Reporting and Analysis Issues

Many companies struggle to obtain the Truth with their reporting and analysis. Many installations can access some of the "Truths" about their operations, but this approach creates many problems, namely:

- **Department Exclusivity.** Department heads want their own reporting expressly for their needs because of their own priorities and budget needs. Each department has its own favorite data source.
- **Lack of Coordination.** The reporting for one department is never related to the reporting of another department.
- **Lack of Intelligent Design.** Although a company is overwhelmed with data, too little information is extracted and analyzed in a useful way.
- **Reporting Inconsistency.** Many of the reports do not tie together because they are not based upon data from the same source files that can lead to management confusion and lack of credibility. Users make data grabs from different and disparate data sources. Measures, data fields and metrics will have the same words, but will be computed differently between departments.
- **Lack of Analytical Controls.** Extensive use of Excel and Access, although sounding like a cheap solution to reporting, actually promotes different calculation methods because no one person maintains the data.
- **Reliance on Manual Labor.** The effort to prepare reports is mostly manual and inherently expensive because of the extensive aggregation and reconciliation process.
- **Timeliness.** By the time the data is analyzed, the next month or quarter has arrived.

What is the Truth? The Truth represents a concept of reporting what actually happened to a company. This concept of Truth applies to the requirement that running a report today as of a prior date should produce exactly the same numbers that would have been produced had the report been run at that prior date. This principle of reporting stability is fundamental to data warehousing. Insurance business presents some challenges to this, such as restatement of reserves, late reporting of claims and changes due to subsequent events.

A DW will help you find the Truth, but only if the DW incorporates a proper business data model. A DW connected with a usable data model and a good analytical tool for reporting and drill-through functionality can eliminate the shortcomings listed above.

Best-of-Breed DW design will eliminate those faults listed above.

- **Department Consistency.** Department heads can still have their own reports, but the underlying data comes from one centralized database. Now, reports built by a department will agree and intersect with another department's reports.
- **Reporting Consistency.** The multiple data grabs from different and disparate data sources are no longer needed. Reporting will have consistently defined measures, data fields and metrics. And, if the data model is open, then everyone will be able to see how the metric is computed.
- **Control of Reporting Tools.** Excel and Access reporting is replaced by the pivot table functionality of the querying tool built into the DW.
- **Savings due to Automation.** Huge savings can be realized by eliminating all the manual effort to produce the same report over and over again.
- **Immediacy.** Answers to difficult analysis will arrive instantly.
- **Intelligent Design.** Lastly, everyone will be working from a data file that is cleansed and represents the Truth, so everyone's credibility is no longer at risk.

"Best-of-breed tools will result in the best system."

The first area of failure typically comes from the project being led by IT requirements and the search for the best-of-breed tools to build a DW. Buying the best-of-breed DW, ETL (extract, transform and load) tool, analytical tool, reporting tool, and so on, will not do much good if deployed with no business model behind it. A business model suited for your business means it should include all the pertinent information for informed decision-making specific for an insurance company *and* the analytical applications associated with that data.

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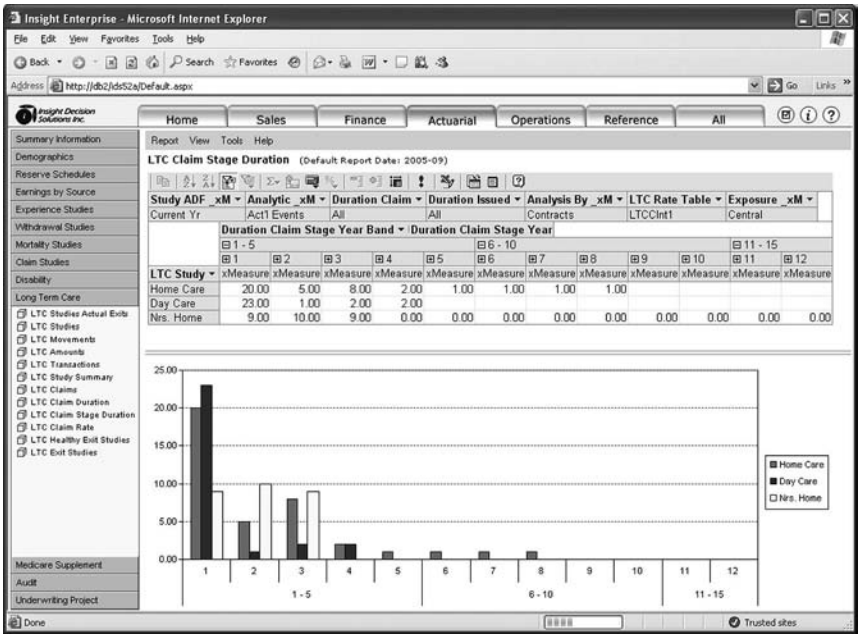
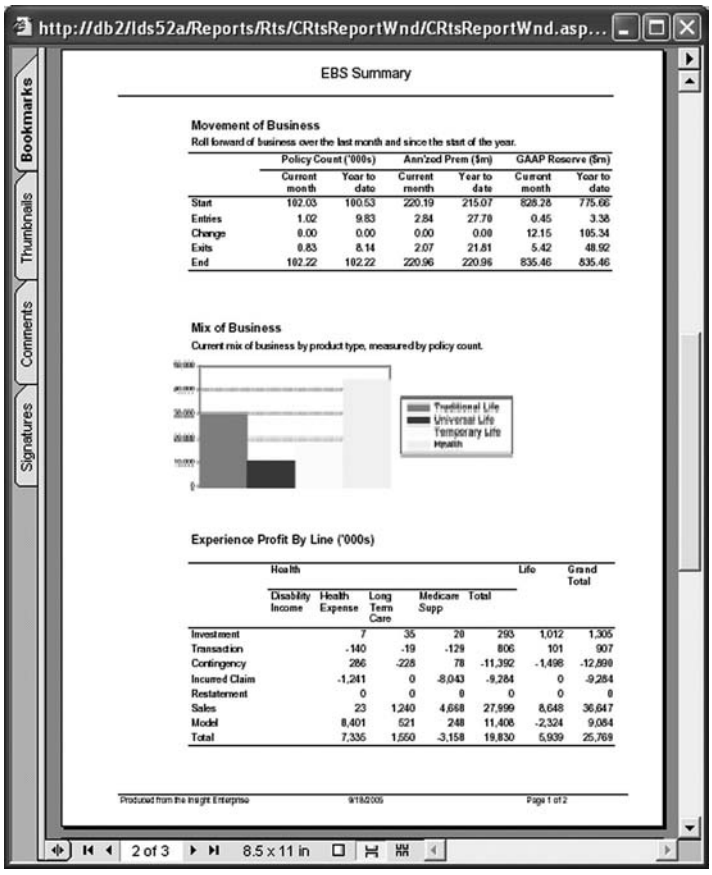
What is the truth? The truth represents a concept of reporting what actually happened to a company.



