LONG-TERM CARE
INSURANCE SECTION

"A KNOWLEDGE COMMUNITY FOR THE SOCIETY OF ACTUARIES"

August 2007, Issue No. 19

Long-Term Care News

Aging and Long-Term Care Insurance: A National Policy Perspective

by Chris Orestis and Eli Rowe

The aging baby boom generation and the burgeoning LTC financing crisis that lays in their wake has been a subject of national discussion for well over a decade. No one institution, be it public or private, will be able to handle the care of our nation's aging population alone. The debate about this issue has been ongoing since the administration of FDR conceived of social security; then Lyndon Johnson ushered in the era of Medicare and Medicaid.

We were fortunate enough recently to sit down with Robert Blancato, a principal and president of Matz, Blancato & Associates at their K Street office in Washington, D.C. to discuss the perspective of national policymakers regarding the current state of the LTC insurance industry.

Blancato is a recognized expert and leader on the topic of aging, having spent 30 years in Washington, D.C. involved in this issue. He was staff director on the House Select Committee on Aging's Human Services Subcommittee from 1977-1988. He currently serves on the Policy Committee and Executive Committee of the 2005 White House Conference of Aging, as appointed by Speaker of the House of Representatives Nancy Pelosi. He was executive director of the 1995 White House Conference on Aging, as appointed by the president of the United States. In 1998, Blancato was a delegate to the White House Conference on Social Security. He has worked closely with the insurance industry over the years through numerous initiatives with the major trade organizations and carriers of LTC insurance, and serves on the boards of numerous advocacy and charitable organizations with the mission of improving the quality of life for the aging.

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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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A Few Good Words: Figaro! Figaro!

by Brad S. Linder

Over 10 years ago, I remember laughing when I first heard of the term "the sandwich generation" at a LTC conference. The term refers to those who happen to have the problem of taking care of their parents as well as their non-adult children at the same time. I laughed because I knew that the problem was a bit more serious than that. I knew of families that were taking care of their grandparents as well as other extended family.

There are a lot of us who happen to have parents old enough to have "conditions" of their own, causing them to be incapable of caring for the needs of their grandparents. Call it now a super-sandwiched generation, but a surprising number of examples exist. Perhaps my ears just happen to perk up whenever I hear of another fellow member of the super-sandwiched generation. I knew back then that my grandfather was too old for LTC insurance despite his incredibly good health. Indeed, the theoretical premium would have driven him into bankruptcy before he even needed the policy benefits. I wondered if others had similar problems. They did, and more.

Our plan became one of carefully managing his remaining assets. Our fallback was always one where my grandfather would spend his remaining days with my family. The key would be to minimize his disorientation caused by moving into a new home. The difficulty of that decision would be made harder as his cognitive impairment increased and his mobility decreased. Fortunately, the nursing home transition from his right-next-door senior living facility went very well. The staff was wonderful—no, incredible is really a better description. Our strategy changed. It was important to keep him in that care facility where the staff provided a warm and loving environment and excellent care as he needed it.

My supporting role changed. I became the provider of periodic "adventure" visits to the neighboring mall where we became the Bad Boyz—experiencing all that the senses could withstand in our time together. Imagine each of us having a cup of caramel coffee with whipped cream topping while watching the trains at the train museum. Those were the best cups of coffee I've ever had.

There are a number of observations from the nursing home that should be presented to you: from medication tracking to billing; from the merits of occupational

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therapy to organized activities; and from living wills to last wills. Several observations concern the new medications available and being used within the nursing home setting. I must report that they are highly promising for cases of cognitive impairment. ***In my opinion, these medications are astounding!*** They will have a definite and profound effect on the underwriting, claims and actuarial tracks. Since this issue is a full one, I must present these to you in future newsletters. It is my hope that other authors will send us articles on these new medications and their effects.

In this issue, we are as busy as Figaro, the legendary barber of Seville! Why so busy? Not because everyone needs a haircut! We had another wonderful LTCI Conference in Dallas, Texas packed with interesting sessions causing good follow-up ideas. And, while at the Dallas conference, a front page article appeared in *The New York Times*. Reactions were swift and hot at the conference. I've included letters to *The New York Times* editor as well as several articles on the reaction and perspectives.

Soon after the conference, two articles in *Best's Review* raised interesting discussion on several marketing issues. The articles are reprinted with permission to keep you aware of the discussion.

Another topic of discussion concerns professional standards. All of us may recognize via television and newspapers that certain professions have these standards. The most commonly known ones are from the medical profession, lawyers and accountants. Although non-actuaries are becoming more educated about what we do, it may be helpful for our readers to have a description of the professional practice standards for members of the American Academy of Actuaries.

Additionally, we have an article on the topic of random variation on claim reserves and two articles from authors in the group track. The group track articles make comparisons of LTC products and highlight important considerations that should be made. Okay, the random variation article is one that's really a lot of fun to examine, particularly for those of us who are actuaries. Would you say that the results are expected or are surprising?

Many thanks go to each of our esteemed authors.❋

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Chairperson's Corner

Or "What Have You Done for Me Lately?"

by Dawn Helwig

Dawn Helwig, FSA, MAAA, is employed at Milliman, Inc. in Chicago. She can be reached at *dawn.helwig@milliman.com.*

If you are receiving a copy of this newsletter, chances are good that you attended this year's Intercompany Long Term Care Insurance Conference in Dallas in March. Even though the ILTCi conference is technically independent of the Society of Actuaries, attending the conference gets you an automatic membership in the SOA's LTC Section, and members of the SOA LTC Section and the ILTCi Conference Board work closely together to achieve a successful conference result.

This year, the ILTCi Board and the SOA LTC Section are taking their "connectedness" one step further. We are each contributing $50,000 into a research fund and plan to use that money to jointly sponsor a small number of long-term care related research projects this year.

So, at the ending luncheon on the last day of the conference, we asked you—the section members—for your ideas on research topics. Your responses were overwhelming … both at the luncheon and continuing for weeks afterwards. A total of 42 unique research projects were identified. It seems that there is still a lot that we don't know about LTC-related issues!

The LTC Section Council and SOA staff organized the 42 proposed research topics into the following related categories: claims, underwriting, public policy, marketing and combo products. We then asked the Section Council members, the LTC Section Track chairs and the ILTCi Board members to each vote for his or her top five choices.

The end result? We plan to issue an RFP this summer requesting proposals on eight different research topics, all of which garnered the threshold number of votes. While we know that we will not be able to fund all eight topics this year, we decided to put all of them into the RFP and then choose the topics with the best responses (while still keeping within our budget!). The eight topics include a nice cross section of interests, and research on any of them would add greatly to our body of long-term care knowledge!

In addition to choosing and supporting research topics, the LTC Section has also been active in preparing sessions for upcoming SOA meetings (the spring meetings, the annual meeting and the LIMRA/LOMA/SOA meeting), has updated a long-term care study note, and has kept involved with other professional activities. We have several active tracks (underwriting, claims, group, operations, compliance and marketing) who are always looking for more participation and volunteers. And, we are already beginning to collect articles for our next newsletter!

