



Long-Term Care News

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Taming a Wild Ride: Investment and Risk Management Strategies for Long-Term Care Insurers in a Challenging Market

by James G. Stoltzfus and Angelika Feng

OVERVIEW OF THE LTC MARKETPLACE

An analysis of the long-term care (LTC) insurance market shows an industry undergoing significant changes, and one in which the future is difficult to predict. With sales declining significantly in 2008 and 2009, insurers outside of the top ranks of LTC sellers have struggled to build new sales, and several companies have decided to limit their participation in the LTC market, take substantial rate increases, or stop selling LTC policies altogether. However, despite these recent trends, we have started to see improvements in sales since 2010. According to the U.S. LTC insurance annual review reports¹ by LIMRA (an association of insurance and financial

services companies), sales in 2010 grew 13 percent and 24 percent in the individual LTC market and the group LTC market, respectively. The number of lives covered by U.S. individual LTC insurance policies increased 11 percent, and new premiums at the top 10 individual LTC carriers combined grew 20 percent in 2010. The individual LTC sales showed continued growth in the first half of 2011.

One bright spot in the market is products that combine life insurance with LTC, for example

FOOTNOTES

¹ LIMRA, Group LTC Insurance, Annual Review 2008-2010, Individual LTC Insurance, Annual Review 2008-2010

Microcosm of Economic Concerns in 2011

by Bruce A. Stahl



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The articles in this issue of *Long-Term Care News* represent some of the same issues that many in 2011 think were characteristic of the U.S. economy. The articles reflect excessive regulation, excessive spending, and an attempt to align available cash with liabilities.

Alignment of cash with liabilities. Of course many have been concerned about the government spending now with the intent of paying for it later. Although LTC insurance risk managers have much different reasons for a mismatch of liabilities and the ability to pay them, Jim Stoltzfus and Angelika Feng identify investment strategies that may help LTC insurance managers address the intrinsic differences between the timing of LTC liabilities and the timing of asset maturities.

Excessive spending. We have included testimony provided to the U.S. House Subcommittee on Health Care, et al regarding the topic, "Examining Abuses of Medicaid Eligibility Rules." Most of our readers probably already understand that Medicaid is often erroneously understood to be an entitlement program rather than a need-based program. Yet this particular testimony came from Janice Eulau, a 36-year-long employee of the Department of Social Services in Suffolk County, New York. Her testimony is clear and succinct. Also it included a number of attachments which we did not include in the newsletter, but if you are interested, you may go the House website to obtain your own copy:

http://oversight.house.gov/index.php?option=com_content&view=article&id=1445%3A9-21-2011-qexamining-abuses-of-medicaid-eligibility-rulesq&catid=35&Itemid=40

Excessive regulation. We have included a letter that the American Academy of Actuaries and the SOA LTCI Section jointly sent to the U.S. Department of Health and Human Services with regard to its plan to apply the prohibitions of the Genetic Information Nondiscrimination Act on LTC insurance. The letter provides an example of why the prohibitions would actually hurt the industry and be costly to the government.

As always, our intent is to provide you with information that is helpful to you and that challenges your thinking about topics related to the long-term care industry. We hope you find these articles informative and helpful and we thank the authors for their contributions. If you have any questions or comments, please send them our way. ■

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My Thanks Goes To . . .

by Jason B. Bushey

When I decided two years ago to run for the LTCI Section Council, I never thought two years later I would be required to write the Chairperson's Corner, one of my duties of being chairperson of the council. Given that I have never written an article for a publication, and am many years removed from writing papers during my college years, I wondered how I was going to handle this challenge.

As I thought about potential topics for my first "Chairperson's Corner" article, I started to list the activities that the section was involved in over my first two years on the council. One activity dealt with premium rating issues; another focused on outreach and making refinements to the industry; still another involved collaboration between members from different areas of the industry to propose solutions to the challenges facing the industry. These are just three of the many activities that the section participated in.

The one common theme among all of the activities is that the section's involvement was only possible due to section members volunteering their time. In addition to these ad hoc activities, the section also coordinates with the many ongoing industry meetings to help produce breakout sessions. It is important to recognize the contribution of the members who were presenters at these various industry meetings.

I am glad that so many of the members of the section are actively engaged in supporting the section, the actuarial profession and the LTC insurance industry—thank you and please stay engaged. To those who are not, I encourage you to become involved. Here are some ideas:

- Join the section's LinkedIn group and participate in discussions of current topics.
- Provide feedback to the council as well as suggestions on the issues the council should address.
- Consider speaking at one of the industry conferences.
- Volunteer for a work group that is tackling a particular issue.
- Run for section council.

I hope you decide to become active in the section.