A pivot interface is critical for users who wish to restructure analytics, while executives often prefer reports formatted for printing.



"IT will take care of the data model."

Some DWs are built without much thought about how the business will be analyzed. For example, executives will want to see lapse rates by agent. Financial people will want to see source of earnings and compare their actual earnings to expected earnings. Actuaries will be interested in actual-to-expected metrics relative to pricing assumptions. Sales and marketing will want to see agent performance. If the design of the DW is such that it expects the end user to build the specialized applications with the data, then the design is at risk for failure. This DW does not have the necessary data to do the analysis or the data must be again off-loaded to a data mart where the analysis is carried out. A single integrated design is critical for consistency. For example, sales and marketing analysis of persistency rates by agents should be related to product lapse rates presented by actuarial.

The DW should include core insurance functionality such as movement (including health transitions for LTC) studies, source of earnings studies, experience studies, underwriting lag time studies, claim runoff, agent productivity and so on. Just putting transactions into a DW and using a query tool will not do the trick.

The DW will include transactions, but it should also include any calculated measures or pieces of information such as exposures, assumptions relating to expected experience, and relationships between information. Consider an experience study; analysts will want to look at the results as rates, exposures, events and actual-to-expected ratios. They will want to slice and dice this information based on experience they see and wish to explore. This will involve looking at it by gender, duration, band, geographical area, this month to last month or this quarter to a comparable quarter last year—views that cannot be predicted in advance. Conventional experience study systems require another run to get each slice of information because it has to build the entire computation for each study, including the parameters that define the view.

A properly deployed DW means providing one source for analysis and data. This requires the loaded data to have one, and only one, meaning. The objective is to eliminate multiple definitions for premium, commission or other data items that may have slightly different meanings within disparate systems. A properly deployed DW should allow an analyst to slice and dice analysis

and drill-through to the underlying data. For example, if five policies terminated last month, which ones were they? If three policies went from receiving nursing benefits to receiving home health care benefits, it would be nice to know which ones they were.

"Do you need valuation system results?"

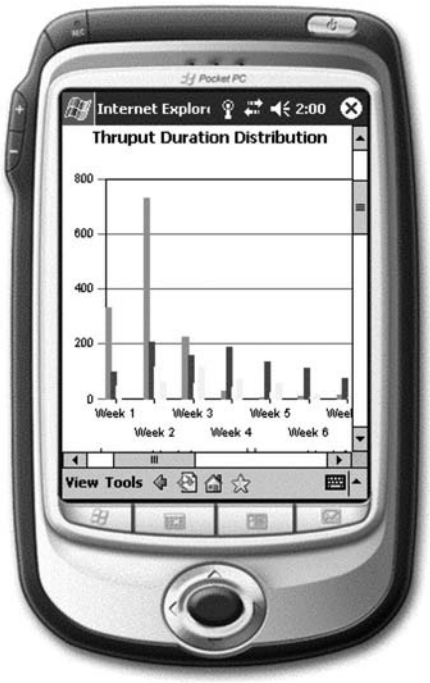
Most DW installations will include data from the available systems in the company. These range from multiple administrative systems to claims, commission, agent, CRM, general ledger, accounting and valuation. This last item, valuation, is vital because of the need to query and reconcile reserve movements. Most DW installations at companies do not even consider linking to the valuation system because of not knowing what to do with the data.

Companies who write LTC business have all the reporting requirements of a regular life insurance company. The fact that an LTC policy can offer different levels of benefits and exist in many different statuses (active, various claiming states, terminated, etc.) imposes some special reporting requirements.

Insurance people like to look at results at a point in time, over a period of time. Most importantly, we also want to look at events based on internal policy time such as duration since issue, duration since claiming or event duration since entering a certain claim stage. In addition, we might want to know how many policies are in a certain claiming status, how many are in their first, second, or nth month and so on. These statuses and the transition between statuses is the cornerstone of LTC analysis and leads us to the need for some temporal functionality.

"I'm not interested in this detail right now."

You might be thinking, "I'm not interested in this detail right now," but a good DW will be structured for the questions that might be asked and questions that may arise from the answers received from questions. Too often managers ask questions and don't get the answers they expect or are not consistent with information from other business areas. The answers need further investigation. The ability to respond to these problems is the greatest asset of a well-designed DW as they provide the greatest insight to the company's operations; unfortunately it is also the most common failing of a poorly designed system. Clearly this is only possible with an enterprise solution designed at a level of granularity beyond your current business questions.



Pocket PC delivery of a DW.
'Information at your fingertips' should be true when you are away from your PC, perhaps in meetings.

A common DW mistake is selecting a perceived best-of-breed technology over addressing the data model. Delivery of information is important. In today's world Web delivery is a standard, as is a range of delivery methods incorporating pivots, statistical analysis and formatted reports. The tools used should be proven to work together and proven for the demands placed on them by the nature of the business and the data model. Finally, the delivery tool should accommodate a wide range of users from executives through to actuaries. Compared with other industries, actuaries should be thought of as super-power users, and not as easy to satisfy as many of the tool vendors believe.

