LONG-TERM CARE

The Newsletter of the Society of Actuaries
Long-Term Care Insurance Section

NUMBER 1 SEPTEMBER 1999

Chairperson's Corner

by James M. Glickman

Welcome to the first newsletter for the Society of Actuaries Long-Term Care Insurance (LTCI) Section. Last October, the process began to form this Section. The many hours being spent by both the organizing committee and this first year's Council are primarily attributable to our belief that a need exists for a centralized source of information, education, and interaction within the LTCI industry.

In addition to this newsletter, which we plan to produce regularly, and expanded participation in the Spring and Fall SOA meetings, I hope our Section can take the lead in developing a national long- term care insurers conference. This type of conference would allow multiple educational tracks in underwriting, claims, compliance, and marketing, as well as actuarial, with the appropriate body, such as the Home Office Life Underwriters Association (HOLUA) or the National Association of Health Underwriters (NAHU), coordinating the educational track for their home office area of expertise. This type of conference would also present a unique opportunity for all of the different LTCI home office departments to network with one another, improving communications and knowledge within the industry.

If anyone is interested in planning or participating in this type of conference, or has contacts with the non-actuarial organizations, please contact me at

Jim.Glickman@ltcadmin.com

As a final note, I would encourage all who are interested to join the Section and participate in determining its direction. A form for joining and/or participating is included elsewhere in this newsletter.

James M. Glickman, FSA, is president and CEO of LifeCare Assurance Company in Woodland Hills, CA.

In This Issue

LONG-TERM CARE
Issue Number 1, September 1999

Published quarterly by the Long-Term Care Insurance Section
of the Society of Actuaries

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World Wide Web: *http://www.soa.org*

This newsletter is free to Section members.
A subscription is $15.00 for nonmembers.

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Editor's Column

by Bartley L. Munson

Welcome to the first issue of the newsletter for the Long-Term Care Insurance (LTCI) Section of the Society of Actuaries.

The Section is the creation of LTCI leaders who recognized the growing need of actuaries toiling with LTCI to exchange ideas, share breaking news, and provide assistance in this growing and challenging field of practice. In March, the SOA Board of Governors approved the petition and bylaws to form the Long-Term Care Insurance Section and the Section was born.

While focused primarily on the actuarial aspect of LTCI, the line between that and "outsiders" is sometimes blurred, as it should be. Therefore, the Section intends to reach out to others and help actuaries engage, for mutual benefit, with others working with important, relevant aspects of LTCI. See Chairperson Glickman's column on page 1.

This first issue of the newsletter is driven post-Seattle meeting (see Secretary Amy Pahl's minutes) to provide you with our first issue before the SOA's meeting this fall, where LTCI has a couple of specific sessions and the Section has its own breakfast meeting on Tuesday, Oct. 19, 8 - 9:30 A.M.

Some "housekeeping" notes are provided in this issue to give us all a base of understanding of the Section to work from. Take particular note of our Mission Statement and the list of your Section Council. If you have suggestions for what the Section can do to best serve your needs and interests, let a member of the Council know.

This issue provides some articles that may be continued within subsequent issues or may become ongoing features—such as monitoring of NAIC and federal developments, some currently hot topics surrounding design, pricing, reinsurance, and some research news.

While some of these authors and Council members are committed to providing follow-up articles in future issues, this newsletter will only be as helpful as you help make it. Please give me your suggestions for what you'd like to see in future issues—with or without your offer to write it.

I can be reached at *bartmunson@itol.com* or by phone or fax, both at 920/743-9255. Mail will reach me at:

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I look forward to hearing from you and receiving your help to make this newsletter what you want it to be.

Happy reading!

NAIC Summary of LTCI Issues

by Bill Weller

Long-term care insurance (LTCI)was a topic at several meetings during the National Association of Insurance Commissioners (NAIC) June 4 to 9 Regular Meeting. Issues related to (i) rate increases and potential regulatory changes that could mitigate future rate increases and (ii) changes to bring the NAIC models in line with HIPAA.

Rate Stability

The regulatory actuaries have stated their desire to include additional provisions (beyond the Contingent Benefit of Lapse provision) that will further encourage companies to seek to avoid rate increases on in force LTC policies. Tom Foley noted his concern that there are two types of companies.

- The first has a "non-cancelable mentality" where the premiums are built with margins to avoid the need for rate increases even though the product is guaranteed renewable.
- The second has a "beat-the-market mentality" where the concern is the competitiveness of the premiums and less concern with the potential that the assumptions cannot be realized or that rate increases will be needed.

During the June meeting other regulators raised concerns. There was a review of the ongoing legislative actions in California dealing with LTCI policies and limits on rate increases.

The regulators requested industry input to draft changes which were exposed with a date of 5/26/99.

An Interim Meeting was scheduled for August 23-24 in Kansas City, MO, to continue these discussions.

HIPAA Changes

During several prior Regular Meetings of the NAIC changes have been proposed and reviewed so that the NAIC models will address issues created by HIPAA, e.g. tax qualified vs. non-tax qualified LTCI policies and 90-day certification requirements. It appears that most issues have been resolved, although the specifics for calculating and reporting claim denial ratios have not been worked out.

"The regulatory actuaries have stated their desire to include additonal provisions...that will further encourage companies to seek to avoid rate increases on in force LTC policies....there are two types of companies. The first has a 'noncancelable mentality' and the second has 'beat-the-market mentality.'"

Interim Meeting

The Health Insurance Association of America (HIAA) and the American Council of Life Insurance (ACLI) have prepared a joint response to the regulators' request for comments on rate stability. The response supports the inclusion of many of the elements first developed in the NAIC's Filing of Rates For Additional Benefit Individual and Group Health Insurance Forms Model Regulation. The principal elements are:

- to remove regulatory review of initial rates based on loss ratio standards in favor of increased disclosure (including a history of rate increases on similar products); but
- to increase the amount of regulatory review and to apply loss ratio standards if a rate increase is filed.

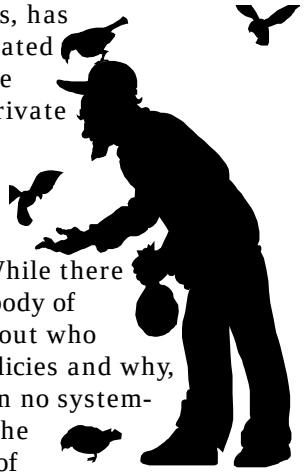
It is also expected that some regulators will propose additional items, including some elements of California Senate Bill 898, e.g., pooling of experience if a rate increase is requested and review of rate increases and assumptions by an independent (uniquely qualified) actuary.