Finally, I want to thank outgoing chairperson David Benz as well as outgoing members Mark Costello and Roger Gagne for their contributions over the past three years. Their hard work and dedication will be missed. ■



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It is important to recognize the contribution of the members who were presenters at these various industry meetings.

by including a rider that allows policyholders to draw death benefits early if they end up needing LTC coverage. Products that combine an annuity with LTC insurance are also growing in popularity, with several benefit designs being offered in the market today. The market penetration of these products is partly due to favorable tax rules created by the Pension Protection Act of 2006 that became effective in January of 2010, including tax-favored access to account values and tax-free distributions from combination annuities.

In addition, alternative funding techniques are being increasingly utilized including reverse mortgages.

OVERVIEW OF THE KEY RISKS FACED BY THE LTC WRITERS

These combination products represent a fairly small part of the LTC insurance market, which itself is only a small fraction of its potential size. The need for LTC insurance is clear, but in addition to relatively low consumer demand, insurers face significant challenges in pricing and managing the risks associated with these products.

Chief among these is the long duration of the LTC coverage. Cash flows are typically positive in early years, but negative later on, requiring extremely careful asset management over the long term. Over the course of the decades that LTC policies are typically in force, the potential for long-tail liability risk rises. In fact, the economy is still in recovery from an economic “perfect storm” so improbable that leading economists failed to predict it—one that has had significant impact on LTC insurers. Over long time spans, these are the kinds of risks for which insurers must plan.

One important consequence of the economic situation that has a major impact on LTC insurers is the depression of interest rates to extreme lows. This greatly impacts the yields on Treasuries and investment-grade corporate bonds, which represent a significant portion of the LTC assets. According to Milliman research², for every percentage point long-term interest rates drop, insurers may need to increase premiums 10 to 15 percent to cover the gap depending, of course, on the assumptions utilized to price the product. Prolonged low interest rates create reinvestment risk, meaning that higher-

interest investments maturing today might be rolled into new, lower-interest vehicles, barely providing any interest rate margin over valuation rates.

Additionally, LTC insurers face risks created by the mismatch between the duration that assets take to mature and the long duration of policy coverage. Bonds and other low-risk investments have a typical maximum duration of 10 to 15 years, while the duration of liabilities can often be 20 years or much longer. This makes it exceedingly difficult to match investment returns with anticipated claims. This problem is exacerbated by lower-than-anticipated lapse rates for policies that were issued and priced using the historical experience from earlier generations of LTC.

Traditional investment strategies are not looking as viable as they once did. Longer duration assets reduce liquidity, making it difficult for LTC insurers to adjust to market conditions with anything other than rate increases. Large market value fluctuations occur with small changes in the current market rates due to the long duration of assets. Convertible bonds and equities can lengthen asset duration, but there are regulatory restrictions on the portion of the insurer’s asset portfolio that can be held in equities.

Along with lower-than-anticipated lapse rates, these risks and economic challenges have caused many LTC insurers to apply for significant premium increases, ranging from 10 to 40 percent or more. Some insurers, including MetLife and, more recently, Guardian, have chosen to stop selling LTC policies altogether.

Given these challenges, what can LTC insurers do to remain solvent and, hopefully, profitable while continuing to sell and service LTC policies? This paper focuses on strategies that companies are using today to invest assets more profitably and manage risks more effectively to help ensure that they can meet their obligations and move forward in an uncertain market.

FOOTNOTES

² “How Do You Spell LTC Profitability?” Presentation by Dawn Helwig at LIMRA/LOMA/SOA DI/LTC conference, September 2009.

ASSET INVESTMENT STRATEGIES

Since the recent financial crisis, traditional assumptions about the performance of various assets have been turned upside down. Low interest rates have made conventional “safe” investments such as government bonds less attractive to back LTC liabilities as they do not presently provide sufficient yield for most purposes, although most insurers are required to keep a certain proportion of their assets in such vehicles. The equity markets suffered massive losses. Although they have recovered a substantial amount of value recently, volatility and uncertainty concerns remain. Because of these realities, more companies are looking for alternative investments. Also, improved pricing assumptions have enabled a more realistic determination of the liability durations. This allows companies to better manage their investment strategies and asset portfolios early on in the policy life cycle, which reduces risks now and in the future. In this section, several of these investments that have been utilized are discussed in terms of their benefits and risks for long-term care insurer asset portfolios. Obviously, new asset types will be developed in the future. This list is not meant to be an all-inclusive list. Rather, it is meant to offer some alternatives to traditional assets that have been used to help meet the long-term duration and mitigate reinvestment risks.

Convertible Bonds

Convertible bonds are instruments that pay a fixed yield until a specific date, at which point they can be converted into equity shares in the issuing entity at an agreed-upon exercise price. They are hybrid securities, meaning that they have both debt-like features (like a bond) and equity-like features (like a stock). While the return during the “bond phase” can be relatively low, the option to convert to equities can provide higher yields in the future. This makes them useful as assets for LTC insurers because the value of the investment will not fall below the value of the bond, but there is the possibility of greater return farther down the road when it is needed to fund LTC claims. While many companies are not investing in convertible bonds today because of the recent downturns in the equity markets, over a time horizon of 20 to 30 years, convertible bonds can be

very useful assets, especially given the low yield for government bonds today.