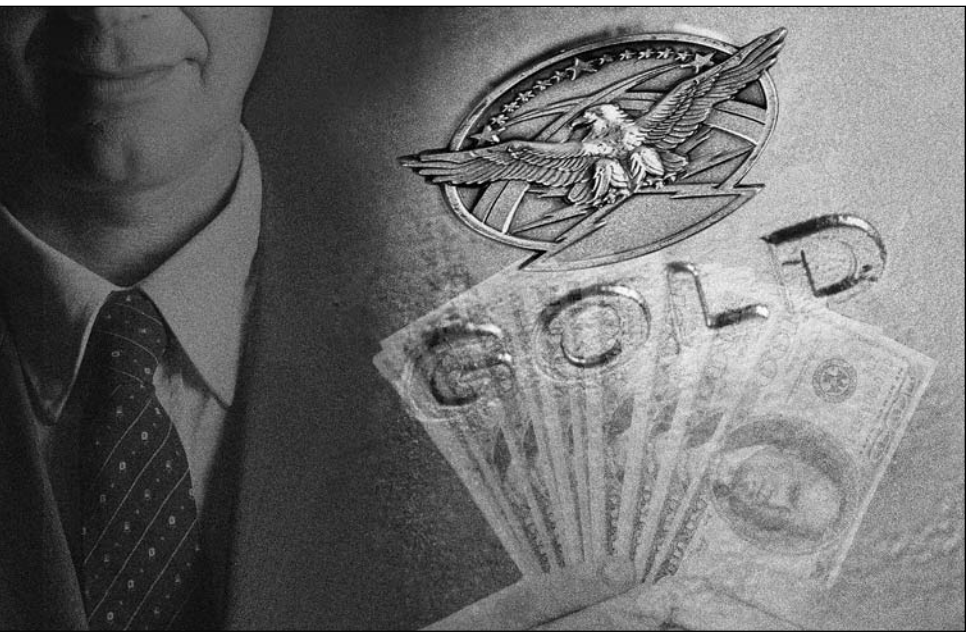
You really can have it all: readily available and relevant information derived from consistent and understood data. Getting at the Truth requires a good DW design and an appropriate business data model. Add a powerful and flexible Web–based analytical interface to get at the data and success in the pursuit of Truth will happen. ❋

Robert J. LaLonde, FSA, MAAA, is vice president and senior account executive with Insight Decision Solutions, Inc. in Glencoe, Ill. He can be reached at *rlalonde@insightdecision.com.*

A Millionaire Mind and the Money to Match:

Are They Prospects for Long-Term Care Insurance?

by Debra C. Newman



When working with wealthy clients, most financial advisors will open a discussion about Long-Term Care (LTC) insurance with this question: *Have you ever thought about LTC insurance?* You might as well pack up your bags right then because the response is going to be one of either, *"I don't need it because I have plenty of money,"* or, *"What is it?"* When you begin painting the picture of them being old and disabled in a nursing home, I can assure you the conversation will be over in a matter of seconds. Then the wise and safe financial advisor, wanting to preserve their position as an advisor rather than an insurance agent, quickly backs off and agrees that the client can probably afford to self insure. If this sounds typical, let me give you some tools to approach the discussion in a different fashion, which will allow the client permission to buy LTC insurance for emotional, as well as economic, reasons.

Open the discussion with a question. *"Oh by the way, who do you have your LTC insurance with?"* If they say, *"I don't have LTC insurance."* or *"What is it?"* You can respond simply: *"We need to talk about LTC insurance because most clients with similar circumstances to yours already own it."* Now, you tell them a few stories that help them validate why other very wealthy people own LTC insurance.

Let me share with you the following three examples:

The Analyst

For 38 years, a mega-successful stockbroker with generations of wealth had his house appraised each year. Then, he would call a Property and Casualty (P&C) agent to assess how much it would cost to insure his home. Each year, he would deposit the exact amount of the homeowner's insurance premium into his "house account" and essentially self-insure the risk. After 38 years, he has $1 million of cash in his "house account" and now his house is worth $750,000. The man knew that the odds of his house burning down each year was less than 2 percent and he was willing to take that risk. INTERESTINGLY, THE MAN BOUGHT LTC INSURANCE. *Why?* He said that he knew what the financial risk of his home was, but he did not know what the financial exposure of an LTC risk could be. He was unwilling to self insure an unknown risk.

The Greedy Heirs

A woman with assets of $30 million asked her good friend, an LTC insurance specialist, if she could buy an LTC insurance policy. Her friend said, *"Why in the world do you want to buy LTC insurance? You could buy the nursing home!"* The woman replied, *"Let me tell you what happens when you have a lot of money. If I ever need care and can no longer make decisions for myself, I want to make sure that I have the highest quality of care available without my heirs worrying about* ***spending their inheritance on my care****."* (I tell this story to a lot of estate planning attorneys that just sit there and nod their heads in agreement.)

Getting Rid of the Guilt

This story is about a 60-year-old woman with assets valued at more than $1 million dollars. One could quickly determine that interest income alone would pay for the best quality care for this

Debra C. Newman, CLU, ChFC, LTCP, is the chief executive officer of Newman Long Term Care. She can be reached at *LTC@newmanLTC.com.*

woman without ever depleting principal. But, she was asked a vital question: *"As you live out your retirement, what most concerns you about your family?"* Her reply: *"I cared for my mother in my home for six years, and while I would never take back that time, I do not want my children to have to care for me."* She did not want her children to feel that they needed to stop their lives and take care of her because they witnessed the sacrifice she had done for her own mother. She bought the insurance so that she could give her children permission to hire someone to help care for her.

These are all clients that financial advisors may have walked away from because they were not willing to ask deeper questions, listen attentively and share stories in order to get beyond the objection "I have plenty of money." Sell with emotion, validate with logic!! ❋

Marketing to Women:

Where Have All the Single Women Gone?

by Barbara J. Stahlecker

I recently had an opportunity to be a panelist at a session called "Marketing to Women." During the session, one of the audience members asked a question that stumped the panel. The question was, "Where do I find single women clients?" At the time, I flippantly suggested "the courthouse"—mainly because I couldn't think of anything better. However, since then, I have had plenty of time to think about that question. It was truly a good question that deserved a better answer.

Since then, I have done some research and here's what I have come up with: Cold calling doesn't work with this group. Many single women report feeling vulnerable and as such, are wary of this type of marketing. Here are a few suggestions on how to locate and work with qualified single female prospects:

1. **Partner with a Financial Planner or CPA.** When a woman becomes single late in life (due to divorce or spouses' death), they rely heavily on their financial advisor. Since this is already a trusted established relationship, a single woman will be more receptive if your services are referred to her in this manner.

2. **Sponsor a "Women and Investing" Workshop.** You can do this relatively inexpensively through your local Parks & Recreation Department, Adult Education Facility or Chamber of Commerce. If you can include another topic, you are likely to get better attendance. Sample topics might be "Understanding Annuities," "Mutual Funds versus the Stock Market" or "Medicare: What to Expect."

3. **Hold a Luncheon at Your Local Country Club.** This is the perfect location to find financially qualified prospects. Most women are aware they are likely to outlive their husbands. Many country clubs allow widows and/or divorcees to maintain their memberships. A widow generally inherits significant portions of her deceased

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husband's estate, thus increasing the potential for improved financial security.

Independent female members are likely to be successful, financially savvy and leaders in their community. As they are usually in the 40-65 year old range, they are also good candidates for this type of insurance from both a financial and health perspective.