***Bill Weller, FSA, is assistant vice-president and chief actuary at Health Insurance Association of America in Washington, D.C. He is also a member of the Long-Term Care Insurance Section Council and can be reached at* bweller@ hiaa.org.**

Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community

by Don Charsky

A recent series of government actions has signaled the federal government's continuing desire for individuals to accept personal responsibility for planning and paying for their long-term care (LTC) needs. Limited public funding for LTC expenses, coupled with tax incentives for individuals and companies to obtain private long-term care insurance (LTCI) policies, has once again heated up sales in the burgeoning private LTCI market.



But does private LTCI represent a "good buy"? While there is a growing body of knowledge about who buys LTCI policies and why, there has been no systematic study of the effectiveness of such policies. On an industry-wide basis, no one knows:

* how benefits are being used
* whether claimants feel they are getting good value for the premiums they pay
* whether the patterns of formal (paid) and informal (unpaid) service use differ for LTCI claimants compared to similarly disabled persons without LTCI policies

Our research study was designed to:

- answer these questions
- provide basic socio-demographic and service utilization profiles for disabled private LTCI policyholders
- to compare such data and findings to the experiences of non-insured disabled community-dwelling elders.
- to discuss the implications of such findings on the service delivery system as well as on the design of private and public LTC programs and policies

The study was funded by grants from the Department of Health and Human Services, Office of Disability, Aging and Long-Term Care, and the Robert Wood Johnson Foundation Home Care Research Initiative. The project entailed interviewing 700 community-dwelling LTCI claimants and their informal care-givers, as well as 500 privately insured institutional claimants, all receiving benefits under their policies.

Only the results of the community dwelling sample will be discussed here. There will be reports available in the near future that discuss the results of the informal caregiver sample, the institutional sample and a comparative analysis of the community and institutional samples.

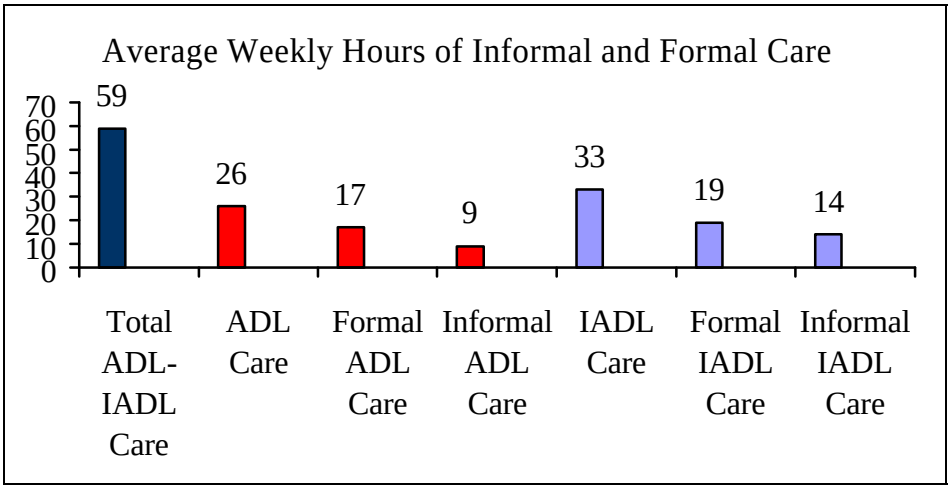
The Profile of Community-Dwelling LTCI Claimants

- Privately insured disabled policyholders are more likely to be older and widowed, and less likely to have children living nearby than are elders in the general population.
- LTCI benefits are well targeted. The vast majority of recipients (79%) have significant dependencies in activities of daily living (ADLs)—on average 3.3 dependencies—or is cognitively impaired (32% of the sample).

Socio-Demographic Characteristics	Privately-Insured Disabled Claimants	General Population 65 and over
Average Age	79 years	75 years
Male	32%	31%
Female	68%	69%
Never Married	4%	4%
Married	46%	4%
Divorced/Separated	5%	7%
Widowed	45%	34%
Any children within 25 miles	54%	69%

Use of Formal and Informal Care Services among Privately Insured Claimants

- About one in four claimants relies solely on formal (paid) services for their care.
- On average, claimants receive 59 hours of care a week. Insurance pays for an average of 36 hours per week, which is equal to about 60% of the total care received.
- Formal caregivers split their time fairly evenly between ADL and instrumental activities of daily living (IADL), whereas informal caregivers are more likely to be providing greater amounts of IADL assistance.
- Formal service providers spent 44 hours in the homes of claimants of which 36 hours were spent on ADL and IADL assistance. About 18% of the time was spent on non-ADL/IADL activities.



Benefits Paid under Insurance Contracts and Insurance Policy Designs

- For more than 70% of claimants, insurance pays all of the costs of care.
- The average monthly insurance benefit paid to claimants is $1,527. This compares to an average public insurance benefit (i.e. Medicaid waiver) for home care of $450.
- As of the interview date, the average claimant had been in claim for about 13 months and had received $18,000 in benefits. This amount represents less than 20% of total available insurance benefits.
- The typical coverage for home care reimburses up to $80 in daily costs for a period of about four years.
- One-third of claimants have some form of inflation protection provision in their policy.

Claimant Satisfaction with Insurance Policy and Insurance Company

- The vast majority of claimants (86%) are satisfied with their policy and most (75%) had no difficulty understanding what their policy covered. Most (70%) found it easy to file a claim. About 19% felt that the company could have provided additional customer support and more information about how to use benefits.
- About 90% of all individuals filing claims had no disagreements with their insurance companies or had a disagreement that was resolved satisfactorily.
- While most claimants felt they had purchased enough home care coverage (75%), the rest (25%) wished they had purchased more.

Impact of Private LTCI on Claimants and Informal Caregivers

- About 60% of claimants indicated that without their policy they would not be able to afford their current level of services and would have to consume fewer hours of paid care. Many also indicated that without their policy benefits, they would have to rely more on informal supports.
- About half of all claimants and informal caregivers indicated that without private insurance, they would have to seek institutional alternatives—nursing home care or assisted living facilities.
- The presence of insurance benefits has not significantly reduced the level of informal care received by claimants. Roughly two in three informal care-givers have not reduced the level of care that they provide, with half maintaining the same level of care. This finding suggests that for most informal caregivers, insurance financed formal care is not a perfect substitute for informal care.
- Where formal care does substitute for informal care, the substitution is selective; that is, the formal care financed by insurance benefits may substitute for the care provided by adult children but not necessarily for the care provided by a spouse.
- About two in three informal caregivers indicate that the presence of private insurance benefits has reduced their level of stress.

Levels of Met and Unmet Need

- The majority of claimants do not report unmet (82%) or undermet (77%) needs. Yet for those who do, the principal contributing factors are service availability, scheduling, continuity and coordination of caregivers, claimant preference and the quality of caregivers.
- While LTCI is succeeding in bringing formal caregivers into the homes of disabled elders, in some cases the services of these providers are either not being utilized by claimants or are not being supplied to the claimant.