Derivatives

Derivatives have been bashed by the popular press as a source of instability in global financial markets and one of many causes for the financial meltdown. Some of this criticism is fair, but the truth is that derivatives are and will remain a critical part of the global financial system. They enable organizations to trade risks and can be used to manage reinvestment risk and asset and liability duration mismatch risk in the LTC markets.

A common type of derivative is the interest rate swap in which two parties exchange one set of cash flow payments for another at dates specified in the contract. For example, one party could be paying a floating rate while the other is paying a fixed rate. Executing a long-dated receive-fixed interest rate swap can allow insurers to synthetically create long-tenored investments with durations much longer than other available cash market instruments.

Other commonly used types of swaps include:

- **Currency swaps:** Used when a company wants to hedge interest rate movements and currency movements simultaneously, particularly when assets are denominated in different currencies. This could give access to longer-duration assets in foreign markets which could be swapped back to the U.S. dollars, though counterparty credit risk is higher in the case of currency swaps.
- **Swaptions:** Gives the contract holder the right to enter an interest rate swap agreement. A receiver swaption is the right to enter into a swap at a specific future date as the fixed rate receiver at a rate specified in the swaption contract. Companies often use swaptions to hedge future movements of the interest rates. Insurers can reduce reinvestment risk by using swaptions to lock-in future reinvestment rates.
- **A forward-starting swap** is a forward security which locks in the rate today for an interest rate swap agreement to be entered in the future. For example, companies sometimes use “receive

Some of this criticism is fair, but the truth is that derivatives are and will remain a critical part of the global financial system.

CONTINUED ON PAGE 6



fixed/pay variable” forward-starting swaps to hedge their future purchases of long-term bonds in a declining interest rate environment. These swaps are usually terminated at the time that the future purchase is expected to occur.

Derivatives do carry risks. Counterparty risk is the risk that the counterparty will default on the agreement. Additionally, it is extremely important for insurers to stay abreast of how derivative investing is affected by regulations and capital requirements. Finally, accounting for these assets is complex, and accounting treatments can be different depending on the purposes of the hedges and how they are categorized.

Collateralized Loan Obligations

Collateralized loan obligations (CLOs) pool loans and the associated payment streams into securities with varying degrees of risk and return. CLOs are securitized assets similar to collateralized debt obligations (CDOs) where the underlying collateral is bank loans instead of other types of debt instruments. Typically, these consist of a pool of higher-risk, higher-yield medium and large commercial loans and the overall credit risk of which has been reduced through the collateralization process.

Despite receiving bad press in the same fashion as derivatives, many of these investments performed well during the financial crisis, leading a growing number of companies to consider adding well-diversified CLOs to their portfolios. Tranches can range from relatively short-term investments to medium-term, so they may not address the duration mismatch issue, but the performance of CLOs can make them attractive for backing claim reserves.

Private Placements

Private placements are investments that are not traded or bought over the counter but are created in a private agreement between two companies. They may provide higher yields than other types of investments, but they tend to have higher risk for several reasons. First, although they are listed as securities, they are not publicly traded, so there is less information available about them. If an organization needs to use a private placement to raise capital, it may have credit risks that prevent it from obtaining traditional financing, so further research of the organization is important. Lastly, there may not be an active market in which to sell private placement investments, and this could create liquidity risks for the holder.

Other Asset Types

Companies have recently looked at Build America Bonds, which are taxable municipal bonds funded by the 2009 American Recovery and Reinvestment Act. The primary market for this asset type has passed its sunset in 2011. However, they may begin a secondary market in 2011. Given the higher earnings rates, it is likely the purchase price is at a premium thereby reducing the prospective buyer’s yield on the asset. Other asset types which have been available in the past are obviously still available, and generally these traditional assets make up a large portion of company portfolios.

LIABILITY RISK TRANSFER

In addition to considering alternative investment strategies, LTC insurers could look at innovative ways of managing the liability risks inherent in their business. Three significant possibilities are securitization, offshore reinsurance and product redesign.

Securitization

Securitization of insurance risk has been practiced

in other insurance or liability markets for many years. It is a means for transferring risk from an insurance company to capital markets by exchanging risk-prone cash flows for lump sum payments, much like a bond. One key in successful securitizations is finding buyers who understand the risks sufficiently to want to take them on. Many insurance securitizations are highly complex, and, therefore, create informational asymmetries between the issuer and the investor.