4. **Contribute Regularly to Women's Publications.** Our local newspaper has a women's section and I contribute an article about four times a year. This establishes me as an "expert" in my community and gives me credibility. Be sure to include your contact information. You should also include a picture of yourself if possible.

5. **Offer to be a Speaker.** Single women report they feel less threatened when approached in a group setting. Contact your local bank, Chamber of Commerce, VFW Women's Auxiliary—any group that has female members—and offer to hold an "educational" session.

6. **Worksite Marketing.** Besides the obvious benefits of enrolling an employer group, you will find that many single women are still working. They are more likely to embrace you and your product if it is presented to them in a workplace environment and recommended by their employer.

7. **Market in Her Environment.** Put your brochure or card in every hair salon, nail salon, boutique, grocery store, jewelry store, tanning salon, gym, spa and OB/GYN office that you can think of.

8. **If You are Male, Be Willing to Meet Somewhere Other Than Her Home.** As I mentioned above, many single women feel very vulnerable. Inviting an unknown man into her home can make her feel threatened—especially in metropolitan areas. If you have an office, invite her to meet with you there. If not, mention that she is welcome to invite a friend when you go to see her. Or, offer to meet at her advisor's office (and to meet with the advisor as well). Who knows—you might get two sales for the price of one!

9. **Place an Ad in the Yellow Pages.** Sample headings would be: Insurance, Investing, Financial Planner and Financial Services. Be sure to include your picture.

10. **Ask for Referrals!** The best way to market to single women is through other single women. Once you establish a trusting, working relationship she will recommend you to her friends. Count on it!

These are a few of the ideas I have culled from producers who have been successful working with single women. I hope this reaches the gentleman who asked the original question—and that he will benefit from it. ❋

Barbara J. Stahlecker, CSA, LTCP, CLTC, is vice president and national marketing director of long-term care with Northstar Network Insurance Agency in Burlingame, Calif. She can be reached at *Barbara@northstarnetworkinc.com.*

The Group Network

by Chuck F. Breen, Group Editor

Happy New Year! This issue of the LTC newsletter focuses on group LTC in three articles. One of our goals is to provide education on not only the differences between the myriad of LTC products, but hopefully ideas on when to use each product. Jon Shreve provides his opinion on the future of GLTC and why this product should become a core benefit. Nancy Boari discusses how to identify an employer as a group prospect and why a group plan was the right fit for her client. Gail Steingold shows how she performed a needs analysis for two law firms and the process she used to determine which product to market.

Hopefully, all of these articles will provide insight when you need to make a decision on whether to market a retail product or a true group product.

I am always looking for articles, ideas, writers and feedback for the newsletter. I can be reached at (800) 330-4598, extension 24006 or via e-mail at: *cbreen@jhancock.com*. ❋

Chuck Breen, CLU, RHU, is regional sales vice president of John Hancock's Group Long-Term Care in Boston, Mass. He can be reached at *cbreen@jhancock.com*.

Why Should Insurers Offer True Group Long-Term Care?

by Jonathan Shreve

The current design of group Long-Term Care (LTC) products does not optimally serve employers and employees, which is limiting growth in the employer market. Current employer LTC products fail to deliver in one very important way: too few employees participate in the coverage. Over the long term, low participation rates cause higher per member premiums, further reducing potential participation. As well, the current design of group coverage does not achieve many of the typical employer's goals, such as minimizing cost and rewarding the right employees. The high cost of coverage in the individual market has scared many employers away from purchasing group LTC coverage. Providing alternatives to employers may help increase an insurer's market share.

I would note that most LTC coverage today is approached with a very strong individual focus. If we step back and ask what is important to employers rather than individuals, we wind up with different conclusions.

What is Wrong with Current Group LTC Coverage?

Current group LTC offers some nice features for employees. Employees can easily enroll at work. Often, employees can pay their premiums with payroll deductions. Also, it can be cheaper for employees to purchase coverage through their employer because of the reduced commissions as compared to what they would pay in the individual market. However, these voluntary benefits are not as popular as they should be, given how critical LTC coverage will become for many employees.

However, current group LTC coverage offered through the workplace mimics individual products. Current group products typically offer much lower commission rates and decreased rigor in underwriting, but in reality are similar to just writing a group of individual policies. Group LTC coverage designs are not consistent with the way that other lifetime group coverages are written. Typical group coverages are targeted only at longer-term employees, and employers typically pay a portion of the cost to encourage higher participation. Common group coverage features (for retiree medical and pension benefits) include waiting periods and vesting, as well as possibilities for self-funding or alternate funding. These design features help the employer keep the cost down while also targeting their objectives of rewarding and retaining longer-term employees. The current designs for group LTC coverage do not have these features, and often are not properly satisfying the employers' objectives.

Our bias toward individual products is so strong that, to achieve a "true group" label, products only need to have a contract written with the group rather than with each individual employee. Below, we propose a version of true group coverage that focuses on the objectives of the employer and takes advantage of group features.

What is True Group LTC Coverage?

In order for group LTC coverage to be more appealing to employers, it will need to become a true group benefit, which encourages high employee participation while keeping costs down. True group LTC coverage rewards longer-term employees, and protects these employees from future financial destitution.

Comparison of True Group and Voluntary LTC Coverage

True Group LTC	Current Voluntary LTC
Employer contribution	No employer contributions
Targeted at long-term employees using waiting periods and/or vesting	Participation available to all employees immediately
Benefit design set by employer and may be changed	Benefit design set by insurer and is immutable
Possibly self-funded or alternate financing	Always fully insurerd
High participation expected, providing cost efficient and meaningful coverage	Participation around 1% to 10%
Cost to employer around $5 to $25 per employee per month	Negligible cost to employer

The table to the left contains a summary of the differences between current voluntary group and true group LTC coverage.

In a true group LTC plan, the employer takes on some responsibility for those employees who are employed longer term. In exchange, the employer can share costs with employees and only pay for those longer-term employees. Employers exchange a plan with no cost for one with a small cost, which helps target and retain the most desirable employees. The plan design features that achieve these objectives are waiting periods, vesting and employer contributions.

Waiting periods, here meaning an eligibility period rather than an elimination period for benefits, require that an employee be employed for a defined period of time before they may start participating in the plan. This way, the employer does not spend money on employees who leave after short terms of employment.