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Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community

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- Claimants with multiple caregivers report greater levels of undermet need. This suggests that clearly delineated lines of responsibility may be particularly important in assuring that needs are adequately met.

Comparing Disabled Privately Insured and Non-Privately Insured Community-Dwelling Disabled Elders

- Compared to those without private insurance, disabled elders with private insurance are more likely to live alone and less likely to have children living nearby. They are also four times more likely to have some college education, eight times more likely to have incomes greater than $30,000, and are overwhelmingly white.
- The prevalence of physical impairments (i.e. ADL limitations) is much greater among the privately insured disabled elders than among the non-privately insured disabled elders; on the other hand, cognitive impairment is much more prevalent among non-insured disabled elders.
- About 90% of the non-privately insured disabled elders rely on some level of informal care compared with 77% of the privately insured disabled elders.
- Privately insured disabled elders are roughly five times more likely to rely exclusively on formal care than are those with out private insurance. This finding supports the hypothesis that private insurance may be used to compensate for a lack of available informal support.
- The majority (70%) of disabled elders with private LTCI primarily use unskilled services such as home health aides and homemaker services, whereas among the non-insured disabled, nursing care remains the most prevalent Medicare funded home care service.
- The privately insured disabled receive 14 hours more per week of assistance than do the non-privately insured disabled. Much of this is attributable to the receipt of formal services.
- Very few of the privately insured disabled use Medicare as apayment source for home care services. By contrast, roughly 30% of non-privately insured disabled elders use Medicare as a payment source.

Clearly:

- ☛ LTCI benefits are well targeted; they serve those who are truly dependent.
- ☛ The vast majority of claimants is satisfied with their policies, understand their coverage, and find it easy to file claims.
- ☛ Because of their LTCI benefits, substantial numbers of disabled elderly individuals can remain at home instead of being forced to seek institutional care.
- ☛ The availability of LTCI benefits reduces stress among informal care givers and decreases usage of Medicare to fund home health care expenses.
- ☛ Finally, for insured individuals, formal care may substitute for some, but not most, informal care, and the two systems appear to be working together to better meet the needs of claimants.

Expansion in the private market is likely to lead to reductions in public expenditures on LTC, and the insurance is likely to continue to help disabled individuals remain in their homes at the same time as it maintains and enhances the resiliency of informal support networks.

Don Charsky, FSA, MAAA, is president of Life Plans, Inc. in Waltham, MA.

For a copy of this report, please contact the Research Department at LifePlans, Inc., Two University Office Park, 51 Sawyer Road, Waltham, MA 02453.

Long-Term Care Insurance Section Meeting in Seattle

Launching the new Long-Term Care Insurance Section in Seattle are newly elected Section Council members:

(Standing L to R)—Greg Gurlik, Bill Weller, Mike Abroe, David Dickson, Bart Munson (Newsletter Editor)

Seated: L to R)—Andrew Herman, Loida Abraham (Vice-Chairperson), Jim Glickman (Chairperson), Amy Pahl (Secretary). Missing: Gary Brace (Treasurer)

LTCI Section Meeting Minutes, Seattle SOA Meeting

Seattle SOA Meeting, June 17, 1999

Council members present:
Jim Glickman, *Chairperson*; Loida Abraham, *Vice Chairperson*; Amy Pahl, *Secretary*; Greg Gurlik; Mike Abroe; Bill Weller; Andrew Herman; and David Dickson

Council member not present:
Gary Brace, *Treasurer*

Also present:
Bart Munson, *Newsletter Editor*

Jim called the meeting to order and welcomed all those in attendance. Introductions of the Council officers were made. Jim pointed out that everyone should have received a copy of our Mission Statement and a sign-up sheet to reflect areas of interest for participation in the Section. It was mentioned that the Council has had one previous meeting via conference call, where each Council member's role was determined.

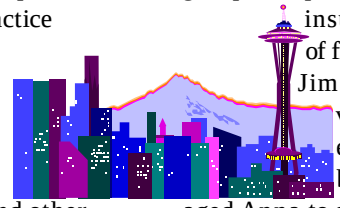
Jim explained that there had been a two-way tie for the ninth Council member position and that to solve the dilemma, Bart Munson offered to step down from the Council to allow both the ninth and tenth elected Council members to be included. Bart further agreed to the time-demanding position of Section newsletter editor. Because of the importance of this position and Bart's LTC expertise, we have asked him to continue to be an active participant in Council meetings.

Bart commented that the three reasons for his willingness to accept the role of editor include (1) his desire to contribute to the SOA and the formative years of the Section, (2) his desire to help solve the ninth place tie, and (3) his expectation of significant Section member contributions to the newsletter.

Bart called for volunteers to write articles for upcoming newsletters and to reflect such interest on the distributed sign-up sheet or contact any Council member directly. Although the date of the first newsletter is not yet known, Jim announced every attempt would be made to distribute it before the SOA Annual Meeting in October.

Each Council member then described his/her role on the Council:

- ***Mike Abroe***—Spring, 2000, Health, Pension & LTC Meeting (in Las Vegas) Coordinator for LTC sessions; Organizer for newsletter articles on group LTC topics; Liaison to Health Practice Committee.
- ***Bill Weller***—NAIC and other regulatory activities liaison; Organizer for newsletter articles on National LTC conferences and other LTC activities.
- ***Loida Abraham***—Organizer for newsletter articles on LTC marketing and sales.
- ***Amy Pahl***—Liaison to E & E committee and contact for developing LTC study materials; Organizer for newsletter articles on LTC education issues.
- ***Andrew Herman***—Organizer for newsletter articles on LTC pricing and product development.
- ***Greg Gurlik***—Annual Meeting October 2000 (in Chicago) Coordinator for LTC sessions.
- ***David Dickson***—Organizer for newsletter articles on LTC reinsurance.



Jim again asked the group to express their interest for involvement in various areas—in particular, interest in other topics not mentioned above, such as valuation, reporting, and CCRC activity.

Jim made a suggestion to create an annual conference on home office issues. The objective of such a conference would be to bring underwriting, marketing, claims, and actuarial expertise together to offer an opportunity for discussion and interaction.

Howard Bolnick congratulated and welcomed the Section Council and expressed his pleasure in the creation of a Section with LTC focus.

Bill Weller provided a brief update on the June 16th NAIC meeting on rate stabilization and summarized by saying he expects to see continued changes with the California non-can bill.

Jim called for general comments and questions from the audience:

- A question was posed to the Council about its role interacting with state legislatures and other regulatory groups. Jim responded that while the Council would not proactively lobby, it would seek to be a source of expert actuarial information for those entities.
- Anna Rappaport challenged the group to expand their focus from LTC insurance to the total issue of financing care to elderly. Jim responded that it was a very good topic and with enough interest it should be pursued. He encouraged Anna to organize activities in this area, especially educational activities at SOA meetings.
- Another question was raised about LTCI topics as part of the new part 8 exam syllabus. Amy responded that as liaison to the E & E committee she would expect to be involved in organizing LTCI-related syllabus and study materials.

