



SOCIETY OF ACTUARIES

**Health Spring Meeting
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**Session # 64 PD: LTC & Disability Insurance:
Learning from Past Experience**

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Society of Actuaries 2009 Spring Meeting LTC and Disability Insurance: Learning from Past Experience

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Introduction to Long Term Care

- First sold in 1970's, as nursing home only product (post-hospitalization, medically necessary)
- In early 1990's, benefits based on Activities of Daily Living or cognitive impairment
- 1996 – tax-qualification introduced
- Home health care now included to make “comprehensive” policies
- Subject to elimination period, daily maximum, benefit period maximum (expressed in “pool of money”)
- Market grew rapidly in 1990's; rate increases and rate stability legislation caused company and agent exodus in early 2000's; sales have declined or been stable since then



Introduction to Individual DI

- Long history in U.S. – back to 1920's
- Non-can is prevalent policy form – 85-90%
- Very competitive market in 1980's and emphasis on medical occupations – led to catastrophic losses in 1990's
- Classic lesson on why risk management principles are important
- Many IDI carriers dropped out
- Remaining companies – tighter UW and contracts, higher rates, more disciplined claim management
- Industry profitability returned but sales growth 1-2% per year
- Market mostly remains rooted in executive – professional occupations
- Competitive pressures are rekindling

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LTC Product Design

- Benefit triggers have evolved: post-hospital; medically necessary; 2+ ADL's or cognitive; tax-qualified triggers
- Nursing home only coverage vs. home health care only coverage vs. comprehensive coverage
- Definition of incurral date and claim continuation
- Definitions of nursing home, assisted living facility, home health
- Coverage of informal care/care by family members
- Restoration of benefits provisions
- Reimbursement, indemnity and disability style policies available
- Risk class differences and single/married rate differences
- Sales have gotten "shorter and fatter" (less lifetime, more inflation)

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IDI Product Design

- Total and residual disability – typical contract
- Few companies still offer lifetime benefits now
- 2 Year MNAD limitation is now common but can rider out
- Unlimited recovery benefits removed by most carriers
- Pure own occ still available – restricted availability to doctors being lifted
- Little innovative product design
- ADL supplemental DI coverage for severe disabilities
- A number of carriers have special IDI products for ER-sponsored IDI market

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LTC Pricing Assumptions

- Morbidity: initial rates based on public studies (National Nursing Home Surveys, National LTC Survey). Now – based on company experience (still not complete for all ages/durations).
- Lapse rates: initially, used ultimate rates of 4-8%. Now – using ultimate rates of 0.5-1.5%.
- Mortality: initially used population mortality, then '83 GAM. Now – '94 GAM or Annuity 2000 Table, with selection.
- Investment income – has come down from 7-8% in 1990's to 5-6% today
- Guaranteed renewable (NOT non-cancellable), so rates can be increased, but rate stability regulation is in place
- Rates are unisex, level premium, (generally) nationwide, risk discounts, marital discounts

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IDI Pricing Assumptions

- Statutory industry morbidity table (85 CIDA) is obsolete
- IDEC studied claim experience of 1990's – preliminary tables released in 2005, but not finalized (YET) – new data call for 2000-08 experience.
- Most companies relying on their own experience to price products
- IDI premiums not as sensitive to lapses as LTC
- Expanded occupation classes particularly for doctors and surgeons
- Geographic loads – CA and FL
- Discounts for nonsmokers and ER-sponsored multi-life sales
- New premium is still 85% non-can

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LTC Underwriting

- Initially – underwritten off of application only, using methods similar to life or health insurance
- Quickly learned that skills of underwriter needed to be different, and the medical conditions that cause concern are different
- Added telephone interviews and face-to-face assessments
- In mid-90's, added cognitive screenings for older applicants
- Now – often using MIB and Rx screens
- Short form applications (and sometimes guarantee issue) used for actively-at-work employees
- Underwriting manuals continually being updated, as more is learned about what conditions lead to LTC claim

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IDI Underwriting

- Experience of 1990's led to more blood testing and financial documentation
- In 2000 maximum issue limit for doctors was \$10k and for other top occ class \$15k
- Mental health histories were typically declined
- IDI underwriting in general became more restrictive
- As more companies target ER-sponsored multi-life market, GSI underwriting became more acceptable – even voluntary GSI
- More simplified underwriting programs for single sale market
- More utilization of tele-underwriting and pharmaceutical databases

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LTC Competitive Pressures

- Benefits are not standardized and there are differences in how risk classes are determined, so rates can be difficult to compare
- Companies tend to have lowest rates for cells they want to attract (younger ages, marrieds)
- New companies feel pressure to meet or beat the rates of those with market share (Genworth, John Hancock)
- Brokers “spreadsheet” premiums, to find company with lowest rate for person of given age and risk class

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IDI Competitive Pressures

- Small number of carriers chasing after very specific markets
- Competition in recent years focused on higher maximum I&P limits including doctors
- Some carriers have maximum issue and participation of \$20k/\$30k for top occ class and \$15k/25k for some doctors
- After-tax replacement ratios can fall in the 85%-95% range in the ER-sponsored multi-life market
- GSI underwriting rules becoming more liberal – particularly for voluntary
- Beginning to see more rate competition in the top occ classes
- Greater pursuit of doctors and surgeons - 21% (2002) to 25% (2008) of new premium

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LTC Claims Management

- Lesson learned: can't just be a "bill-paying shop" with LTC
- Older generation policies may not have policy language to enable company to appropriately manage claims
- Certification of need for care must be made by licensed health practitioner (and often confirmed by company)
- Plan of care must be developed – either by nurse assigned by company or by person's doctor
- Plan of care should outline site and level of assistance needed, number of hours of services needed per week, and for how long
- Re-certification required at least annually (or more often for claim that is expected to have changing needs)
- Litigation and high-profile news reports

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IDI Claims Management

- More specialized resources – large claims, mental-nervous, CA – nurses, MSWs, forensic accountants
- Rehabilitation is not as much as effective in IDI as group LTD, but used on occasion to assist someone back to work
- More companies have claim settlement programs
- Litigation

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LTC Valuation

- No valuation standards for morbidity for either active life reserves or claim reserves
- Some reserve adequacy issues have arisen (due to lapse rates, claim slopes, continuance curves)
- Pricing assumptions (with provision for adverse deviation) used
- Life discount rate (currently 4%) used
- Lapses limited to 80% of pricing in years 1-4, 100% thereafter (subject to maximums of 6% year 1, 4% years 2-4, 2% years 5+)
- Mortality – currently '94 GAM
- Given large build-up of reserves, and the investment income earned in excess of 4% on them, the net to gross ratio is usually conservative, compared to the expected loss ratio (especially for policies with built-in compound inflation)

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IDI Valuation

- Current statutory minimum morbidity bases (CIDA for ALR and CIDC for DLR) are out of date
- Pricing assumptions are seldom used
- Many companies have stronger than minimum DLR's
- Lifetime benefits may be under-reserved due to low current mortality and future improvements
- Statutory ALR are generally adequate due to no valuation lapse rates