As well, true group plans may have vesting requirements, which determine the ownership of the employer contributions, if the employee leaves the company. When an employee leaves, they will be eligible for coverage as funded by their own contributions. The vesting rules determine if the employee will also receive coverage from contributions made on their behalf by the employer. Once an employee is "fully vested," they are eligible to receive benefits that have been funded by the employer through their date of departure. An employer will stop making contributions after the employee leaves. Because vesting only allocates funds to employees who stay with the company for a longer period of time, it can help keep the cost per employee down while also retaining valuable employees. Waiting periods and vesting not only reward longer-term employees, but can significantly reduce the cost of offering these benefits. With these features and a 50 percent employer contribution that accrues to vested employees, we estimate that the cost to employers can be kept down to $5 to $25 per month per active employee.

When compared to a "core/buy-up" program, this design can be much less expensive to the employer, because the employer only pays for employees who choose to purchase LTC coverage (at 50 percent prices) and who achieve vested status. In addition, the plans that employees take into retirement are typically more valuable than a core program.

Is this a Market Opportunity?

While there has been growth in the group LTC market, sales more recently have been down. The current plan designs do not optimally satisfy the needs of the employers. Designing LTC plans in a true group fashion will allow employers to offer higher quality benefits to their most valuable employees, while also increasing participation.

The individual market products have convinced employers and employees that LTC coverage is prohibitively expensive. However, that is simply not the case. Innovating group plan designs to be true group coverage could open more market share for insurers. ❋

Jon Shreve, FSA, is a principal and consulting actuary with Milliman, Inc. in Denver, Colo. He can be reached at *jon.shreve@milliman.com.*

Large Employers Enjoying the Advantage of Group Long-Term Care

by Nancy Boari

Long-Term Care (LTC) Insurance is becoming a popular employee benefit in both small and large companies. As a long-term care specialist, I am experiencing such an advantage for the group LTC product in industries such as law firms, CPA firms, architectural companies, universities and corporate offices that have 1,000-plus employees. The advantages with the group LTC policies are unlike any other employee benefits employers can offer.

First, let's start by defining LTC insurance. Bottom line, LTC insurances are dollars specifically designated in a policy to pay for caregiving during a chronic medical diagnosis. Chronic conditions such as closed head injury, spinal cord injuries due to auto and athletic accidents, and medical conditions such as diabetes, Alzheimer's Disease, dementia, and stroke may result in the need for caregiving. The plans today offer caregiving in the home, assisted living, nursing home and adult day care.

Now let's discuss the differences between group LTC and the individual multi-life discount product. True-group LTC is a master policy that is priced based on volume of employees, specific underwriting of the entire group with appropriate expense savings discount. A range of benefits are sometimes limited unnecessarily by the insurer. Understand there are no real reasons to limit the benefit structure between these two group methods.

The individual multi-life discount product would often (not always) require full underwriting and is priced accordingly. You will often see the individual multi-life product as an "executive carve-out" offering with the group product as a voluntary benefit for all other employees.

Employers offering group benefits have the flexibility of structuring the benefit options to best fit the employee and his or her family. Premiums are based on the issue age of the applicant. Additionally, this employee benefit is totally portable, meaning the employee takes the policy with them when they leave employment, with no change of the premium rate as they leave that employer. The group plans have a unique feature that the individual policies just can't provide; the coverage is guaranteed issue during open enrollment, one time only. Regardless of medical condition, employees can get coverage that might otherwise not be available to them. Another value the group plans offer is the group discount extension to other family members for coverage; employees, mothers, fathers, in-laws, grandparents and siblings are all eligible for the same set of premium rates but which includes the group discount. This is a true family benefit employers can offer that will last a lifetime.

With all the discussion around employee benefits and the cost of healthcare, the opportunity to be creative in ways of structuring this benefit is one of the most attractive features of this type of policy. Employers can elect to pay a portion of the premium with the employee adding out-of-pocket dollars for additional

options. Employers can also pay the premium for a certain class of employees as a "carve out," then make it a voluntary benefit for everyone else. Lastly, the employer can make this a completely voluntary option allowing employees to choose to payroll-deduct the premium. My experience with the large companies is they typically choose a fully voluntary benefit for all employees.

As a broker working with the Group LTC insurance companies, a significant advantage is the enrollment support they provide. Worksite education, online enrollment and personalized internal marketing to the employees prior to enrollment all have tremendous value to the success of the program. I now have a team approach to work with my clients that solidifies my credibility and provides an opportunity to offer other benefits my client may want to implement.

Baby Boomers are facing caregiving concerns with their Moms and Dads, and they are realizing the exorbitant cost of care. Boomers are also expecting that at some point they too will need support. LTC insurance is just one option to preserve retirement plans. Large employers offering group LTC are looked at favorably from their employees.

Remember, discussing group LTC is a door opener for brokers and will increase sales in many different product lines.

Employers are going to continue to look for progressive, value-added, cost-effective benefits for their employees. Suggesting group LTC insurance is a sure way to help the employees and their families stay financially secure during a time in their life that caregiving often comes unexpectedly. As a broker, be proactive, open the conversation and bring a group product representative in to help solidify the need for this timely family financial peace of mind. ❋

Baby Boomers are facing caregiving concerns with their Moms and Dads, and they are realizing the exorbitant cost of care.

Nancy Boari, M.A., is a long-term care specialist with Northwestern Mutual Long-Term Care. She works with both the individual and group products. She can be reached at *nancy.boari@nmfn.com.*

Multi-Life and True Group LTC:
A Tale of Two Law Firms

by Gail Steingold

"Group" Long-Term Care Insurance—a Variety of Approaches

Employer groups of 700 or more lives have choices on how to offer this benefit to their employees, ranging from a completely funded plan to a voluntary program or somewhere in between (usually with buy-up options for all or part of the premium on a pre-tax basis). The LTC specialist who has direct access or works in concert with non-specialist brokers to the large employer must be prepared to meet the challenge of recommending to the client which path to take: do you present the individual discounted platform offered today by many of the carriers or contact your area group LTC carrier representative? The producer needs to feel comfortable and gain an understanding of what products are out there and what makes sense for the client.

Needs Analysis

Every employee population is different. By performing a *needs analysis*, the LTC broker can better recommend a program that reflects the financial situations and lifestyles of the large group's employees and eligible family members. As a result, the LTCI broker will be able to:

- Educate employees on available LTC options.
- Choose the best carrier and method of enrollment (individual discounted plans or certificates of insurance with a master policy).
- Design in concert with the chosen carrier a voluntary or sponsored plan with a variety of contribution and executive options.
- Discuss with the company's or firm's financial officer and tax advisors the most appropriate plan and funding methods.