So, keep your eyes and ears open … for an RFP, for industry meetings, for article content or other relevant material. The LTC Section is dependent on its volunteer members to keep the knowledge coming! ❋

Q: Recently in *The New York Times* there was an article about LTC insurance claims practices. What is your opinion of that article?

A: The article was an unfortunate example of journalistic opportunism to create a more sensational "exposé" than was deserved. First of all, the article was written about the practices of one company, but the way in which it was portrayed would lead many to believe that this was how an entire industry conducts its business. That is unfair journalism and it could not have been done at a worse time.

This country needs to focus its energies on creating comprehensive solutions to deal with the coming crisis in financing the care of our aging population. Fear mongering and casting an unfairly wide net do not help us attain the real goal of harnessing the collective energies and resources of the private and public sectors in finding ways to ensure an appropriate quality of life for those who can no longer care for themselves.

As is the culture of Washington, D.C. during a national election cycle, I would not be surprised to see hearings on this issue as inquiries by the major candidates for president have gone to GAO (the Government Accounting Office) looking into discrepancies between LTC insurance and Medicaid funding for services rendered. This is time and energy that should be spent on solutions and unfortunately could end up instead being spent on investigations.

Q: Where are there examples of positive dialogue and progress on this issue?

A: One of the better examples that I can point to is the 2005 White House Conference on Aging. This is a once a decade gathering of a cross section of disciplines, interest groups and experts from across the United States, with delegations sent from every state, that has been hosted by the president of the United States since President Truman in 1950. The mission statement of the conference (as enacted by law *85-908*) is to, "promote the dignity, health, and economic security of older Americans." Twelve hundred delegates worked together to prioritize 50 major issues that would impact the aged over the next decade. Second only to renewing the "Older Americans Act" (originally enacted as a result of the 1961 Conference on Aging), the delegates called for a national strategy and effort to address issues around quality, choice, financing and defining roles and responsibilities for long-term care of the elderly as their highest priority.

In my opinion this recommendation from the conference report is a blueprint for action that represents the thinking of the best minds from every state in the union and should be taken up by Congress immediately. The report acknowledges the fact that this is a task too big for any one sector or institution and that the crisis is a ticking time bomb that should be moved to the front burner—before we are forced to operate in crisis mode.

Q: How do you explain the delays in taking real action and responsibility on the political and consumer fronts?

A: Unfortunately, it is human nature to wait until there is a crisis to act. Although the prospect of living in a nursing home that is funded by Medicaid dollars, and the quality of life that it would afford is a bleak sounding future, it seems so abstract to us that we either ignore or are unwilling to believe that this could be our fate. Priorities that are here and today command our attention and dollars, and too many of us delay getting ready for the final days until it is too late.

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This country needs to focus its energies on creating comprehensive solutions to deal with the coming crisis in financing the care of our aging population.

It is the same dynamic for lawmakers. They are concerned about spending priorities and budgets that will have immediate impact and the long-term care crisis can seem like it is a long time away, and slips on the list of priorities. Unfortunately, the end results for us as individuals and as a county if we delay are the same—too little, too late—and a poor quality of life could be the end result.

Q: What are some potential "tipping points" to spur action?

A: Any significant efforts to reform entitlements will create a whole lot of action on this issue. But remember, this is the third rail of politics and not many dare touch it. A couple of examples of attempts to make changes that would have an impact in this area include: tightening asset transfer rules which would make it more difficult to qualify for Medicaid—the default payer of LTC services by a vast majority, and "re-balancing" efforts to direct money away from skilled nursing facilities (nursing homes) and towards more community and home/family based care giving. Neither of these efforts has made a significant impact yet. Again it boils down to the simple fact that people don't pay attention to this issue until it hits home and then changes from being a theoretical problem for others to a real problem for the individual.

Insurance companies need to keep up with this rapid pace of evolution and must modernize product offerings if they are going to improve their chances at obtaining meaningful tax qualified status from lawmakers.

Q: What will it take to get lawmakers to help stimulate private market solutions?

A: First and foremost LTC insurance will need to escalate the pace of modernizing to stay relevant with how the public wants to deal with care giving. The vast majority of people want to handle care at the community and in-home level. Policymakers would like to encourage this direction because it decentralizes responsibility and instills in family care givers a personal stake to negotiate in the market for the best value and price of care. Lawmakers favor personal responsibility in health care reform as is evidenced by market innovations such as health savings accounts, and they are equally interested in seeing the LTC market go in this direction as well.

Insurance companies need to keep up with this rapid pace of evolution and must modernize product offerings if they are going to improve their chances at obtaining meaningful tax qualified status from lawmakers. As LTC policies continue to become multi-dimensional, more constituencies will have a stake in the game and the chances for political and market advancement will increase. The emergence of plans combining life insurance and LTC insurance is an example of market innovation, but the tax code has yet to catch up.

Insurers need to continue examining trends and better understand what the consumer wants. Products designed towards in-home care and supporting family care givers will be a bigger winner in the market and on Capitol Hill than products geared towards nursing home care.

Q: Is there enough awareness about private market solutions and the burgeoning crisis?

A: There are some examples of effective public advocacy and awareness initiatives over the years. The LTC Clearinghouse has been doing good work for years. The "Own Your Future" campaign made some inroads in the states where their focused communication effort was deployed. Another example is the broad based coalition, Americans for Long-Term Care Security that I headed up out of Washington, D.C. for a number of years.

I also thought that the launch of the Federal Long-Term Care Insurance program was very effective. They launched the plan for federal employees back around 2001 and it was a very well coordinated communication/education/

marketing program that drove a lot of new subscribers. The challenge is being able to sustain that level of activity. A stop and start campaign is only effective for a short time and then you need to start all over again at a later date.

The recent *New York Times* article is a setback for public perception and acceptance of LTC insurance as a viable solution. The industry still needs to overcome quality issues and a negative perception. It is also difficult to overcome the theoretical versus reality problem with a life issue that seems far off in the future, and one most people don't want to contemplate.

This reality also makes things difficult for the industry politically, because lawmakers have a mixed opinion about LTC insurance and the future crisis continues to be more theoretical than reality for them as well. This makes it a "second tier" issue compared to health insurance or covering children. There is still not enough confidence in the market or urgency about the future crisis to move tax incentives that would have a real impact on sales.

Conclusion

Blancato's observations are common sense and ring true. The LTC insurance industry has been waiting a long time for the level of sales to match the urgency of the pending crisis. People (and lawmakers) by nature will only react to a crisis when it has entered their lives and becomes reality. How much less expensive and disastrous would it have been to spend money preparing New Orleans to handle a Hurricane Katrina instead of confronting the aftermath? It was known for years that it was just a matter of when and not if the big storm would hit—the only question was one of preparedness. The same is the case with the aging baby boomers and the impact they will have when *that* storm hits. It is just a matter of when, not if, and it will take the insurance industry, health care providers, individuals and lawmakers all facing this reality and working towards a common goal of preparedness to avoid the potential devastation.❋

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A Letter to *The New York Times* Public Editor

by Peter S. Gelbwaks

(Editor's Note: This 3/30/2007 edited letter to The New York Times *was in response to an article originally appearing in* The New York Times *when the 2007 LTCI Conference was held in Dallas, Texas. The letter is to Mr. Byron Calame, as the public editor.)*

Dear Mr. Calame,

I am writing this letter because after reading the LTC article on the front page of your newspaper published this past Monday, you should know that there are numerous good stories to be told. And, I believe my family's story is just one of them that you should take the time to read at this point.