LTC securitizations have been attempted in recent years. However, due to the uncertainty of future morbidity flows, differences between actual experience and originally priced expectations in experience, and the long-term risk of future cash flows, much higher risk margins must be assumed, making securitization of an entire block of future cash flows less attractive to outside investors.

Claim Securitization

Claim reserves for policyholders currently on claim are much more predictable. The one component of future claims, claims incidence, is already known. Current claim reserves can be sizable but usually have shorter durations, particularly those not containing lifetime benefits or without future benefit increase options. For example, a block of existing claims consisting of 4-year or 5-year benefit periods may present an opportunity.

Commission Securitization

Another cash flow stream that is more predictable is future commissions. At least two opportunities could exist here. First, the future stream of commissions could be collateralized or securitized into an asset-backed security. Second, the future stream of commissions could be sold to an outside investor, thereby providing cash to the insurer and relieving the insurer of future commission payments as the investor takes over the commission payments. The outside investor may then buy out the agents and pick up a margin on the purchase.

Offshore Reinsurance

Much has been written about offshore reinsurance. Offshore reinsurance involves ceding the business to a reinsurer typically in a jurisdiction with efficiencies around capital requirements, reserve requirements, investment restrictions, regulations, and tax structure. The reinsurer could be a

separately licensed entity or a captive established in the offshore jurisdiction.

Typically, reserve requirements in other jurisdictions outside the United States may be closer to GAAP. Also, there may be fewer investment limitations and fewer capital (RBC) restrictions. For example, it may be possible to keep a higher proportion of assets in equities or enjoy lower capital requirements compared to purchasing U.S. reinsurance. Obviously, disadvantages exist as well. These could include currency risk, excise taxes and ceded reserve credits. The use of offshore reinsurance should be carefully evaluated to make sure all of the risks are well understood.

Product Redesign

It is also useful for LTC insurers to examine the structures of their products to mitigate risks. LTC is not a mature market and new ideas for structuring products arise regularly. One approach that has gained more favor recently is combo products which combine life insurance or an annuity product with LTC insurance, by offering life insurance or an annuity with an LTC rider. Life insurance primarily suffers from the risk that mortality will arise too early in the product lifecycle, while LTC faces the opposite risk. By offering both benefits in one product, the risks can be balanced. For example, an increasingly popular class of product provides an LTC “living benefit” that draws down the balance of the life policy. Other approaches exist or have been proposed in the past as well, such as “universal LTC,” which could be structured similarly to universal life insurance or a deferred annuity. While each of these possibilities has advantages and disadvantages, the key is to better understand the risks and develop a product that appeals to both the policyholders and the insurers in the long term.

REGULATORY IMPACTS ON LTC RISK MANAGEMENT

One more consideration is how changes to insurance regulations, specifically, the adoption of the principle-based approach (PBA) in the United States and the related adoption of Solvency II regulations in Europe, will affect the viability of specific risk management and investment strategies for LTC insurers. These regulations, both



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anticipated in the 2013 time frame at the earliest, will likely change the capital requirements for certain types of assets and liabilities. If specific asset classes result in higher capital needs, the LTC market could see a rising interest in alternative investments as well as strategies for minimizing capital requirements.

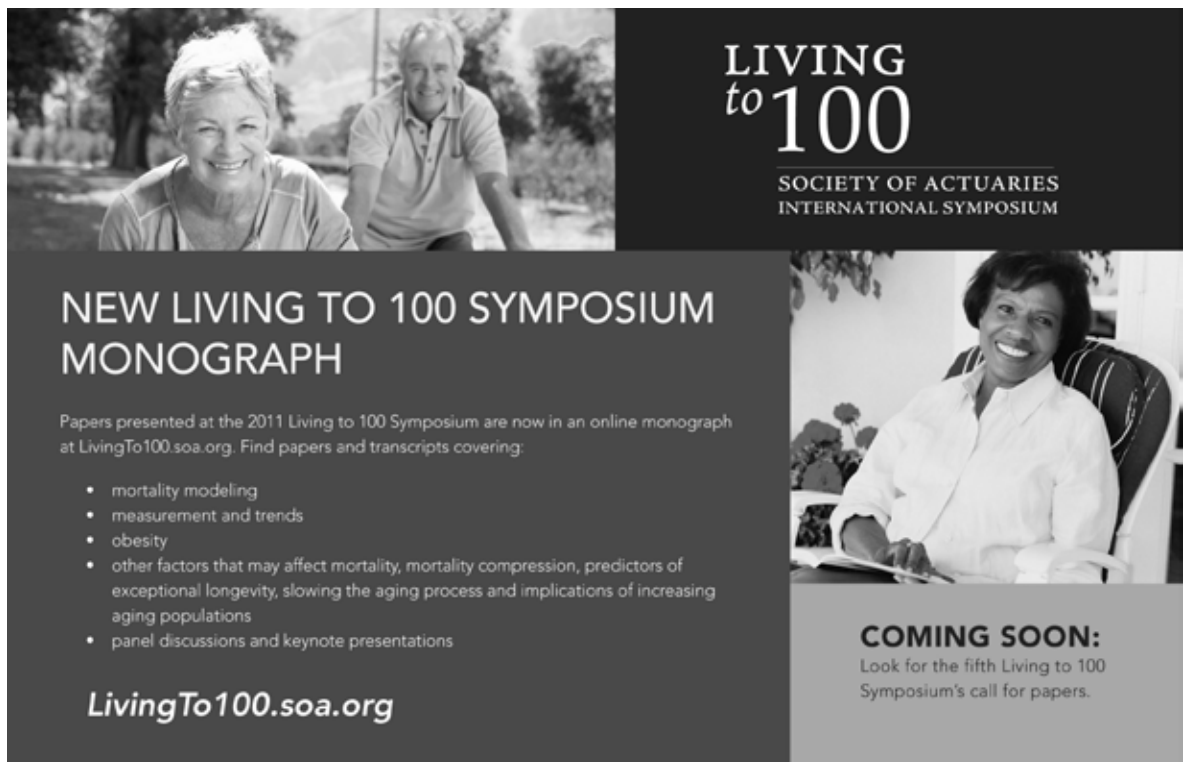
Methods such as Solvency II, PBA and Canadian GAAP (CGAAP) require companies to stochastically determine capital and reserves. In addition, rating agencies have adopted economic capital modeling in their rating process. For LTC insurers, this means active life reserves, claim reserves and capital requirements could all potentially be determined on a stochastic basis. For some companies, especially small companies, this could lead to major overhaul of their systems.