Multi-life and Group Case Study: a Tale of Two Law Firms

Law firms are comprised of highly educated and compensated individuals as well as a host of support employees. In recent years, firms have grown through mergers and acquisitions with an expanding national and international presence. Over the past six years, I've had the opportunity to enroll two of the top ten law firms headquartered in Chicago, both with offices in other major metropolitan locations.

Tale 1: The multi-life discounted "experience"

In 2004, I had the privilege of enrolling a firm of 800 eligible partners, attorneys and staff. During a two-year period of due diligence and needs analysis, the firm chose to present a multi-life discounted program with modified underwriting requirements. The multi-life approach successfully met the wide range of financial profiles of the firm in terms of plan design. The firm did not opt for payroll or list billing; guaranteed issue was not a primary concern. There was a high amount of support from the top level and participation was estimated at 7.5 percent with over $250,000 of annual premium.

A multi-life enrollment such as this not only required non-resident licensing, but also an understanding and ability to implement a comprehensive pre-enrollment education program. Also, it required time and the administrative costs for scheduling of one-on-one meetings with the prospective applicants, travel time and expenses, and marketing costs. Extensive time was spent in the enrollment process (approximately a five month period) with

up-front expense risks to this broker. The firm's benefit manager and team were supportive of office space and additional communication and administrative support.

When evaluating true group versus multi-life business, the broker must therefore address the above stated costs as well as the probability of a new plan series being introduced over time. Continuity between plans is a challenge when new employees inquire about coverage. Today, our major multi-life carriers continue to develop turnkey communication and enrollment to support larger group programs, but still present a time and cost risk to the broker in exchange for vested commissions and higher compensation. **In summary, the multi-life enrollment approach requires the ability of the broker (with support of the carrier, MGA and client) in:**

- Identifying the most successful means of communicating with the group.
- Distributing approved carrier communications such as: seminars, announcements and enrollment meetings, direct distribution pieces, newsletter articles, payroll stuffers, posters, e-mail and voicemail messages.
- Supporting enrollment after the specified open enrollment for new employees and "late comers."

Tale 2: The "true" group experience

A second opportunity and total voluntary true group enrollment was initially launched in 2000 with a group carrier. Total eligible lives were approximately 1,200. At the end of a six to ten-week enrollment program (including extensions), participation was estimated at 12 percent. Several years later, a prominent but smaller firm of 300-plus attorneys and staff was merged with this Chicago firm and also offered a voluntary GLTC insurance program with the same group carrier. In 2005, a re-enrollment was introduced using a different group carrier. True group insurance was again chosen by the firm as a result of the needs analysis performed by our brokerage with the client for the following reasons:

- Size of the firm and multi-state location of the partners and employees.
- Desire for guaranteed issue for all interested employees, attorneys and partners.
- Culture that supports electronic enrollment, Web site education and call center.
- Support of payroll deduction. The GLTC insurance benefit, while not funded as a core, was seen as an integral voluntary benefit program.

The True Group Experience: from the Sidelines into the Partner's Offices

One objection that the broker may face is a more limited range of plan designs and options in a group plan. Group carriers are receptive to adding additional plan designs if the designs have been filed already with respective states. In the original rollout of this firm in 2000, two additional plan designs were added despite a philosophy of group carriers to limit choices to create an easier application process for the employees.

The re-enrollment was a success since the placed premium tripled the original projections! Success was also due to the fact that I was able to meet one-on-one with the partners who typically did not attend the group enrollment meetings conducted on site at each law office. As the broker of record, I felt it necessary to be present at the group enrollment meetings. Fortunately, the client requested me to be present—they saw the wisdom in being present, too. The time spent in the enrollment meetings allowed me to meet one-on-one with the more highly compensated partners. I believe that my presence at the group meetings assured the staff and attorneys that there was a personal connection to the broker should future questions arise. Finally, because this program was transitioning between two group plans, it was essential that those employees and partners—who held the other coverage, had an individual with whom to consult about their coverage options.

Success was also due to the fact that I was able to meet one-one-one with the partners who typically did not attend the group enrollment meetings conducted on site at each law office.

Reasons for and Advantages of the True Group Product

- Size of the group.
- Training of the human resources and/or benefits team for future questions that may arise.
- Multiple office sites. If there is more than one office, the individual producer needs to consider the time and cost of traveling to these offices to implement a multi-life program versus working with a group carrier who will provide enrollers and Web site enrollment support.
- Group enrollment meetings conducted by trained LTC enrollment specialists.
- Customized Web site and toll-free customer service line.
- The carrier absorbed cost of the enrollment campaign.

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Gail Steingold is founder and principal of Burlington Insurance Group Long Term Care, an independent insurance agency based in Chicago, Ill. She can be reached at *steingold@bigltc.com.*

- The group carrier will be available and keep an enrollment call center going, even if it is an employee-pay-all benefit.

In working with a group carrier, the LTC insurance specialist can recommend some of the following approaches for added success with their client:

- **Group enrollers.** Provide guidelines ahead of time to the speaker/representative of the carrier as to the culture of the client in terms of modifying the presentation (e.g., refer to the group as "partners, attorneys and staff").
- **Meet with the partners (or company executives) on an individual basis.** Group carriers will work with you on underwriting questions that may arise before an application is submitted for a family member (e.g., a spouse or parent) that may have some issues. This is similar to the multi-life approach.
- **Results tracking and analysis of applicants and plan designs chosen.** The LTC specialist as the broker of record needs to stay involved and monitor the enrollment results as they come in. For example, at the end of this group re-enrollment, I noted a very small percentage of spouses who enrolled. Upon my suggestion, the carrier agreed to craft a letter and, at their cost, mail it to all employees to remind them of the coverage available to spouses.

Summary

A personal, customized approach can be added to a group enrollment with outstanding results. The responsibility and challenge for our industry, multi-life and group carriers, is to make it easier for both the broker and employer/client with their turnkey programs to communicate the LTC benefit as part of the company. Rather than bumping heads, learn from the tale of the two law firms. Success can be found in both "tales." ❋

The Compliance Network

by Steve Serfass

The Compliance Networking Track leadership team, which was assembled over spring and summer of 2005, includes representatives from large and small LTC insurers. Our mission is to provide a forum for the exchange of ideas and information about compliance related issues. The track will also serve as a conduit for education, research and professional development for compliance professionals. One of our founding principles is that our membership will follow both the letter and spirit of antitrust laws, which prohibit any activities that might lessen or tend to lessen desirable competition among insurance companies.