Jim encouraged LTCI Section members who are also members of other SOA Sections to volunteer to coordinate communications between the activities of those Sections and the LTCI Section.

A question arose about the Council assisting in the development of experience data. In response to the question, Gary Corliss, chairperson of SOA LTC Experience Committee, commented on Experience Committee work, and his involvement.

Eric Stallard commented on his work at Duke University with non-institutional data and that a CD would soon be available containing numerous tables derived from the 1984 and 1989 National LTC Surveys, accompanied by a comprehensive 100-page written report.

Jim announced the next LTCI Council meeting will be a breakfast meeting on Tuesday, October 19 from 8 to 9:30 am. He asked for topic ideas for the meeting.

He also encouraged those interested in specific topics or in speaking in Las Vegas to contact Mike Abroe. The first planning meeting of the Spring Program Committee will be held in September.

Jim thanked those in attendance for their interest and the meeting was adjourned.

LTCI Product Pricing Discussion

by Andrew Herman

Editor's Note: This article is extensively edited from a presentation on LTCI product pricing given by Andrew Herman at the 1999 SOA Spring Meeting in Seattle, WA. The complete transcript will be available in the Record.

This article shares some professional and regulatory considerations in LTCI product pricing, selection of pricing assumptions, the impact of product features, and some of the common pricing pitfalls.

I'm sure most have read the revised Actuarial Standard of Practice (ASOP) No. 18, which has been around for many years, but was just recently revised and is effective for all work performed on or after June 1, 1999. The revisions are actually pretty significant.

ASOP No. 18 addresses coverage and plan features, assumption setting, premium rate and reserve determination, sensitivity testing, cash flow testing, experience monitoring and communications and disclosure. There are several new features in the revised standard that are of particular importance, the most notable being that the actuary is to establish claim incidence rates, claim termination rates, and costs of eligible benefits separately for at least nursing home, assisted living facility, and home care benefits. Those actuaries who have been adding a claim cost load to their facility assumptions to cover the costs of home care are not following the ASOP. Even more significant is the guidance with respect to assisted living facilities.

Another important point is to identify experience assumptions that are likely to change materially over the plan term, and consider reflecting changes when setting assumptions.

One point which cannot be overemphasized is that the actuary should not rely on anticipated future premium increases to justify unrealistic assumptions.

The final point is that the actuary has a responsibility to inform the sponsoring entity of the need to collect experience data in a manner that permits the actuary to compare assumptions with emerging experience.

Pricing actuaries who are involved in product filings, of course, are familiar with the actuarial certification that must be in the actuarial memorandum to obtain product approval, and most states accept fairly standard language that benefits are reasonable in relation to premiums. A couple of states, such as Colorado, require special language. In Colorado, one has to certify that premiums for the line of business are not excessive, inadequate or unfairly discriminatory.

There's an annual rate filing requirement in Florida, and the state has been enforcing this requirement. If one is filing new LTCI products at this time and the company is out of compliance with the annual rate filing requirement, one might encounter some difficulty getting the products approved. The required rating certification is meaningful because the actuary must consider actual past experience relative to pricing expectations before certifying that premiums are still reasonable in relation to benefits. Essentially, through regulation the state is requiring active management of premium levels for in force long-term care business. And since new product filings must compare benefits and premiums to in force products, the state's requirement of active rate management in practice extends to newly developed products as well.

Colorado has an annual rate filing requirement. While the state has taken a different approach from Florida, the intent (to encourage proper initial product pricing) is similar. For Colorado business, an actuary must certify that the premiums for the LTCI line of business have remained level for existing policyholders and are expected to remain level over the life of the policy. Of course, this certification would only be applicable for business that does not appear to the actuary to be in need of a rate increase.

In terms of consistency among assumption sets, I have seen actual practice where the actuary has several distinct sets of assumptions. In one case, the actuary had a filing assumption set, a pricing assumption set, and a valuation assumption set, and none of them really had any relation to each other. I would not advise such a practice. But with that said, there are some differences between the assumptions used in your loss ratio demonstration and your pricing assumptions. Consequently, in practice the pricing lifetime anticipated loss ratio generally is not the same as the filing lifetime anticipated loss ratio.

I would emphasize in regard to the loss ratio demonstration that your assumptions underlying the demonstration should be consistent with your pricing assumptions. Any material differences should be disclosed.

I think the key difference between the filing and the pricing lifetime loss ratio is the specific interest rate used. In most product filings, the actuary will present the lifetime anticipated loss ratio as well as expected annual loss ratios; and, of course, the lifetime ratio is calculated using some interest rate. Whether this interest rate should be an after-tax rate or a pre-tax rate does not seem clear; I don't think there's really an industry standard or specific professional guidance. I believe that many actuaries choose to use the statutory

valuation interest rate in the filing lifetime loss ratio calculation, which is close to an after-tax pricing interest rate, but it may actually be a little higher. Personally, I use the valuation rate, and I think that works everywhere except for the states of New Jersey and New York, which mandate some special interest rate.

In terms of the definition of the loss ratio, states will generally accept the present value of paid claims plus change in claim reserves and liabilities (without an interest adjustment) divided by the present value of premiums. Paid claims plus change in claim reserves is sometimes just called policy benefits, and I think most states will accept this definition with the calculation of the lifetime loss ratio made using the valuation interest rates. For individual LTCI, most states have a 60% minimum loss ratio standard, except I believe there are four 65% states: New Jersey, New Mexico, New York and Wisconsin.

If you were to calculate the loss ratio on a paid basis rather than an incurred basis, and use your pricing pre-tax earned rate, you'd likely have a loss ratio in the 50% to 55% range. Since on the surface this result may appear to be out of regulatory compliance, it is especially important to disclose assumptions and methodologies in new product submissions.

In Florida the actuary must demonstrate compliance of each combination of base policy plus optional rider, so there can't really be any subsidies across benefit options. Maine continues to require a paid definition of the loss ratio. Compliance with this definition may require a company to lower premiums in order to obtain product approval, and commissions might need to be reduced in Maine (as they often are in the 65% loss ratio states) to maintain product profitability.

Several states have regulatory requirements of some form of level commissions. Delaware, like Indiana, has adopted the 200% rule, which states that total first year compensation can be no more than 200% of the renewal year compensation, and that must be paid for a reasonable number of years. Wisconsin has a 400% rule. Michigan requires level commissions for the first three policy years for ages 65 and up. Pennsylvania has a commission cap: 50% in the first year and 10% in renewal years for the direct writing agent.