Larger and more diversified companies may be able to gain more capital relief and more competitive pricing, while making it more and more difficult for some companies to compete. Consequently, this could lead to more consolidation in the LTC market going forward. Time will tell for sure.

Companies will need to develop more robust ERM platforms under the new regulatory requirements. Risk management techniques described above such as hedging, reinsurance and capital market risk transfer will become even more important.

CONCLUSION

Despite the happenings over the last couple of years, the outlook for LTC is extremely positive. The key is understanding and dealing with the risks. While the LTC insurance market is growing (albeit slowly) and maturing, it holds inherent risks for insurers in the imbalance between assets and liabilities. Given an uncertain investment and interest rate environment, LTC insurers should aggressively investigate alternative strategies for ensuring that their organizations can meet their obligations over the long term. At the same time, since some of these strategies are both emerging and complex, insurers must ensure they have the appropriate expertise that will help them gauge which strategies will help them reach their goals without undesirable or unforeseen consequences. ■



The advertisement features a black and white photograph of an elderly couple sitting outdoors on a bench, smiling. To the right of the photo is the text "LIVING to 100 SOCIETY OF ACTUARIES INTERNATIONAL SYMPOSIUM". Below the photo is the title "NEW LIVING TO 100 SYMPOSIUM MONOGRAPH". Underneath the title is a paragraph: "Papers presented at the 2011 Living to 100 Symposium are now in an online monograph at LivingTo100.soa.org. Find papers and transcripts covering:" followed by a bulleted list of topics. At the bottom left is the website "LivingTo100.soa.org". On the right side, there is a smaller black and white photo of a woman sitting in a chair, smiling, with the text "COMING SOON: Look for the fifth Living to 100 Symposium's call for papers."

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Papers presented at the 2011 Living to 100 Symposium are now in an online monograph at LivingTo100.soa.org. Find papers and transcripts covering:

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- obesity
- other factors that may affect mortality, mortality compression, predictors of exceptional longevity, slowing the aging process and implications of increasing aging populations
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Be ready to share a brief bio or résumé.

Written Submission to the Subcommittee on Health Care, District of Columbia, Census and the National Archives

TOPIC: EXAMINING ABUSES OF MEDICAID ELIGIBILITY RULES

by Janice Eulau

Note from the Editor: This is an excerpt from the testimony provided to the U.S. House Subcommittee on Health Care, et al regarding the topic, “Examining Abuses of Medicaid Eligibility Rules.” Full testimony can be found at http://oversight.house.gov/index.php?option=com_content&view=article&id=1445%3A9-21-2011-qexamining-abuses-of-medicaid-eligibility-rulesq&catid=35&Itemid=40.

My name is Janice Eulau and I have been employed by the Suffolk County New York Department of Social Services for the past 36 years. I currently serve as the Assistant Administrator for the Medicaid program in that county. Approximately 180,000 individuals receive Medicaid in Suffolk with 5,300 in receipt of nursing home care. In 2010 nursing home care for those 5,300 recipients cost \$429.9 million with a federal share of \$213.7 million.