Our current initiatives include: (1) recruiting writers and people with ideas and strong opinions to participate in drafting articles for the SOA LTCI section newsletter on compliance issues and possibly for other publications; (2) developing our Web page so that it provides timely and useful information for compliance professionals as well as serving as a place where ideas can be exchanged easily; and (3) planning how best to otherwise serve the LTCI compliance community. If you have ideas in any of these areas, we would welcome your participation in the Compliance Track.

If you are interested in learning more about the Compliance Track, or if you would like to become a member, please check out our Web page (can link to through the SOA Web site) or contact Karen Smyth at *karen.smyth@prudential. com* or Steve Serfass at *stephen.serfass@dbr.com.* ❋

Steve Serfass is employed with Drinker Biddle & Reath, LLP in Berwyn, Pa. He can be reached at *stephen. serfass@dbr.com..*

A Solution to the Long-Term Care Financing Crisis?

The New York State Compact for Long-Term Care

by David Bilson

The financing of Long-Term Care (LTC) is an issue that has long perplexed state and local government, as well as the insurance industry and recipients of LTC. This article examines a plan recently proposed to address the LTC financing conundrum in one state. The success or failure of that plan could alter the landscape of the LTC insurance industry.

The cost of LTC can be financially catastrophic. For many, the only assistance available is Medicaid, and the price they pay is impoverishment. Although we tend to view the effects of this mandatory impoverishment from the perspective of the individual, the impact of this policy goes beyond the fiscal devastation of a single person. Ideological arguments aside, many find it unfair to require those in need of LTC to lose their independence, security and life savings in exchange for mere survival—particularly if no other options are offered. Over time, this perceived unfairness can create resentment, which informally encourages circumvention of the rules. Even those who believe in personal responsibility begin to feel justified in divesting or concealing their assets to avoid losing them. Divestiture or concealment of assets increases reliance on Medicaid funding, increased reliance on Medicaid funding increases Medicaid costs, increased Medicaid costs lead to higher taxes, higher taxes lead to public pressure on government for tax relief, public pressure on government fuels enactment of more stringent Medicaid rules, more stringent Medicaid rules cause more resentment in those who need LTC, which leads to additional divestiture or concealment of assets. This cycle ultimately causes a drain on public funds that cannot be sustained.

There have been many ideas on how to resolve the LTC financing problem. Some seek to expand the number of possible payers by

encouraging the purchase of private insurance (e.g., the state LTC partnerships established in the early 1990s). Some ideas center on increasing revenue sources, such as proposals to impose or raise various excise taxes in an effort to supplement Medicaid funds. Others believe eligibility rules are too lenient, while still others think controlling provider charges would alleviate the problem. None, however, have addressed the cycle or questioned the role inherited by Medicaid in the financing of LTC—that is, until recently.

Perhaps the most promising alternative for alleviating the LTC financing crisis is the New York State Compact for LTC (the "Compact"). It is also the most intriguing in terms of its authors and supporters. Based on an original proposal by Gail Holubinka, vice president of business development for MedAmerica Insurance Company, the idea is the product of a collaborative effort between unlikely allies—an LTC insurer and the Elder Law Section of the New York State Bar Association.

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Design of the Compact

The Compact proposes to reshape the structure of LTC financing by removing Medicaid as the central player under the assumption that need due to poverty and need due to a single overwhelming expense differ and should be managed differently. The new structure is an agreement between the State of New York and its citizens to adhere to a pledge of mutual responsibility. Specifically, if an eligible New York resident agrees to privately fund the cost of his/her qualified LTC services up to an amount equal to the established program maximum or one half of his/her non-housing assets, whichever is less, the State agrees to provide financial support for certain subsequent LTC services through the payment of a subsidy.

A person may apply for the Compact when they are determined to be chronically ill.

A person may apply for the Compact when they are determined to be chronically ill.[1] Enrollment and management of the pledge portion of the Compact is the responsibility of a private organization chosen to administer the Compact. Through that organization, participants pledge to pay the cost of their qualified LTC services[2] in an amount equal to one half of their non-housing assets (a Dollar Pledge) or an amount equal to the cost of 36 months of facility care in their region (the Maximum Pledge). The Dollar Pledge protects the other one half of the participants' assets while the Maximum Pledge protects all of their assets. Pledge amounts can be fulfilled through any non-government source, such as cash or insurance.

During the pledge period, the participant is private pay. Documentation evidencing the amount of private funds paid (not incurred) by or on behalf of the participant is sent to the Compact administrator. Qualified LTC services need not be covered or paid by Medicaid to be credited to a participant's pledge amount.

Once the pledge is satisfied, the participant's remaining assets (including the homestead) are protected. The participant remains private pay, but becomes eligible for a Subsidy from the State (the "Subsidy"). The Subsidy equals the amount Medicaid would have paid for the qualified LTC service received by the participant. Participants who have met their pledge are charged a Compact Rate (the "Compact Rate"), which may not exceed 110 percent of the Subsidy amount.

Participants who have satisfied their pledge and are entitled to receive the Subsidy are responsible for paying the State a participation fee equal to 25 percent of their monthly income. In addition, participants must pay out-of-pocket the difference between the Compact Rate and the Subsidy, as well as any expenses not arising from the receipt of qualified LTC services. Participants who have satisfied their pledge and are entitled to receive the Subsidy could use any provider willing to accept Compact Rates, even if the provider has not contracted with the Medicaid program.

Rationale of the Compact

The seeming simplicity of the Compact belies the year of work that has gone into testing its underlying assumptions. Cost effectiveness, inclusiveness, regulatory compliance and operational ease were just a few of the issues with which the Compact's authors grappled. "The hardest part," according to Ms. Holubinka, "was constantly reminding ourselves that this was not a Medicaid program. Whatever we did had to be compatible with, but not governed by, the Medicaid paradigm. Each of the issues was examined from the viewpoint of all

1 For purposes of the Compact, the definition of "chronic illness" is taken from the Health Insurance Portability and Accountability Act of 1996. *See* 26 U.S.C. § 7702B(c)(2) (2005). Under the Compact, determinations of whether a person is chronically ill would be made by that person's health insurer or, in the case of a person making cash payments for his or her care, a state approved assessment organization. Assessments would be paid for by the person or his or her insurer.

2 For purposes of the Compact, the definition of "qualified long term care services" is taken from the Health Insurance Portability and Accountability Act of 1996. *See* 26 U.S.C. § 7702B(c)(1) (2005).

involved. No matter how appealing an idea, if it didn't result in a benefit to all, it had to be adjusted or discarded."