As the regulatory environment for LTCI continues to evolve, new state regulatory issues generally emerge with each new product filing. Here are three product issues that have surfaced recently:

1. Care coordination provisions, which serve the company's interest by helping to control claim costs, may also serve to minimize disputes between claimants, doctors, and the insurance company. Yet, several states generally resist approval of LTCI products that include such provisions. Texas consistently resists approval of policy incentives in which a higher level of benefits is paid when benefits are accessed through the company-approved care coordinator. Missouri just very recently has been going the route of Texas. Other states that closely review care coordination provisions include Pennsylvania and California.

2. Spousal discount is another. Most of today's policies offer a 10%, 15% or even 20% spousal discount for both policies when a husband and wife are issued. Michigan requires an actuarial statement certifying that the spousal discount is experience-based.

Recently, Florida began rejecting spousal discounts that are based on the purchase of a separate contract and, interestingly enough, the state cites the entire contract provision of the policy. While this makes some sense, when both spouses purchase a policy the carrier has evidence that a healthy care-giver is present. National statistics along with the vast majority of LTCI industry experience indicate that the presence of a primary care-giver significantly impacts benefit utilization. In Florida one very well may have to base eligibility on marital status alone with no other requirements. Further, the state generally resists approval of discounts that may be removed in the event of divorce or death.

New Jersey and South Dakota are other states in which one may encounter some difficulty obtaining approval for spousal discounts.

3. The industry is leaning increasingly towards selling tax qualified (TQ) LTCI coverage rather than non-tax qualified (NTQ) coverage. However, many carriers, particularly in the brokerage marketplace, need to have a NTQ product available because the agents like to sell it.

California is the one state that requires a NTQ product offering, based on state-regulated benefit triggers.

For a NTQ product in Tennessee, three benefit triggers are required. One of these is medical necessity, which is particularly of concern for home care benefits. Many carriers that market NTQ home health care coverage will not offer such coverage in Tennessee.

A company's field force may desire to sell a TQ policy with the familiar

(continued on page 10, column 1)

"One point which cannot be overemphasized is that the actuary should not rely on anticipated future premium increases to justify unrealistic assumptions."

LTCI Product Pricing Discussion
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two of six ADL benefit triggers, and a NTQ policy at the same rates but that triggers benefits from only one ADL. From an actuarial perspective, this construct may be feasible, for instance, when the ADL list in the NTQ policy is pared down to five ADLs by excluding bathing (which is generally the first ADL lost). But, with states that have adopted a regulation that requires definition of six ADLs (including bathing) in the NTQ policy, the construct breaks down. Either the premiums would need to be increased, or the NTQ ADL benefit trigger would need to be changed to two of six, as in the TQ policy.

Regarding pricing assumptions, I have seen several cases where a rate increase is needed because the original termination assumptions were on the high side. Now that the industry is a little more mature, we're getting a feel for what the ultimate lapse rate looks like. Some carriers are experiencing an ultimate voluntary lapse rate as low as 2%. If the actuary priced with 10% ultimate lapse, there's really going to be a deficiency in the premiums. It may be appropriate to vary lapse rates by issue age, payment method, benefit type or other factors. The first year lapse rate and the Not Taken Out (NTO) rate may be influenced by your distribution system. High pressure tactics generally will lead to high NTO rates and first year lapses.

When setting mortality assumptions, most actuaries would agree that life insurance tables are inappropriate because they are conservative in the wrong direction for LTCI. Good sources for mortality assumption may be U.S. population data along with selection factors or an annuity table such as the 1983 GAM or the 1994 GAM.

For morbidity assumptions, I think everyone would agree that your own company's experience is the most relevant source. You should consider the sales region, the type of distribution system, and the level of underwriting expertise. Region has been a real issue. Some of the states in the Midwest, including North Dakota, have had util- ization problems with facility coverage. Other regions, such as South Florida, have experienced claim problems with home health care. Home health care utilization in general will be higher in large met-ropolitan areas, such as Chicago, Houston and Los Angeles, relative to rural areas. Regional pricing may be the best strategy, particularly for a stand-alone home health care policy.

The net investment income assumption is going to have a huge impact on these products because there's a very long tail on them. I've seen some companies recently setting the assumption for the pretax interest rate as low as 6.0% level. Larger carriers often are more aggressive in assumption setting, as they can segment their assets to benefit from the longer duration of the LTCI liabilities. Today, they may be able to use a rate of 7% or 7.5%, perhaps grading down over time. It is critical to avoid a disconnect between your assumptions and your actual investment practices.

Agent compensation is the biggest piece of expenses. Broker total compensation rates as a percent of premium are usually in the neighborhood of 75% first year and about 15% renewal years. The first year rate may be even higher, particularly at the younger ages. To help maintain product profitability, it may be helpful to design riders to pay no commissions or just first-year commissions only. Like riders, guaranteed purchase option increases are an element of coverage in which full commissions may not be paid. It also helps profitability to not pay commissions on waived premiums or rate increase premiums, if there are any.

In thinking about how product features impact claims, several features come to mind.

- Whether your coverage is stand-alone or comprehensive is very, very important. Stand-alone coverage, most notably home health care, has had different experience relative to policies that cover the whole continuum of LTC. Many carriers market stand-alone home care coverage with premium rates that are two times or two and a half times the rates of a home health care rider, and it's actually the right number.

- In particular for stand-alone home care coverage, care coordination has proven effective in controlling claims; the pricing should take into consideration any such provisions..

- Automatic inflation increases of 5% compounded annually are generally required by states, so these benefits are offered everywhere. The high price tag has really limited sales. Some companies sell about 90% of their business with no inflation protection, which becomes a consumer issue, but guaranteed purchase option provisions help address the issue. Through these provisions, policyholders that don't purchase inflation protection at issue will have the ability to increase coverage later without providing evidence of insurability. It is critical to price compound inflation benefits properly. There may be a tendency for the actuary to inflate the claim costs by 5% compounded annually. That doesn't quite work, because one thereby ignores the continuation of inflation protection after claim status begins. That could mean understated attained age claim costs by 30% at age 50 decreasing to 10% over attained age 85.

- Waiver of premium for confinement is a standard feature in today's contracts. Competition has led carriers to waive premium on home health care; often benefits with some regularity are required, such as eight days per calendar month or four or five days per week. Waiver of

premium provisions are very, very costly at the older issue-ages, and it generally would not be suitable to load premiums across the board by a flat percentage. Using a proper modeling approach, the waiver provision should cost 20%, 30% or even more at the older issue ages.

- Dual waiver is popular among some of the carriers, particularly in the brokerage marketplace. There, the premium for a spouse policy may be waived whenever the policyholder's premium is waived; or one may waive the spouse's premium just on the policyholder's confinement rather than on home health care, to keep the cost down.