Attachment 1 lists Medicaid expenditures in Suffolk County New York for 2010. Nursing Home Care accounts for approximately 24% of the total expenditures.

As a long time employee of a local Medicaid office, I have had the opportunity to witness the diversion of applicants’ significant resources in order to obtain Medicaid coverage. It is not at all unusual to encounter individuals and couples with resources exceeding a half million dollars, some with over one million.

There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant’s nursing home care.

Wealthy applicants for Medicaid’s nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves. There is limited understanding that Medicaid for nursing home care remains a means-tested government pro-

gram, not an entitlement program. This misunderstanding seems to be perpetuated by the Elder Law and Medicaid Estate Planning industry.

A tool most often used by single clients is the promissory note. Half of the applicant’s excess resource is transferred to the children without compensation. This transfer results in a penalty period where Medicaid will not pay for nursing home care, approximately 1 month for every \$10,000 transferred. The other half of the excess resource is also transferred to the children, but in return for a promissory note which will produce an income stream to cover the cost of care during the penalty period. Our county regularly sees promissory notes in excess of \$150,000 with matching uncompensated transfers.

Attachment 2 is a copy of the website of a Elder Law Attorney explaining the process of preserving assets through the use of a promissory note.

For couples, the most common method of preserving resources is spousal refusal. In this case, the spouse in the nursing home transfers all resources beyond those he is allowed to keep to the well spouse living at home, since transfers to a spouse do not incur a penalty period. In New York the institutionalized spouse may retain \$13,800, the spouse living at home can retain up to \$109,000. In addition, the home and pre-paid burial expenses are exempt. Any amount in excess of these resources is deemed available to meet nursing home costs. However, federal law allows the spouse at home to refuse to support the applying spouse and requires states to then base the Medicaid eligibility determination on the income and assets of only the applying spouse. States have the right to bring support proceedings against the refusing spouse. My county has pursued the refusing spouse in the past, however family court is only able to address the excess income and attach resources for past Medicaid payments. Any further proceedings would need to be addressed in New York’s Supreme Court, a process that would

There is limited understanding that Medicaid for nursing home care remains a means-tested government program, not an entitlement program.

take months or years for each case and strain our limited local resources.

Attachment 3 includes the federal regulation for the “Treatment of income and resources for certain institutionalized spouses” (42 USC 1396r-5).

Attachment 4 is a form supplied by the Human Resources Administration of the City of New York to be completed by any legally responsible relative refusing to support their spouse or minor child. The form advises that the refusing individual may be taken to court for failure to support the Medicaid recipient.

Attachment 5 is the copy of a website of an Elder Law Attorney explaining the process of spousal refusal and its use in New York. The author again comments that other states are not allowing spousal refusal and failing to follow federal statute.

The remedy for these abuses lies in education as well as changes to law. Many seniors believe that Medicare and their supplemental insurance policies will pay for their nursing home care, when, in fact, these policies will only pay up to 100 days of care, and only under certain circumstances. Medicare communication through their annual handbook and on their official website is woefully lacking information in this area. Not surprisingly, wealthy seniors fail to realize the value or need for Long Term Care Insurance. Having a better understanding of the limits of Medicare would enable seniors to make timely and informed decisions regarding their future care needs.

I also respectfully suggest that the law allowing spousal refusal be adjusted to enforce the current resource limits and allow the spouse at home to petition the court for higher resource levels should his/her circumstances call for such an increase instead of requiring the state to address each refusal.

Allowing wealthy spouses to ignore their financial responsibility to one another is a policy we cannot afford.

Attachment 6 is a copy of a website listing excerpts from an undated presentation to the National Academy of Elder Law Attorneys. Comments include a participant questioning why the statute



included as attachment 1 above is not followed in states other than New York, Florida and the District of Columbia. Based on the comments and information in the article, it appears that it was written prior to the Deficit Reduction Act of 2005, however the basic premise of spousal refusal remains the same.

In closing, I would hope that the Medicaid program can fulfill its original mission to provide quality health coverage to individuals who are unable to afford such care or the insurance to pay for care. However, individuals with resources above and beyond the level prescribed by law should not be allowed to fund their children’s inheritance while the taxpayers fund their nursing home care. I strongly believe that this is not a partisan issue. I also believe in the merits of the Medicaid program, but feel just as deeply that these issues regarding resource diversion need to be addressed.

Thank you. ■

Dear Secretary Sebelius

Oct. 13, 2011

The Honorable Kathleen Sebelius
Secretary U.S. Department of Health and
Human Services

Hubert Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On behalf of an ad hoc work group comprised of members of the Society of Actuaries¹ (SOA) Long-Term Section Council and the American Academy of Actuaries² (Academy) Federal Long-Term Care Task Force, we offer the following analysis of the key actuarial considerations associated with respect to the potential application of the Genetic Information Nondiscrimination Act of 2008 (GINA) to long-term care (LTC) insurance. As you know, the Department of Health and Human Services (HHS) has proposed extending GINA's prohibition against using genetic information for underwriting purposes to LTC insurance.³ We ask that you consider this analysis of the effect of GINA on the cost and availability of LTC insurance as you finalize the regulations.