I experienced many painful years watching my 80-year-old mother Lea, suffer from multiple diseases (16 surgeries and 60 hospital stays). She never qualified for LTC insurance because of her pre-existing conditions. After having to pay out over $250,000 out of my own pocket just to keep her alive, without any hope, she spent her final three years in a nursing home. These experiences motivated me to make a career change and I began selling LTC insurance as my specialty. After all, I was a sociology major in college. I always wanted to truly make a difference in other people's lives and to have a positive effect on as many people as possible.

That was over 20 years ago. Looking back today, it was one of the proudest times of my life. Since then, I have been joined in business by my wife, Sharon, my two daughters, one son-in-law and ex-son-in-law. Also, I've been joined by my two sisters-in-law and even my two best friends as well as a number of other very good people who truly understand our "mission."

We all have a common goal in mind. That goal is to help people understand the need for proper planning by assisting them in purchasing LTC insurance and helping people come to an understanding that this decision can truly make a huge difference in their lives and the lives of their loved ones. Most of us in our company, unfortunately, know this because of first-hand experience.

You see, my mother's lesson was one we all learned from. As painful as it was, it has helped us assist not only thousands of my firm's clients, but, just as importantly, it has made an enormous difference in our personal lives.

Unfortunately, my 89-year-old mother-in-law, Anita, needed LTC assistance five years ago. But very fortunately, due to what we learned from my mother's problems, Anita secured adequate coverage. Anita has just completed five years on a fully insured claim. The coverage she has made all the difference in her not needing to ask Medicaid to be involved. It saved our family just under $200,000 and, just as importantly, allowed us to continue living our lives while allowing Anita to maintain her independence and dignity.

Anita is celebrating her 90th birthday in a few weeks. She thanks me almost every day for taking care of her by obtaining for her the coverage that has made all the difference in her quality of life.

With those lessons in mind, Sharon and I bought LTC insurance for ourselves 11 years ago while we were still in our 40s. Our daughters and their husbands all have coverage too—purchased while in their 30s.

My business partner's mom, Pat, is receiving insured care for COPD for the last three years. This has allowed my partner to maintain his single lifestyle and rest assured that someone is taking good care of her. My other friend and co-worker has a wife who has had over 20 heart-related procedures. During these trying times, his spouse has been assisted by home health aides who have been paid for by her policy. Again, her policy allows him to earn a living and help others secure theirs.

Three months ago Sharon, now 57, was told she had an extremely unstable vertebrae and needed immediate, very risky surgery to keep her from becoming permanently paralyzed. We reluctantly agreed to the procedure knowing there would probably be some complications. But not having the surgery, we were told, was an even greater risk. The surgery was successful but complications have caused Sharon to need LTC assistance for quite a while. We have high hopes for a full recovery, but we are both aging boomers. We have worked the last 40 years together. We have diligently saved and invested for our retirement. We never wanted to be a financial burden on our two daughters or our four wonderful granddaughters. Well, the LTC insurance we have in place will guarantee that will never happen and that our saving and investments will still be there for their intended use. Also, the generations following will not have to become the responsible parties concerning any LTC illness either of us may be affected by.

The lessons we have learned in life are that bad stuff can and does happen to good people, including ourselves. The relatively few insurance carriers who have been willing to take the risk of insuring people for a LTC event that is very likely to occur at some point in our lifetime should be applauded for their actions. They should be applauded for the response they have given to those in need and not demonized with inaccurate and sensationalized reporting.

The fact is that our collective excellent experiences as LTC insurance claimants are the norm for over 95 percent of insureds. And, we are also very proud to be a part of this industry.

Sincerely,
Peter S. Gelbwaks, CLTC

Peter Gelbwaks, CLTC, is the president of Gelbwaks Insurance Services, Inc. and is immediate past chairman of the National Long Term Care Network. He can be reached at *peter@gelbwaks.com*.

Response to *The New York Times*

by Stephen R. LaPierre

In his article entitled, "Aged, Frail and Denied Care by Their Insurers," of March 26, 2007, Mr. Duhigg took an unfair and one-sided view of the long-term care insurance industry, and in doing so has done a grave disservice to the growing population of seniors in America.

While I am respectful of the presumably differing opinions surrounding the individual policyholder situations he showcased, Mr. Duhigg's article sacrificed balance and accuracy. A long-term care insurance policy contains provisions for qualifying for claim payments and processes for filing documents to receive those benefits. Mr. Duhigg's story implies that any steps taken by an insurance company to confirm the validity of a claim are egregious and unfair. The fact is that all insurance companies must confirm the legitimacy of claims for benefits as a matter of fiduciary responsibility and in the interest of all policyholders who are counting on the insurance company to be there for them in the future.

Mr. Duhigg mischaracterized the facts by printing an opposing attorney's improper characterizations of a case involving fraud and representing it as my personal testimony. My office had communicated to Mr. Duhigg that his statements were inaccurate, that he did not have my deposition and that he did not have the full facts of the case. The statements he attributed to my testimony never came out of my mouth and were in reality the opinions and implications laced within the opposing attorney's questions and *are not* substantiated by my testimony.

In fact, I have spent the majority of my working years in providing service to senior Americans. Through many years of nursing home administration and directing hospital-based senior outreach programs, I have strived to bring services to seniors that would maintain or improve their quality of life.

I have brought this same compassion for serving seniors to Penn Treaty Network America Insurance Company. Our long-term care insurance policies help to preserve an individual's choice for long-term health care services. Our employees share the same compassion and desire to serve, working with our policyholders every day to answer their questions, assist them in understanding their benefit options and help lighten their burden in their time of need.

As a result of Mr. Duhigg's story, many Americans will be afraid to purchase a long-term care insurance policy. Many who have purchased a long-term care insurance policy will make the unfortunate decision to cancel their policy, leaving them with no choice in their time of need but to finance their health care with their lifetime savings, or limit their care choices as enrollees in government welfare programs.

As with all insurance products, long-term care insurance provides benefits for covered individuals who meet the eligibility requirements of the policy. There is no smoke, no mirrors and no intentional agenda by any long-term care insurance company to withhold benefits that are due and payable to their policyholders. Penn Treaty is dedicated to delivering on the promise of service and support that each policyholder receives when they purchase a long-term care insurance policy.

Mr. Duhigg presented an inappropriate and factually incomplete picture of the long-term care insurance industry and his decision to proceed with printing such information is questionable at best. ❋

Stephen R. LaPierre
Senior Vice President
Penn Treaty Network America Insurance Company

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LTC E-Alert #7-043:

125,000 LTCI Policies and No Claims Payment Problem

by Stephen A. Moses

Thursday, April 5, 2007

Note to Center members: If you think today's LTC E-Alert would help to buck up discouraged LTCI producers who are not members of the Center, feel free to forward it to them.