- The lifetime waiver of premium for surviving spouse benefit is appealing from a marketing perspective but presents significant risk to the company. The policy becomes non-can once it's paid up. I'm not sure how one reflects that in pricing, but one certainly should think about it. Currently, there are many variations in the benefit design on the market, yet it may be difficult to obtain approval in certain states. Florida will object to benefits of this nature if they are included in the base policy; the benefit must be offered only as an optional rider.

- Limited pay policies tend to be even riskier than lifetime waiver provisions. In today's marketplace, several carriers are marketing ten pay, and a few are even offering single pay. I personally would not advise doing single pay at this point unless one can charge quite a bit of extra premium to cover the non-cancelable aspect.

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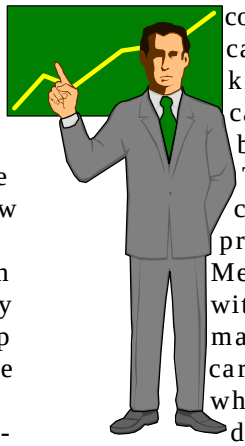
President Clinton's Long-Term Care Initiative Presentation on January 4, 1999

by Gerald Elsea

On January 4, 1999, President Clinton and Vice President Gore unveiled a long-term care initiative to support family caregivers and help address growing long-term care needs.This is a 4-part initiative, costing $6.2 billion over five years. Over 5 million Americans need long-term care due to illness or disability. Two-thirds are elderly and one-third are younger adults or children that have either birth defects or have developed a chronic condition. The number of Americans 65 and older will jump from 34.3 million presently to 69.4 million by the year 2030. Twenty percent of Americans will then be elderly. The population of 85 and older individuals will rise from 4 million currently to 8.4 million in the same time frame and almost half will need assistance with activities of daily living.

The initiative has four parts and is designed to address the broad-base and varied needs of the population. The four parts are:
1) A $1,000 tax credit to individuals who need long-term care or to the family members who care for and house their ill and disabled relatives. The tax credit would support a wide range of formal or informal long-term care for people of all ages. This proposal would provide needed financial support to about 2 million Americans including 1.2 million older Americans, over 500,000 non-elderly adults and approximately 250,000 children.

2) The creation of a National Care Givers Support Program. This new program would support families who care for elderly relatives with chronic illnesses or dis-abilities by enabling states to create "one-stop shops" that provide quality respite care and other support services; critical information about community long-term care services that best meet a family's needs; counseling and support, such as teaching model approaches for care-givers that are coping with new responsibilities and offering training for complex care needs.



3) Launch a national campaign to educate Medicare beneficiaries about the program's limited coverage of long-term care and how best to evaluate their options. Nearly 60% of Medicare beneficiaries are unaware that Medicare does not cover most long-term care and many do not know that long-term care services would best meet their needs. This new nationwide campaign would provide all 39 million Medi-care beneficiaries with critical information about long-term care options including: what long-term care does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care pol-icy; and how to access information about

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home and community-based care service that best fits beneficiaries' needs.

4) Offer quality private long-term care insurance to federal employees. The President is calling on Congress to pass a new proposal that allows the Office of Personnel Management to use its market leverage and set a national example by offering non-subsidized quality private long-term insurance to all federal employees, retirees and their families at group rates. The Office of Personnel Management anticipates that approximately 300,000 federal employees would participate in this program.

More details are available; however, many details are sketchy and there are numerous questions to be answered.

Gerald Elsea is a guest columnist for this issue of* Long-Term Care. *He can be reached at the Employers Reinsurance Corporation in Overland Park, Kansas at (913) 676-5200.

Treatment for Alzheimer's Disease: Good News Or Bad News?

by Philip J. Barackman

Alzheimer's disease (AD) causes dementia and behavioral disorders which can lead to costly long term care (LTCI) insurance claims. New diagnostic and therapeutic approaches are being developed that are likely to influence future LTCI experience. These treatments may have a favorable or adverse effect on LTCI claims depending on the nature and degree of the therapeutic effect. This article seeks to review some of these developments and to encourage LTCI insurers to monitor ongoing progress in the treatment of AD.

Basics of AD

AD is one of the leading causes of dementia. The American Psychiatric Association defines *dementia* as memory impairment plus at least one additional problem related to language (aphasia), complex movement (apraxia), identification of objects (agnosia), or the making of everyday decisions (executive functioning). AD typically involves a progressive decline in cognitive function which may be accompanied by apathy, agitation, aggression, anxiety, sleep disorder, withdrawal, loss of appetite, and hallucinations.

It is estimated that 4 million people in the United States have AD, including 10% of persons over 65 and nearly half of those over 85, but AD can even strike people in their 30s and 40s. Life expectancy is eight years from the onset of symptoms, but some continue to live 20 years or more. U.S. society spends $100 billion annually on AD. AD costs U.S. employers $26 billion in lost productivity of caregivers. Seven out of 10 people with AD live at home. Family and friends provide 75% of home care for AD. Half of all nursing home patients suffer from AD or a related disorder.[1]

Many other disorders can have symptoms that mimic those of AD, including vascular dementia, AIDS dementia, frontotemporal dementia, Parkinson's disease, Pick's disease, progressive hemiatrophy, diffuse Lewy body disease, Huntington's disease, amyotrophic lateral sclerosis (ALS), progressive supranuclear palsy, meningitis, hypothyroidism, hydrocephalus, brain tumor, multiple sclerosis, drug toxicity, alcoholism, vitamin B12 deficiency, folate deficiency, depression, and psychosis.[2] Because some of these conditions are responsive to treatment and/or are partially reversible, an accurate diagnosis must be obtained if possible.

Evaluation of Patients with Symptoms of AD

AD is often a diagnosis of exclusion, i.e., diseases with similar symptoms are eliminated from consideration. In patients with symptoms of AD, routine blood tests are ordered to rule out hypothyroidism, alcohol abuse, AIDS encephalopathy, and other causes of dementia. Radiologic tests can rule out certain disorders (e.g., brain tumor, hydrocephalus) and sometimes even provide a diagnosis of AD. For example, late-stage AD can be diagnosed with magnetic resonance imaging (MRI), and pro- gress has recently been made in efforts to diagnose early-stage AD using high resolution MRI which measures neuroanatomic degeneration.[3] Positron emission tomography (PET) is another imaging technology with a high diagnostic accuracy for AD, even in patients with mild cognitive impairment. PET scans are particularly useful because they can differentiate between AD and vascular dementia (the disorder

most often confused with AD).[4]

In symptomatic patients, identification of genetic variants such as the ε4 allele of the apolipoprotein E gene and the presenilin-1 mutation supports a diagnosis of AD. The apolipoprotein E ε4 allele is also associated with a highly elevated risk of developing AD and an earlier onset of AD, but it is not an absolute predictor of AD.[5] More tests are anticipate as new genetic risk factors are discovered.