Barring LTC insurers from obtaining test results already known to such applicants could result in a significant imbalance of information between LTC insurers and applicants. Such asymmetric information could result in adverse selection that would have a direct and significant impact on LTC insurance-premium and insurance coverage rates.

GINA did not affect life insurance and LTC insurance when it was signed into law. That exclusion was not arbitrary; these insurance products are fundamentally different from medical coverage. Both life insurance and LTC insurance have substantially longer terms than medical insurance, with premium rates intended to remain stable or fixed for long periods of time. Neither product is seen by consumers as a practical necessity to ensure access to health care. Both life insurance and LTC insurance depend on insurers having access to similar information as the applicant so that insurers can charge appropriate premiums and protect their risk

pools from adverse selection. If applicants were to adversely select against the insurer, premium rates would be significantly higher (and less stable in the case of LTC insurance), fewer carriers would offer such coverage, and significantly fewer individuals would elect to purchase it.

In the 2009 proposed regulations for implementing GINA, HHS indicated its intent to apply the law to LTC insurance. Because the final regulations have not been released yet, we want to take this opportunity to point out that LTC insurance is more akin to life insurance than to medical insurance—both with respect to both the use of genetic information in underwriting and the voluntary nature of the purchasing decision. As such, the adverse effect on consumers if GINA were applied to LTC would be greater than the relatively modest effect on medical insurance. We believe, therefore, that GINA should not apply to LTC insurance.

Like whole life insurance, LTC insurance premium rates are designed to remain level for the life of the policy, and the pricing period is measured in multiple years, rather than in months as is true for medical insurance. Also like whole life insurance, the decision to purchase LTC insurance is entirely voluntary and premiums rarely are subsidized; only about 10 percent of eligible Americans have LTC insurance coverage.⁴ In contrast, with approximately 85 percent of Americans currently having

FOOTNOTES

- 1 The Society of Actuaries (SOA) is the largest professional organization dedicated to serving 20,000 actuarial members and the public in the United States and Canada. The SOA's vision is for actuaries to be the leading professionals in the measurement and management of financial risk. To learn more, visit www.soa.org.
- 2 The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
- 3 Federal Register 74(193):51698–51710 (Oct. 7, 2009).
- 4 A.M. Best Company. U.S.—Long-Term Care. March 29, 2010

medical insurance coverage,⁵ the purchase of medical insurance will become mandatory in 2014 and the premiums for such coverage will continue to be subsidized for large proportions of the population.

The economic impact of applying GINA to LTC insurance would be significant (using the \$100 million “significance” threshold in Executive Order 12866 as cited by HHS in its 2009 notice in the *Federal Register*).⁶ Indeed, the potential effect for the LTC insurance industry of having no genetic information available to them, when the LTC insurance applicants have such information, eventually could be significantly in excess of \$100 million per year based on the following considerations:

- New sales of individual LTC insurance in 2010 generated \$525 million in new annual premium.⁷
- If, for example, apolipoprotein E (APOE) genetic information—one gene associated with a higher risk of developing Alzheimer’s Disease—were to become readily available to potential applicants, but not to the insurers, the adverse selection eventually could result in an increase in premiums by an amount in excess of 30 percent.⁸ This would be based solely on currently available genetic testing for the disease.
- The final amount likely would be much greater due to continuing advances in genetic testing.

An ad hoc work group was convened to quantify the potential impact of the proposed regulations on the LTC insurance marketplace. To quantify the effect on consumers, the work group conducted a morbidity analysis using Alzheimer’s Disease, which provided the basis for estimating the substantial negative economic impact this extension of the GINA regulations would have on the LTC insurance marketplace. Based on this analysis, we believe that GINA should not apply to LTC insurance. The remainder of this letter presents the work group’s findings and our conclusions.

EXECUTIVE SUMMARY

Voluntary insurance mechanisms function properly if rates charged to individuals reflect actuarial risks that are based on known characteristics of the insured. Each insured is assigned to a homogenous risk pool, a pool of multiple insureds with similar risks. If an applicant for LTC insurance has mate-

rial knowledge that he or she is likely to require LTC services but the insurance company is not allowed to obtain and factor in that information, the homogenous risk pool mechanism will break down. Applicants who understand that their risk is substantially higher than the risk of other applicants likely would use that information to buy insurance coverage that effectively pools their higher risk and cost with lower-risk insureds. For a voluntary product, like LTC insurance, with fairly low sales penetration, higher-risk applicants have a significantly greater effect on the overall risk pool than for mandatory or other insurance products with significantly high participation rates, such as the current medical insurance marketplace.