LTC Comment: I was in Dallas at the LTCI conference when the *The New York Times'* hit piece struck last week. A few days later, I was in Des Moines, Iowa and found what I initially expected to be a "me too" editorial bashing long-term care insurance in the local daily.

Here's the lead from "Read policy fine print for long-term care; Contact Insurance Division about problems," in the March 31, 2007 edition of the *Des Moines Register.* The full article and readers' responses, including mine, are at *http://www.desmoinesregister.com/apps/pbcs.dll/article?AID=2007703310302.*

"Long-term-care insurance can help ensure future nursing-home expenses don't burden children or grandchildren or force seniors to turn to government health care programs such as Medicaid. The insurance is designed to protect assets and give people peace of mind.

"But that's assuming the insurer actually pays the bills when a policyholder enters a long-term care facility.

"According to an investigation by *The New York Times*, some long-term-care insurers are denying a substantial number of claims. Some insurers have 'developed procedures that make it difficult—if not impossible—for policyholders to get paid,' the *Times* reported."

Sounds pretty bleak so far, doesn't it? But read down a few lines and here's what you find:

"So is this happening in Iowa, where more than 125,000 Iowans have purchased long-term-care insurance?

"We checked with the Iowa attorney general's office, the Iowa Insurance Division and the Iowa Department of Elder Affairs. None identified denial of long-term care claims as a common problem."

Well, miracle of miracles, no complaints about denied claims in Iowa.

What do we know about LTC in Iowa?

The state has the lowest percentage of nursing home residents dependent on Medicaid in the entire United States. It is also one of only five states in the country with long-term care insurance market penetration in excess of 15 percent for people over the age of 50.

Compare New York. That state's LTCI market penetration is among the lowest in the country (1 to 5 percent). New York's Medicaid nursing home census is 73 percent, the seventh highest in the United States.

New York is a long-term care basket case. It has the worst LTC public policy in the country. The state discourages responsible long-term care planning with perverse incentives that trap its frail and elderly citizens on public welfare. It rewards heirs for taking their parents' wealth and placing them on the public dole.

When *The New York Times* cherry picks problems with long-term care insurance while totally ignoring the inferior care and impending insolvency of government LTC programs, it does its readers, the public and LTCI producers a major disservice.

Here's how I responded to the *Des Moines Register*'s editorial:

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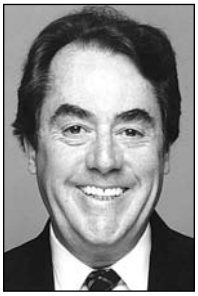
The main reason to have private LTC insurance is so you can keep control of your life and receive red-carpet access to top quality long-term care at the most appropriate level ...



Stephen A. Moses is president of the Center for Long-Term Care Reform, Inc. in Seattle, Wash. He can be reached at *smoses@centerltc.com.*

"Scrutiny of long-term care insurance is good. I'll let people in that business defend their product. But to be fair, what happens if people don't have private LTC insurance? Most likely, they end up on Medicaid, which is a means-tested public assistance program.

"Although it is welfare, Medicaid for LTC is easy to get. Income is rarely an obstacle and most assets are protected, a home (up to $500,000) plus a business, car, home furnishings, personal belongings, term life insurance and prepaid burials of unlimited value.

"Free long-term care? What's not to like? First of all, it isn't free. You'll have to contribute all but a pittance of your income toward your cost of care.

"Then consider that Medicaid is tax-payer financed. It's always short of funds. In Iowa, Medicaid pays nursing homes $10.07 per bed day less than their cost of providing the care.

"So what?

"Medicaid has a dismal reputation for problems of access, quality, reimbursement, discrimination and institutional bias. Depend on Medicaid and you'll probably end up in an under-financed nursing home if you can find one at all that will accept such low reimbursement.

"The main reason to have private LTC insurance is so you can keep control of your life and receive red-carpet access to top quality long-term care at the most appropriate level: home care or assisted living and a top-notch nursing home, but only if you need it.

"If Medicaid financed long-term care is problematical now, just wait a couple decades until baby boomers need LTC. By then Social Security ($15 trillion unfunded liability) and Medicare ($71 trillion unfunded) will be in big trouble. Those programs prop up Medicaid now by offsetting its LTC costs (Social Security) and paying nursing homes more generously (Medicare), but by the time most boomers need LTC, those supports will be long gone.

"Wise consumers should use caution when selecting a private LTC insurance policy, but they should also apply similar scrutiny toward Medicaid. Because, without private insurance, that's where they'll likely end up."

(Note: Reprint permission granted from Stephen A. Moses).

"LTC E-Alerts" are a feature offered by the Center for Long-Term Care Reform, Inc. to members at the $150 per year level or higher. We'll track and report to you news and analysis regarding long-term care financing, service delivery, and research. We hope The LTC E-Alerts will help you attain and maintain a high level of knowledge and competency in this complex field. The Center for Long-Term Care Reform, Inc. is a private institute dedicated to ensuring quality LTC for all Americans *(www.centerltc.com).* ❋

The ABCs Behind the Actuarial Standards of Practice

by Bruce A. Stahl

The high speed train line from southern New Jersey into Philadelphia has three rules posted on the car walls: "No radio," "No food," and "No smoking." Generally, many will find these negatively stated rules quite liberating. They can do a variety of things and still abide by these rules. They can read, sleep, talk, solve crossword or soduko puzzles, work, chat on cell phones, play electronic games, just to name a few.

Actuarial Standards of Practice (ASOPs) are similar: they do not normally state precisely how to do actuarial work, but rather grant a great deal of latitude to the professional. An associate of mine once remarked, "You have to go way out of your way to violate an Actuarial Standard of Practice."

One might wonder why the Actuarial Standards Board of the American Academy of Actuaries produced the standards if they allow so much latitude. In the "Introduction to the Actuarial Standards Of Practice," the Board answered such a question with eight statements. I have taken liberty to rearrange their order, stating them in a sequence that seems more logical to me. I also entitle each such that they follow the first eight letters of the alphabet.

A. *Actuarially articulated (Section 3.1.4).* The intended user of the ASOPs is the actuary. They are designed for people who have the education and experience of an actuary, and anyone else seeking to use them or interpret them ought to seek the understanding of an actuary. This may seem a trivial point, but it protects the actuary from a number of possible difficulties. One example is identified in the introduction itself. An attorney may not shift the burden of proof in litigation by citing a failure of an actuary to comply with one or more ASOP provisions. Another example is that an actuary should not alter his interpretation of an ASOP simply because his client or manager tries to tell him there are other ways of understanding the provision. A particular provision says the, "actuary should perform ... testing of reasonable variations in assumptions prior to finalization of assumptions." If the actuary's manager tells him that he thinks this means the final assumptions can favor their financial objectives as long as the final assumptions are based on reasonable assumptions, and as long as the range of variations is identified, the actuary may need to disagree and explain that the context of the provision points toward using a best estimate assumption. The purpose of the testing of variations is to identify the best estimate rather than to simply provide a range of reasonable outcomes.