Neuropsychological testing is both a diagnostic tool as well as a method of tracking cognitive decline and the psychological disorders that often accompany AD, e.g., depression. Tests include the Mini-Mental Status Exam (MMSE), Blessed test, Alzheimer's Disease Assessment Scale (ADAS-Cog), Consortium to Establish a Registry for Alzheimer's Disease memory measures (CERAD), Neuropsychiatric Inventory (NPI), Geriatric Depression Scale (GDS), and Cornell Scale for Depression in Dementia (CSDD).[6] One of the more recent tests to appear is the 7 Minute Screen which includes the Benton Temporal Orientation Test, enhanced cued recall, clock drawing, and verbal fluency.[7] LTC underwriters have developed cognitive assessment tools based on elements of these and other tests such as the Short Portable Mental Status Questionnaire (SPMSQ).

Potential Impact of AD: Inferences from Population Data

Annual incidence of AD increases from approximately 1% for ages 70 to 75, to more than 8% for those aged 85 and older. The pre-valence of AD is about 5% at age 70, nearly 20% at age 80, and 50% at age 90.[8] These figures may vary depending on the method of diagnosis and possibly on other population characteristics. This high prevalence of AD is of concern to LTC underwriters, and U.S. insurers routinely request cognitive assessment screens on all LTC applicants above a specified age, typically age 75, although a somewhat lower age would appear to be justified.

Analysis of the National Long Term Care Survey of 5-year AD outcomes for three time periods (1984, 1989, 1992) sheds some light on the potential impact of AD on LTC experience. At the time of AD diagnosis, 22% of patients were institutionalized and 78% were living at home. Of those alive 5 years later, 49% were institutionalized and 51% were living at home. The annual probability of nursing home placement increased from about 12% during the 1st year after AD diagnosis to 36% during the 5th year. Clearly, AD is related to high utilization of institutional care. [9]

However, careful analysis is required. For example, discharges from nursing homes by primary diagnosis at time of admission does not directly support the fact that AD leads to lengthy institutional confinements. The 1985 National Nursing Home Survey (1985 NNHS) reported that the average nursing home stay in patients with a primary diagnosis of "AD and other …degeneration of the brain" was 373 days, compared to 401 days for all categories combined.[10] However, duration of stay was 1,005 days for "senility without psychosis" and 763 days for patients in the "unknown" diagnosis group. These latter categories may well include persons with early- to- mid-stage AD.

Another possible distorting factor relates to AD as a primary versus a secondary diagnosis. Patients may enter the nursing home with a primary diagnosis of the condition that prompted confinement (e.g., hip fracture), and a secondary diagnosis of early- to- mid-stage AD. Progression of AD in the nursing home may well become the primary reason for continued confinement.

Finally, nursing home stay durations do not translate directly to LTC benefit periods. One reason is that almost half of the live discharges in the 1985 NNHS (about one-third of total discharges) are attributed to short-stay hospitals. For many, these hospital stays represent only temporary interruptions in an otherwise lengthy nursing home confinement (e.g., a nursing home patient transfers to the hospital for treatment of an acute illness and later returns to the nursing home). The discontinuous lengthy confinement (nursing home-hospital-nursing home) is therefore recorded as multiple nursing home admissions of shorter duration. Another reason for the imperfect correlation between duration of nursing home stay and LTC benefit period is that admissions to nursing homes are frequently transfers from other nursing care facilities. The analysis of the 1985 NNHS by the Society of Actuaries Long Term Care Experience Committee links such confinements in order to approximate the benefit period concept.[11]

Factors with a Direct Bearing on Impact of AD

It is apparent from the prior discussion that general population data do not necessarily provide a clear basis for estimating the portion of LTC benefit costs that are causally related to AD. Similarly, although most insurers monitor cause of claim or maintain the necessary data to do so, results to date are typically not very meaningful because (1) the business is immature (both in respect to underwriting selection period and attained age), and/or (2) there is insufficient claims volume from which significant results can be drawn. However, one can identify certain factors that should have a direct bearing on the impact of AD on LTC experience.

Plan design

Clearly plan design plays a role, given that the maximum benefit period (or dollar amount) truncates the continuation of benefit payments on lengthy AD claims. It

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can also be argued that AD-related claim amounts would increase with plan designs that provide benefits for home care, as well as institutional care, because of the significant proportion of AD victims who are cared for in the home during the early- to- mid stages of the disease. Because much of the AD home care is informal, paying benefits to informal caregivers may prove to be more expensive than is currently anticipated. The often heard rationale that it is a lower cost alternative to institutional care would not apply to those AD victims who would not yet be institutionalized anyway.

Issue age, persistency, mortality, duration from issue
AD is primarily a disease of the elderly, so issue age, persistency, mortality, and duration from issue will affect AD experience as a cause of claim. Companies that issued LTC insurance to young and middle-aged adults would experience few AD-related claims for many years. However, if benefits were designed to keep up with inflation, then greater benefit payouts would be experienced in the years when AD would most likely develop. Effects of AD on ultimate claims experience and profits should therefore not be dismissed for younger issue ages.

Underwriting requirements
The method and degree of underwriting with respect to cognitive function will have a significant impact on the AD component of claims experience. Effectiveness of any underwriting is related to the extent of anti-selection at the point of sale, and also therefore to how the business was marketed. For example, an independent insurance agent may assess the applicant's condition in the context of underwriting practices of the companies for which the agent writes business, then sub-mit the application to the insurer(s) most likely to issue coverage. An LTC insurer that has a higher minimum age for cognitive assessment than its competitors would tend to attract business from those who wish to avoid the cognitive underwriting screen. Advanced genetic and other diagnostic or predictive tests may become more readily available to the market, and less available to the underwriter due to regulatory restrictions. This could present greater challenges to LTC risk classification in the future.

Policy wording
In wording LTC policies, special attention needs to be given to the definition of cognitive impairment as a benefit trigger, and claims administration should be based on clinical evidence and standardized tests of cognitive function, consistently and objectively applied. If LTC policies specifically cover AD (as opposed to do not exclude AD), then it may be difficult to avoid claims for which cognitive function is still quite normal once very early stage AD diagnosis becomes readily available.

Ultimate experience
Although somewhat speculative, one estimate is that 30-50% of claim payments could ultimately be related to AD under a comprehensive LTC plan design.[12] Thus, development of an effective prevention or cure for AD would have a dramatically favorable impact on future LTC experience. However, if properly underwritten, immature blocks of business would initially tend to see much lower percentages.

"Another possible distorting factor relates to AD as a primary versus a secondary diagnosis. Patients may enter the nursing home with a primary diagnosis of the condition that prompted confinement, and a secondary diagnosis of early- to- mid-stage AD."