For example, a primary goal of the Compact's authors was to relieve some of the LTC costs currently shouldered by Medicaid. Because the majority of LTC costs are incurred within the first three years after the onset of a chronic illness, the Compact shifts much of this significant financial burden away from Medicaid by effectively requiring Compact participants to privately fund all or most of the expenses associated with their initial years of LTC. At the same time, participants will have less incentive to conceal or divest their assets because they know that they will not only qualify for the Subsidy once their pledge is satisfied, but will be able to maintain some or all of their assets once they qualify for the Subsidy.

Another factor that received considerable attention from the Compact's authors was the effect the Compact would have on the sale of LTC insurance. Would the Compact support sales of LTC insurance policies as well as the state LTC partnership concept? A program that begins at the point of need would seem to discourage the public from planning ahead. On the other hand, one of the greatest drawbacks of partnerships in terms of reducing public costs is that they do not address those who are uninsurable or simply do not plan how they will finance their long terms care. Because the Compact does not discriminate regarding the source of pledge payments (pledge payments can be made from cash or insurance benefits), it is more inclusive and expands privitization. Concurrently, the incentive to purchase LTC insurance likely would increase, as purchasing insurance is a more attractive option than risking half or more of one's assets. Furthermore, since the financial stakes associated with the Compact are known, the LTC market might expand as a result of the Compact. Those with smaller at risk assets or buyers who, faced with unlimited risk, may have rejected any coverage, could, under the Compact, become purchasers of LTC insurance coverage.

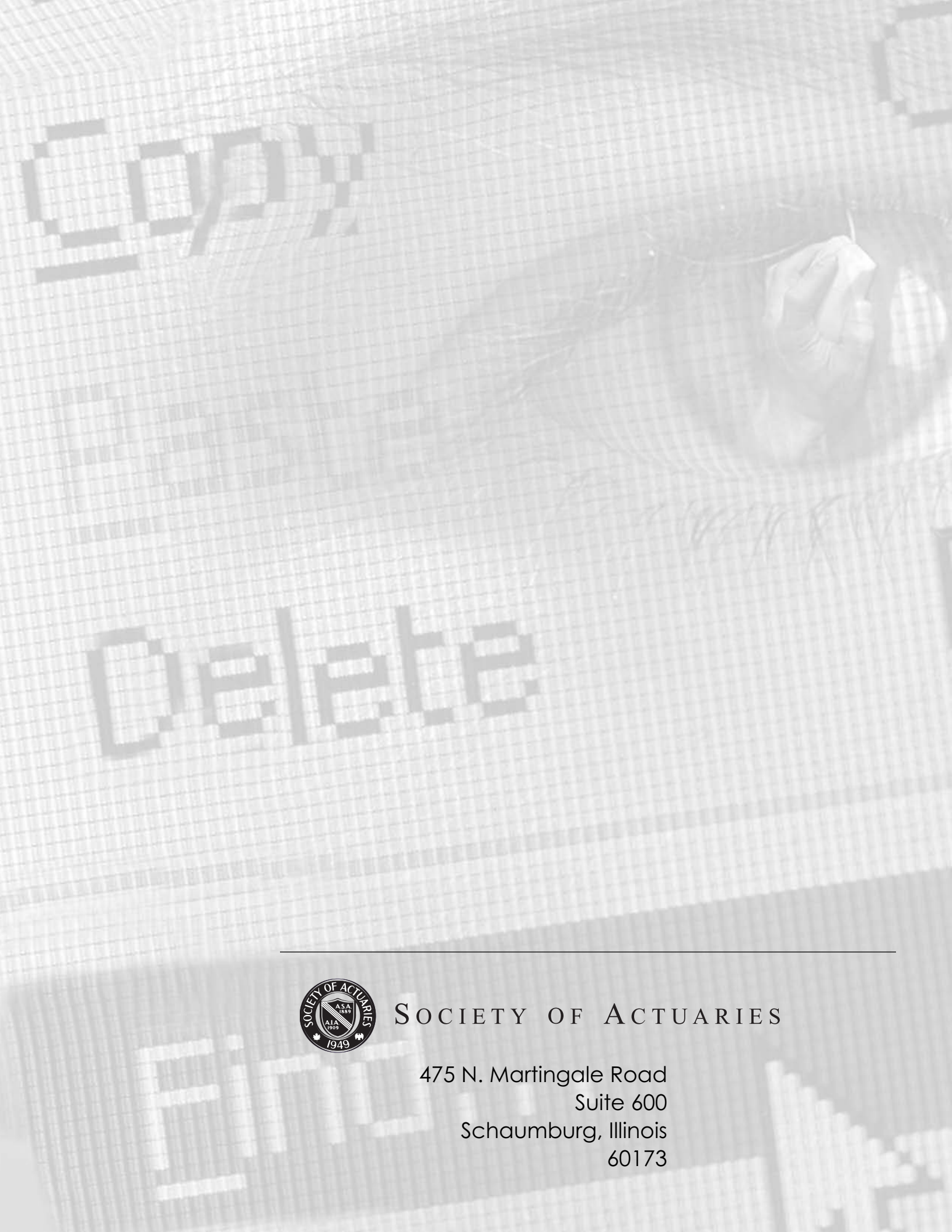
Progress of the Compact

In New York, legislation to establish the Compact is due to be introduced in the new session with support from both houses. "But," as Ms. Holubinka says, "regardless of the outcome of the Compact bill, the circumstances surrounding its development demonstrate that an intense concern regarding LTC financing is shared by even the most disparate sources. It also shows that a concerted effort to meet the needs of each stakeholder and innovative thinking are concepts that resonate." According to Ms. Holubinka, this fact is demonstrated by, "the broad scope of interest the concept has created. Providers, legislators, public interest organizations, and even nascent groups in other states have weighed-in with inquiries, suggestions and offers of help. It's exciting to be part of the dialogue."

Although there is no single solution for all of the problems associated with the financing of LTC, the Compact is a promising alternative to the untenable program that is currently in place. By focusing on Medicaid's proper role in the financing of LTC and shifting the perception of Medicaid from the primary source of funding to a "safety net" of last resort, the Compact has the potential to alleviate some of the financial burden from Medicaid while allowing the chronically ill to retain their dignity and a measure of financial independence. As such, the fate of the Compact in New York warrants close attention by state and local governments, recipients of LTC and the insurance industry. ❋

David Bilson is an associate with Drinker Biddle & Reath, LLP. He can be reached at *david.bilson@dbr.com.*

Gail Holubinka is vice president of Business Development for MedAmerica Insurance Company. She can be reached at *Gail.Holubinka@medamericaltc.com.*



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475 N. Martingale Road
Suite 600
Schaumburg, Illinois
60173