B. *Binding upon the actuary (Section 3.1.8).* In contrast to other actuarial literature, such as practice notes produced by Academy committees, ASOPs are requirements for actuaries to follow. An actuary's client or manager may ask the actuary to make an exception, perhaps suggesting that he use assumptions that produce a smaller liability than the best estimate, in order to grant him time to restructure his company and delay the consequences of using the actuary's best estimate. The actuary may not comply with the request if the ASOPs require a best estimate for the task at hand.

C. *Compliance guidance (Section 3.1.7).* Sometimes governing bodies require processes that disagree with otherwise accepted actuarial principles. The Actuarial Standards Board apparently recognized that the, "Academy is the voice of U.S. actuaries on public policy and professionalism issues." Therefore they included ASOPs that focus on compliance issues.

D. *Direct the use of professional judgment and relevant experience (Section 3.1.5).* Sometimes, if not usually, actuaries work with limited data, limited time and with probabilities of future events. Therefore, the ASOPs encourage the actuary to use his professional expertise. This can be frustrating to those who are not actuaries. The chairman of a board of directors once complained to me that actuaries must have interesting debates over meals at their conferences, as they disagree so much. He

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A particular provision says the, "actuary should perform ... testing of reasonable variations in assumptions prior to finalization of assumptions."

pictured them throwing egg rolls across the table at each other. He had been told the addage that if you ask a hundred actuaries the same question, you get a hundred different answers. This purpose for the ASOPs can explain such differences. Yet the non-actuary needs to know that as more sufficient information is available to the actuaries, the range of divergent answers ought to be smaller.

E. *Emphasize process over outcome (Section 3.1.6).* Actuaries may use different methods in their work as well as derive different outcomes. The ASOPs allow the actuary to use professional judgment when selecting methods for completing a task. For example, in setting Incurred But Not Reported claim reserves for LTC insurance, some actuaries may prefer a lag method on the claim counts, applying an expected average claim length and size to the derived counts. Other actuaries may prefer backing into the IBNR after projecting the loss ratios, being more comfortable with the credibility of the projection of loss ratios than with the projection of lag counts. Others yet may use an entirely different approach. All should attempt to compare the IBNR reserves against the historic development of IBNR claims, addressing weaknesses in their method. In testing the method historically, an actuary will find that some methods are inappropriate for the task. For example, if someone tried to derive total LTC claim reserves by applying a typical lag method to the dollars paid each month following the incurred month (a typical claim triangle), he would likely find the reserves test poorly. The lag method assumes fairly uniform distributions of daily benefits, diagnoses, benefit period maximums, inflation benefits and so on. Such uniformity does not normally exist with LTC claims.

F. *Framework for performance (Section 3.1.1).* The ASOPs do not try to narrowly prescribe an approach or outcome. Rather they try to provide a framework for performing the work. They expect the actuary to recognize relevant issues and appropriate methods, to maintain adequate documentation and to provide adequate disclosure. While this grants the actuary plenty of latitude, he should still place himself within the framework of professional standards. For example, the LTC Insurance ASOP addresses Premium Rate Recommendations: "… the actuary should not use assumptions that are unreasonably optimistic;" "… the actuary should use assumptions that ... have a reasonable probability of being achieved;" and "… the actuary should not use assumptions that are unreasonably pessimistic." This is a framework that allows the actuary to use professional judgment and experience to determine what is "reasonable." It even gives latitude on provisions for adverse deviation in assumptions, stating that it "may be appropriate" to include such a provision. Yet the actuary will need to document, and perhaps disclose, why the assumptions and provisions for adverse deviations are reasonable.

The process for developing each ASOP includes steps for exposing the draft to the actuarial public, to allow individual actuaries to express disagreement.

Bruce A. Stahl, ASA, MAAA, wrote this article prior to joining RGA's LTC Division, where he is now vice president and actuary. He can be reached at *bstahl@rgare.com.*

G. *Generally accepted practice (Section 3.1.2).* The ASOPs attempt to document what are the acceptable general practices in the profession. The process for developing each ASOP includes steps for exposing the draft to the actuarial public, to allow individual actuaries to express disagreement. Such disagreement can be in the form of asserting a practice is not generally acceptable or offering yet another generally acceptable practice. For example, based on responses to the exposure of the LTC Insurance ASOP prior to its adoption, the sentence:

"In order to estimate total claim costs, the actuary, where appropriate, should establish claim incidence rates and claim termination rates."

… was appended to include, "… , and costs of eligible benefits."

H. *Heightens the level of generally accepted practice (Section 3.1.3).* Generally, the ASOPs elevate the level of practice with advances in actuarial science. Perhaps the LTC Insurance ASOP is itself a good example of an ASOP increasing the level of practice. In the past, actuarial assumptions for LTC insurance had been based on non-insurance data, or extrapolated from experience of other insurance products. With the increase in credible historical, insured LTC data, the LTC insurance ASOP has heightened the level of accepted practice by anticipating more use of additional information and by anticipating more sensitivity testing.

Perhaps an example for the future is in the exposure of the Actuarial Communications ASOP, which generated a recommendation to include peer reviews in the standard. The board decided not to address it under Actuarial Communications because the subject was broader than that. The board also decided to consider the recommendation further as a separate item. One can argue that peer reviews are a generally accepted practice. Actuarial consulting firms typically try to maintain records of their peer review process on each task. Their level of peer review may vary, being more intense for more material tasks. Perhaps an ASOP on peer review will not insist on a specific degree of peer review for each particular task, but rather anticipate the actuary consider what a reasonable level of review would be, just as the typical consulting firm tries to do. Yet a codified framework for peer review may be useful. A consulting actuary who finds himself "managing" a peer review process by assigning different parts to different actuaries in his firm, in an attempt to prevent any one actuary from questioning him on the whole, may fail to follow a reasonable framework for peer reviews.

This article represents the author's interpretation of the Actuarial Standards of Practice and as such, they are not necessarily those of the American Academy of Actuaries. ❋

Reply from the ASB

by Godfrey Perrott

Editor's Note: "Reply from the ASB" was written in response to an article authored by Bruce A. Stahl entitled, "The ABCs Behind the Actuarial Standards of Practice." It appears in this issue. We shared an advance copy of Bruce's article with the Actuarial Standards Board (ASB) in case they wished to comment. Their comments follow.

This is a good summary of the introduction, but the introduction is three years old and our emphasis has changed in that time. The ASB is considering revising the introduction and will probably send out an exposure draft towards the end of the year.

I have the following specific comments:

1. ASOPs are written to tell the practicing actuary what to:
   a. Consider before and when doing the work.
   b. Document while doing the work.
   c. Disclose in the work product.

   In our opinion they are more demanding than Mr Stahl's friend appears to think.

2. When the ASB drafts a standard, it catalogs generally accepted actuarial practice and then it considers whether that is the appropriate level at which the standard should be set, or whether it is appropriate to set it at a higher level. Our objective is always to set standards at the appropriate level, while not inhibiting improvements in actuarial practice.

3. While the author correctly states the ASB is housed in the AAA, it would be easy to read from his article that the ASB is an AAA committee. In fact the ASB exists to serve all U.S. actuaries (not only those who are MAAAs) and all U.S. actuaries contribute to its budget. The ASB is independent of all other actuarial bodies with respect to creating, revising and repealing standards.