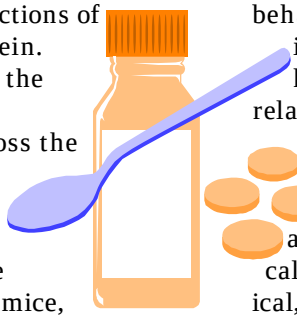
Treatment for AD

Currently, there is no effective prevention or cure for AD. However, many medications and other therapies have been shown to alleviate AD symptoms to varying degrees. Three medications are approved by the United States Food and Drug Administration (FDA) for treatment of AD: Tacrine (Cognex TM), Donepezil HCl (AriceptTM), and Risperidone (RisperidolTM). Many new drug applications are pending at the FDA including ENA-713 (Exelon), Metrifonate, and Physotigmine LA (Synapton). In addition, Idebenone is in Phase III trials, and a half-dozen medications are in Phase II trials. Other less conventional treatments include psychotherapy (early AD stages), aromatherapy (behavior), music therapy (attitude/behavior), herbal therapy (modest cognition improvement), electroconvulsive therapy (surprisingly, overall memory improvement in about half the cases), phototherapy (adjusted sleep-wake cycle), and wine (decreased incidence of AD is reported to be associated with moderate consumption).[13]

Tacrine, although shown to improve cognition in early AD, causes liver toxicity in almost one-half the patients, and only about one-third show a positive response.[14] Donepezil has been shown to benefit cognition and memory loss in patients with mild to moderate AD, and serious side effects and costs are less than with Tacrine. However, as with Tacrine, only about

one-third of patients respond, and there appears to be no prevention of the neurodegeneration that characterizes the progression of AD.[15] Both Tacrine and Donepezil are acetycholinesterase inhibitors. Risperidone is a serotonindopamine antagonist used to treat the behavioral disorders of AD, but there is mixed evidence regarding positive and negative impact on cognitive skills.[16]

Very recently, scientists at Elan Pharmaceuticals reported exciting experimental results that suggest a possible immunization for the prevention and even reduction of beta-amyloid protein accumulation within the brain—the suspected cause of AD. Surprisingly, the immunization simply involves injections of that very same protein. Apparently, some of the antibodies that are produced sneak across the blood-brain barrier and call other immune cells to action. Although the subjects to date are mice, testing on people is to be-gin by the end of this year.[17]



Impact of Treatment on LTC Insurance

Prevention or total cure would have a favorable and undoubtedly significant effect on LTC claims experience. What is unclear is whether current and emerging treatments will have a favorable impact. If a treatment has only a modest benefit and extends the period for which a claimant receives benefits (a situation favorable to the insured), one could argue that the impact on LTC experience could well be unfavorable to the insurer. One model predicts that if interventions could slow progression of AD by 20%, then, over a 5-year period, absolute survival would increase by 2%, ADL impairment would decrease by .25 ADLs (e.g., functional im-pairment for the entire cohort might average 3.65 ADLs rather than 3.90 ADLs), and the probability of institutionalization would decrease by about 5%.[9] These results ap-pear to be meaningful but not dramatic.

Significant LTC claim savings could result from any treatment that would delay institutionalization and make it possible for care to be provided at home and/or by informal caregivers. Home care is frequently limited to a lower daily maximum benefit (e.g., 50% of what would be paid for institutional care), and informal caregivers typically receive little or no payment from LTC insurance.

The proverbial "straw that breaks the informal caregiver's back," thus precipitating institutional placement, is often behavioral problems rather than cognitive dysfunction per se. Therefore, therapies that modify behavior may hold promise for reducing LTC claims. Neuro-leptics have been used to treat AD-related psychosis, aggression, and agitation, but these medications can have problematic side-effects. One interesting alternative is a non-pharmacological approach that focuses on medical, psychological, environmental, and social factors which contribute to the unwanted behaviors.[18]

Insurers interested in a managed care approach to LTC would do well to investigate this alternative for its potential in delaying transfer of care from the home to a more costly institutional setting. The insured would also benefit in terms of an enhanced quality of life, including an improved relationship with the informal caregiver.

Summary

Although the impact of AD on LTC underwriting results is without question highly significant, carefully designed experience studies will be needed to quantify its role as a cause of claim, especially in the context of medical advances that will make it possible to diagnose AD in patients who are not yet clinically demented. New treatments should be closely monitored by LTC insurers to determine if they will have a favorable or unfavorable impact on future experience. As managed care protocols for LTC continue to evolve, new diagnostic and therapeutic approaches should be investigated for their potential to enhance the efficiency of care, both in economic terms as well as for the insured's quality of life.

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ing care retirement community LTC experience in which nursing home stays accounted for 60-70% of claim days were related to dementia as a primary or secondary diagnosis, coupled with an estimate of AD as a cause of 50-75% of the dementia.
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LONG-TERM CARE FOR YEAR 2000

Planning has started for the Spring 2000 Pension/Health SOA meeting. We are looking for topics and also volunteers for the meeting. We want to develop a full track of Long-Term Care Insurance sessions/workshops. We need your help in order to finalize sessions prior to the end of September, 1999. Please send in your thoughts and ideas. E-mail to *mike.abroe@milliman.com* is preferable.

As a reminder, the following LTC sessions are scheduled for the annual meeting this fall:

LONG-TERM CARE—THE PARTNERING PRODUCT?

Some companies are looking to increase sales while lowering expense by packaging the sale of long-term care coverage with complementary products. Attendees discuss the feasibility and success achieved with this strategy. They address the relative package value of various products, such as Medicare supplement, disability income, life insurance, and medical insurance from both sales and administrative perspectives.

LONG-TERM CARE—REGULATORY DEVELOPMENTS

With the creation of Aqualified@ LTCI plans behind us, companies now have additional information regarding interpretations from the Treasury Department, regulations and directives from insurance departments, and feedback from the consumer. This session looks at what we have learned in the past two years and what state and federal regulatory changes may be on the horizon.

Long-Term Care Insurance Section Mission Statement

The mission of the Long-Term Care Insurance Section shall be to encourage and facilitate the professional development of its members through planning, implementing, and actively promoting educational programs and resources on Long-Term Care Insurance issues.

Join the Long-Term Care Insurance Section

This is your opportunity to join a Section dedicated solely to the fastest growing marketplace in insurance, Long-Term Care Insurance. The LTCI Section will provide access to all of the latest developments in this ever-changing market. In order to accomplish our mission, we plan to:

1. Offer seminars
2. Participate and assist SOA committees in developing intercompany data studies
3. Assist in developing actuarial study materials
4. Develop a newsletter

To become a member of the new Long-Term Care Insurance Section, please fill in the information below and mail, along with your $10 check (payable to the Society of Actuaries) c/o Lois Chinnock, Section Coordinator, Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226.

YES, I want to join! Enclosed are my dues of $10.00.

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