We are delighted that Mr. Stahl has read the introduction so carefully. ❋

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Random Variation in Claim Reserves

by James Berger

Periodic financial statements reflect the progression of a business and for many companies every detail of the quarterly results is the source of much scrutiny. Some income statement items have little judgment involved so that comparison to plan usually has a quick (though potentially nontrivial) explanation. For example, the determination of earned premium for Long-Term Care Insurance (LTCI) "is what it is." There usually isn't much to the concept. Perhaps new business was above or below projections or in-force terminations materialize differently for the quarter, but the explanations are straightforward.

Actuaries are responsible for the reserves. The change in active life reserves is formulaic and while there is some discussion as to why it didn't match "plan," once other-than-expected persistency and new business are factored in, the story is largely told. Occasionally, a calculation glitch is discovered or a data problem comes to light.

One place where the actuary's explanatory powers can be greatly tested is with the reserves associated with claims, specifically the Incurred But Not Reported claims (IBNR) …

One place where the actuary's explanatory powers can be greatly tested is with the reserves associated with claims, specifically the Incurred But Not Reported claims (IBNR) and the tabular reserve for known claims commonly called the Disabled Life Reserve (DLR). These reserves are typically increasing for LTCI blocks as most are in their adolescence. Tracking metrics such as new claims for the quarter, closed claims in the quarter, open claim count on the valuation date, average claim size, average time on claim, etc., can be useful in making sense of the movement of the DLR period-over-period. Yet these metrics may not give a fully satisfying explanation to the actuary and much less to senior management. If the DLR or incurred claims for several consecutive quarters bounces around, or if the change in the DLR impacts the financials positively one quarter but negatively the next quarter, the logical question is whether the actuaries got it right. Were the claims fully reported? Properly reported? Was the data accurate? Was the reserve calculation correct?

There are four basic sources of DLR variation from expectation.

1. Unreasonable expectations: "Plan" set at the wrong level.
2. Data: If the data for a claim changes each period, the results will be volatile.
3. Process: Poor procedures and execution lead to variable results.
4. Randomness: Claims tend to follow a continuance pattern—the variance from the anticipated continuance is the focus of this article.

Of course, inaccurate assumptions also bring down the accuracy of estimating the true claim reserve.

A small block of claims can be expected to vary widely from the continuance table's prediction, while larger blocks of claims can be expected to have variations that are small relative to the overall claim reserve, i.e., as a percentage of the block, a small block will have greater variation than larger blocks. Quantifying the magnitude of random variation can fire warning signs when results are outside the "random" boundaries.

To study this variation, a sample of 1,000 claims was taken from an existing claim listing. A quick review determined that there were no outlying claims, ones with atypical characteristics. This group of claims was then run through a spreadsheet model that allowed each claim to randomly terminate within the boundaries of the claim characteristics. For example, a claim with a 90-day elimination period and a three-year benefit period could terminate any time before the end of the benefit period which was considered to be three years and 90 days from the incurral of the claim. No consideration was given to claim intensity (the amount of the daily benefit used on average) that might cause a claim to persist longer than the calendar day benefit period would otherwise allow. This would have some impact on the results.

A Monte Carlo simulation was run in which the "claim reserve" was calculated using age/gender termination rates replaced by random terminations based on these rates. The Monte Carlo method is well suited for this process since the claims are not identically distributed. The "termination rate" is 1 until *rand()*, the Excel uniform distribution random number generator, is less than tabular termination rate, then 0 thereafter. Each simulation involved roughly 1,000 iterations. Iterations were run on a "practical" basis (overnight—Excel isn't that fast in this exercise), not a theoretically based number of iterations, to minimize the risk of missing the mean by x percent.

The analysis examined the 95 percent spread of Monte Carlo outcomes divided by the calculated/deterministic claim reserve. The 2.5 percentile and 97.5 percentile were determined and the value of the "spread" ***SPR = [0.5 x (97.5 percentile - 2.5 percentile)]*** / **(claim reserve)** was calculated.

For example, for 1,000 claims with claim termination rates directly from the 1985 National Nursing Home Survey, SPR = 8.4 percent. The

interpretation of this result is that a random outcome would be within 8.4 percent of the reported claim reserve 95 percent of the time.

A similar simulation was done with a sample of 250 claims. This time, SPR = 16.7 percent or about double that of a sample size four times as large. This is as expected: If the variance of a sample of size n is $\rho 2n$, then the variance of a sample of 4n is $\rho^2_{4n} = 4\rho^2_n$ size and the standard deviation is $\rho_{4n} = 2\rho_n$.

$$SPR_{4n} \approx (\rho/\mu)_{4n} = \rho_{4n}/\mu_{4n} = 2\rho_n /4\mu_n =$$

$$0.5 \times (\rho_n/\mu_n) = 0.5 \times (\rho/\mu)_n \approx 0.5 \times SPR_n$$

If a company has a claim reserve of $280 million made up of 4,000 claims, then the actual PV of payout over the life of the 4,000 claims should be within 4.2 percent or about $11.75 million of the deterministic reserve of $280 million (if the assumed continuance is correct).

The lifetime stochastic variation can indicate what level of capital may be desired or what level of reserve and capital we should hold in one possible version of a "principles-based" world.

If results need to be explained each quarter, then what should be said as to how much variation is due to random movement? To examine quarterly random movement, the claim reserve calculation used monthly termination rates of 1 or 0 for the three months subsequent to the valuation date, and then used tabular rates (i.e., deterministic, not stochastic) for the following months. Comparing the tabular termination rates to randomly generated numbers between 0 and 1 generated the first three months of 1s or 0s.

The following table shows the random variation for blocks of 250 claims and 1,000 claims, for termination rates of 100 percent of the 85 NNHS and of 75 percent of the 85 NNHS, and over the life of the claims and over just one quarter. Quarterly variation in the claim reserve is likely understated as new claims may occur and their randomness would add to the variation, especially since new claims are in the more volatile earlier durations in a claim. Additionally, the claims chosen for this study were from the known claim listing and thus did not include IBNR claims which can be expected to increase the random quarterly variation due to higher anticipated termination rates over the three stochastic months. Overall, these tables give a reasonable guide or a benchmark to random variation for further analysis. Each company will want to perform this analysis on a block of claims representative of their claims listing.

Number of claims	Percentage of 85 NNHS termination rates	Life of Claim SPR	Quarterly SPR
1,000	100%	8.4%	2.8%
250	100%	16.7%	5.5%
1,000	75%	8.0%	2.3%
250	75%	16.8%	5.0%

As can be seen in the next table, for 1,000 claims this random variation can swing results by over $2 million. Note that the driver of variation is count, not the size of the total DLR.

Number of claims using 100% termination rate	Average reserves per claim	Total Claim Reserve	Quarterly Random Variation, 95% confidence interval
1,000	$90,000	$90.0 MM	+/-2.5 MM
250	$90,000	$22.5 MM	+/-1.25 MM

Further investigation was undertaken to examine the impact of the various parameters of a claims such a benefit period, age and gender. The greatest variation comes from the duration of the claims, as newer claims have more variation. ❋

Number of claims	Percentage of 85 NNHS termination rates	Selected Parameter	Quarterly SPR
250	75%	no inflation protection	5.1%
250	75%	all simple inflation	4.7%
250	75%	all compound inflation	4.6%
250	75%	all female	4.8%
250	75%	all male	5.4%
250	75%	0-day EP	5.1%
250	75%	90-day EP	4.9%
250	75%	all age 50	4.3%
250	75%	all age 60	4.2%
250	75%	all age 70	4.4%
250	75%	all age 80	5.0%
250	75%	all age 90	4.9%
250	75%	all new claims	9.0%
250	75%	all claims 2 yrs old	4.1%
250	75%	all claims 5 yrs old	4.1%

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The Lost Promise of Long-Term Care

by Robert W. MacDonald

(Editor's note: The following article and subsequent commentary highlight a number of important issues to be aware of. Mr. MacDonald's article is presented first, then the commentary by Mr. Gelbwaks. They are reprinted by permission of the A.M. Best Company. This article and subsequent commentary was first published in the March, 2007 edition of the Best's Review magazine.)

For almost as long as it takes to grow old enough to need long-term care benefits, long-term care insurance has offered the promise of lucrative marketing opportunities for both companies and agents.

Yet that promise has gone unfulfilled, and probably always will be. Sure, it has grown into a niche market, but not much more than a cubbyhole in the corner of industry offerings.

Clearly long-term care insurance fits a need. The continuing explosion, indeed a shortage, of assisted living and long-term care facilities speaks to an aging population that is living longer. No one disputes the high cost of providing long-term senior care or that most people do not have the resources to pay for the services privately. Yet, the sales of long-term care insurance have lagged and even appear declining.

What Went Wrong?

For one thing, long-term care insurance is one of those products that no one likes to think about needing. When you are young and don't need long-term care insurance, it is almost free; when you need it, it's virtually unaffordable. For years, the government has promised to take care of the infirm and elderly with Medicare. Generally, people believe that if the government is going to pay for something, why should they? On top of all that, long-term care insurance is complicated to the 'nth degree and is policed by more regulations than the IRS code. All of these issues create a fairly hostile climate for the sale of the product; so much so that we should probably be amazed that any sales are made at all.

What to Do?

Long-term care will never be a big seller as an individual product, but if the benefits are bundled with other products, it could become attractive to consumers and enhance the marketability of the host product. The wider distribution of the long-term care benefits also would substantially reduce the cost. But, it is not enough to simply offer a long-term care rider to, say, an annuity. That could even make matters worse. With so many problems, maybe the best idea would be to wipe the slate clean and dump the idea of long-term care insurance all together. That does not mean ignoring the need the product meets but maybe changing the way the need is met.

Remember, all that long-term care insurance does is to pay doctors, nurses and hospitals directly for long-term care. Instead of this approach, why not offer "senior disability income" and pay the cash directly to the person who is sick and he or she can decide who and what to pay. The disability payment could be included as part of an income annuity and the amount of the benefit set as a percentage of the annuity payment. If an annuitant is receiving $1,500 per month and becomes disabled, the income could be doubled. This helps meet the needs of long-term care without the product being long-term care insurance.

Whether this idea works or not is not the issue. The point is that if the insurance industry is ever to reap the benefits of meeting the need for long-term care, then the old ways must be discarded and substituted with creativity and innovation. ❋

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Long-Term Care: Public, Advisors Need Education

by Peter S. Gelbwaks

I am writing a response to the article written by Robert MacDonald in your March 2007 issue of *Best's Review*. First, let me say that I have respectfully followed the career of Mr. MacDonald for many years and he has many wonderful past accomplishments. However, his research concerning long-term care insurance is flawed and his article entitled "The Lost Promise of Long-Term Care" has totally missed the mark.

Is it true and accurate to state that this product to date has been underbought and undersold? Absolutely. Is it true that the perception of many is that it is too complicated? No question. However, a good part of that has to do with lack of proper carrier funding and focus to get the word out to the "credible centers of influence."

MacDonald writes—"remember all that long-term care insurance does is to pay doctors, nurses and hospitals directly for long-term care" and "why not offer senior disability income and pay the cash directly to the person who is sick and he or she can decide who and what to pay"—both need a direct and public response.

Long-term care insurance specifically does not pay benefits for care provided by doctors and hospitals. No long-term care insurance contract ever written, that I am aware of, has ever paid for hospital stays or doctor bills.

Traditional reimbursement long-term care insurance model contracts do pay insureds directly (if benefits have not been assigned) by reimbursing insureds for actual expenses incurred for nursing home stays, assisted-living costs, adult day center care, Alzheimer's facility charges, at-home care provided by nurses, home-health-care aides (certified nurses assistants), and various types of therapists, provided through a home-health agency or registry, or in some cases directly by a nurse or other caregiver. There are many other features and benefits that current long-term care insurance contracts offer at this time.

Additionally, referencing MacDonald's second statement, "senior disability income" has existed for quite a number of years within the long-term care industry and is an excellent choice for all consumers considering long-term care insurance. This is a version of "indemnity" coverage referred to as "cash benefit or disability model" care insurance.

Once qualified, this coverage does exactly what MacDonald requests of our industry, "it pays the cash directly (currently $260 per day tax free) to the person who is sick and he or she can decide what and whom to pay." Ironically, this is the type of coverage my wife and I own and my wife is currently on claim and receiving these benefits.

The long-term care insurance industry has done a wonderful job of responding to a broad segment of consumers and has addressed, in various ways, their wants and needs. What we have not done is an adequate job of educating the public or their advisors. We are working diligently on this issue. ❋

Peter Gelbwaks, CLTC, is the president of Gelbwaks Insurance Services, Inc. and is immediate past chairman of the National Long Term Care Network. He can be reached at *peter@gelbwaks.com*.

Dissecting the Work Site:

Where True Group and Multi-Life Long-Term Care Fit

by Laura Smith

It appears that there is nothing but green space for LTC insurance—especially when it comes to the employer market. Years ago, the industry offerings were well defined. Individual products were developed for the retail over the kitchen counter sale. Group products were developed for the employer market.

Recently, however, there has been a blending of these markets. With the addition of multi-life, our industry has become much more complex and requires more from the LTCI producer than ever. A producer should present all the options available. However, there are some telltale signs for a producer if an employer should lean toward one product or another. Both product lines have their advantages and disadvantages. It's important for the producer to determine which product will best suit their client's needs.

Multi-Life Product

Advantages of the Multi-Life Product

- Limitless Options: As a producer, you can really determine how many options you want to offer the group. Decisions will be made at the employee level rather than the employer level giving employees all the options they might want or need based upon their personal financial situation.
- Communication Freedom: You can work with your carrier and your MGA to come up with some pretty innovative ideas as far as communication to the employee population.
- Vested Commissions: As the producer, you do not have to worry about commissions moving to another producer once the case is sold. As long as premium is coming in, you'll continue to receive commission on the case.
- Discounts: Employees can see discounting because of health or marital status.
- Billing Methods: Many true group carriers prefer payroll deduction and are limited in allowing for direct billing to the insureds. Multi-life allows for direct billing, taking the employer out of the mix.

Disadvantages of the Multi-Life Product

- Multi-State Locations: Employers in multiple states can be an issue. From an administrative point of view, it is difficult to administer a plan that could have multiple sets of rates, product design and regulations. From a producer standpoint, you'll have to be licensed in every state in order to sell the case effectively.
- Product Generations: Over the years the individual carriers will come out with new products to offer the employer and will limit the access to the older generations. Over time this will mean the employer could have multiple generations of product which translates into different rates, different options and different bills.
- Producer Involvement: Producer involvement is much greater on the multi-life side of the business. This could be an advantage if you have the resources to provide communication pieces, a Web site, on site enrollers, as well as all the other nuances in enrolling a product. Many producers do not have the resources to do this and may require a strong relationship with an MGA to be successful.
- Underwriting: While there are limited "knock out" questions on multi-life, many employers still view this is as something that may impact participation and could discriminate against portions of their population.
- No Transfers: Unlike many group policies you are married to your carrier. This means that if your client ever becomes dissatisfied with the existing carrier, there is nothing to do except terminate the policy and start all over again.

True Group

Advantages of True Group

- Situs State Rules: Producers can rest easy—wherever the employer is located will dictate the plan design for the rest of the employees. The employer will not have to worry about multiple products with varying rates and the producer will only need to be licensed in the state where the employer is situsted.
- Product Generations: The employer will only see one product generation unless the entire group is upgraded. This makes the product easier to administer over time for the employer.
- Reserve Transfer: If your client is unhappy with the carrier, or if the carrier seems to be in a bit of trouble for the long haul, you can always shop the business and look for a replacement for all of those policies. I would caution you that while this might sound easy, it can be difficult to get two carriers to agree on pricing, product and what is considered "like for like."
- Underwriting: True Group products offer guaranteed issue (meaning no health questions) for the actively-at-work benefit eligible population. In these times of PHI, many employers prefer this over receiving any information about their employee's health.
- Producer Support: True Group platforms require very little from the producer other than access to the client and a recommendation on plan design. True Group carriers provide timelines, communication pieces, enrollment Web sites and implementation strategy. You are partnering with a carrier to bring this to your client rather than navigating the ship. This can be a huge advantage to producers that do not have existing relationships with MGAs or other enrollment resources.

Disadvantages of True Group

- Options are Limited: True group carriers come from the philosophy that fewer options mean higher participation and ultimately lower administration costs on the back end. Producers and their clients must sit down together and come up with options they feel will be the most effective for that client's culture.
- Limited Communication: While the True Group carrier will provide you with a myriad of communication pieces to choose from, you are limited as to what you can do in addition to those pieces.
- Discounts: Very few True Group carriers offer additional discounting. There are some products out there that do offer marital discounts and billing discounts, but they are not common
- Commissions: True Group carriers come from the philosophy that LTC insurance should be treated like other benefits—meaning that if another broker comes along that the client prefers, they should be able to get those LTC premiums. This can be very scary to a producer that spent a lot of resources for implementation.

Each product line has its place and each brings a unique solution to an employer. One is not better than the other, nor should anyone make a blanket statement to suggest that's the case. After all, this market is wide open—we all need to start selling this valuable and important benefit, regardless of the delivery method. The best thing for any producer to do is to evaluate what resources they have, what clients they are pursuing and which product seems to fit the client best. ❋

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Group or Individual LTCI?

A Marketer's Perspective

by Jim Lowder and Steve M. Cain

When the right selection is made, it's memorable.

- The 100-life law firm with 40 partners wanting LTC insurance on a non-qualified compensation basis.
- The 5,000-life engineering firm with 95 percent participation in its 401(k), 80 percent participation in its voluntary DI insurance program, 100 percent access at work to e-mail, and that agrees to use of its logo on mailings to the home.

Whether to market a group or an individual LTCI program becomes a judgment call. As with any judgment call, there are elements of fact, intuition and luck.

The decision whether to use an individual or a group LTCI program seems clear.

But, not all marketing situations are this clear-cut. Consider the employer:

- with hundreds of locations with 10 to 20 employees each; or
- that wants to make LTCI 'available' as an employee option; or
- that does not allow solicitations to be mailed to its employees' homes; or.
- that considers a table in the cafeteria to be the same as an enrollment meeting during work hours.

Group LTCI carriers run from such opportunities—and, perhaps, rightfully so. Individual LTCI carriers leave the marketing to the soliciting agent—who may see the chance to "get in front of" 15 percent of the employee population as an opportunity.

But, within these employers are employees who can afford to equip either their financial or personal plans with LTCI and should be provided the opportunity.

From a marketer's perspective, the difference between group and individual LTCI should be about the efforts required to produce participation—whether the effort is their own, the employer's or the carrier's. Consider a 1,000-life employer. There is no difference in the marketer's first-year revenue between writing a group LTCI program with 10 percent participation and writing an individual LTCI program with 0.8 percent participation—except the amount of effort/energy required to reach potential insureds.

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An assessment of the marketing risk starts with a review of three dynamics: the benefits staff's appetite for marketing, the affinity between the employees and the employer and the logistics associated with the education and enrollment channels. Simply put—when the appetite of the benefits staff for educating employees is higher; when the affinity between the employee and employer is higher; and when the channels of communication are well-defined and well-used—the easier the decision to promote a group LTCI product becomes. As the quality of these characteristics decreases, the discussion should turn towards segmentation of the employee population and communication focused on likely buyers—however that may be defined.

This assessment may include solid facts—participation numbers in other voluntary benefits, previous successes/failures with other programs, demographics and buyers' profiles, etc. Sometimes the assessment may include

intuition about the organization—such as whether employees listen to the employer's messages. And, sometimes, the assessment involves luck—both good and bad, each of which has been the source of many marketing stories.

Replacing the assessment of appetite, affinity and channels with a discussion of product is a diversion. Today, group LTCI programs offer many of the same features as individual LTCI programs. And, a discussion of whether ABI is a more appropriate inflation option becomes academic if access to employees is not available or employees do not heed messages sent under the banner of their employer.

Lastly, the value of guarantee issue in the LTCI market should be tested. Group LTCI programs have seen growth through late entrants when communication about the program, along with communication about all employee benefits, is ongoing, and the relationship between the employee and employer is solid. When an actively-at-work, full-time employee—regardless of employer—is well-motivated to consider LTCI as an element of his or her financial or personal plan, the amount of paperwork can be overcome. There should be testing to determine whether the costs to provide mailings and to facilitate group meetings announcing the value to an open enrollment period—and the importance of its end date—would be better spent on three mailings a year to a targeted, segmented population.

This is not meant to diminish the value to appropriate plan design and having simplified enrollment. Their value should be placed in the context of analyzing the marketing opportunity that an employee group presents—and not necessarily drive the opportunity.

Participation is all about reaching a customer through the context of his/her employment. Realizing that the dynamics of the employment environment are complex and ever-changing makes the decision to offer one product over another a judgment call—not something predetermined. ❋

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