Higher-risk insureds initially are not charged a premium commensurate with the risk they bring to their pool. As time progresses and the higher-risk insureds produce more claims, it then becomes apparent that the risk pool needs a premium rate increase. In other words, the initial premium rate is too low to cover the unexpected claims presented by the higher representation of higher-risk individuals in the pool. When premium rates are increased, lower-risk individuals paying a higher premium rate than the risk they represent are more likely to terminate their coverage. This behavior could be exaggerated by insureds who find through genetic tests that they are not at as great a risk as other insureds. As these insureds opt out of the insurance pool, the average cost for the remaining insureds increases again. This creates a rate spiral in which the increased cost causes lower-risk individuals to forgo insurance, further driving up the cost for those remaining in the pool. The cycle continues its spiral until only the higher-risk individuals remain in the pool.

If LTC insurers do not have access to the health information that individual applicants possess, this rate spiral is inevitable. Underwriting known

FOOTNOTES

- 5 U.S. Census Bureau. Statistical Abstract of the United States: 2011, Table 151, 2011.
- 6 Federal Register 74(193):51698–51710 (Oct. 7, 2009).
- 7 FisherKeller, Karen, *U.S. Individual LTC Insurance—Annual Review 2010* (powerpoint). LIMRA. <http://marketing.cpsinsurance.com/visionscape/2011/April/pdf/LIMRA-%20US%20Individual%20LTC%20Insurance-%20Annual%20Review%202010.pdf>.
- 8 The body of this report shows how this amount was derived.

morbidity risk and assigning to homogenous risk pools is vital to pricing LTC insurance properly. The result will be a shrinking private LTC insurance market and an increase in the number of individuals who will have to rely on programs such as Medicaid. This appears to us to contradict other public and private efforts that have been designed to encourage individuals to plan for their long-term care needs and help alleviate the growing costs of Medicaid programs.

It should be emphasized here that it is not enough to permit LTC insurers to use genetic information for underwriting if the individual provides written permission. Insurers need to be able to decline applicants who have had genetic testing but do not provide permission to use the results. Genetic tests that indicate an elevated risk level likely would not provide such permission unless it was a requirement to get the coverage.

As an example of a potential effect should GINA regulations be extended to LTC coverage, the work group evaluated a single genetic test. Since Alzheimer’s Disease is a leading and costly LTC insurance claim, the work group decided to focus on a gene that has been shown to be associated with a higher risk of developing the disease. This gene is the apolipoprotein E (APOE) gene, and the specific subtype that carries increased risk for developing Alzheimer’s Disease is the APOE ε4 allele.

The total LTC claim costs (including Alzheimer’s Disease and all other causes) for an individual with two APOE ε4 alleles is 5 times as great as for an individual with no APOE ε4. The total claim costs for an individual with one APOE ε4 allele is 1.55 times as great as for an individual with no APOE ε4 alleles (from the data contained in Table 5). Although APOE testing is not commonly performed, if it were to become prevalent, the cost of LTC insurance would increase by as much as 32 percent (see Tables 6 and 7).

As new genetic research finds even better predictors for Alzheimer’s Disease (or other debilitating conditions), the risk of adverse selection would be greater. If GINA were to be applied to LTC insurance, this risk could result in fewer carriers being willing or able to write this business, leading to further strain on public programs.

If insurers were to price for the anti-selection due to the applicants’ enhanced knowledge that the insurer cannot obtain, individuals who are average risks could be priced out of the LTC insurance market. They likely would recognize that they are paying more than their expected future costs without insurance. This would increase the volatility of LTC insurance rates and add another risk factor (more effective testing or more widespread use of testing) that could increase the likelihood of future in-force rate increases.

Details of Analysis

Aggregate claim costs were developed using an SOA intercompany experience study for long-term care insureds.⁹ We divided those claim costs between Alzheimer’s and other conditions. Then we determined the total claim costs for insureds with 0, 1, or 2 APOE ε4 alleles along with their relative risk compared to the aggregate insured population. We applied Appendix D2-A and Appendix E3 to represent incidence by attained age and average length of stay (ALOS) in days by age at claim.¹⁰ We geometrically interpolated figures for missing ages. We multiplied the incidence rates and ALOS values to arrive at claim costs per dollar of daily benefit. Sample age results are provided in Table 1.

Attained Age	Incidence	ALOS	Aggregate Claim Costs*
42	0.0002278	820.90	0.187
45	0.0002787	820.90	0.229
47	0.0003183	820.90	0.261
52	0.0004435	820.90	0.364
55	0.0005411	820.90	0.444
57	0.0006502	820.90	0.534
60	0.0008564	820.90	0.703
62	0.0010290	808.83	0.832
67	0.0020280	779.43	1.581
70	0.0035078	762.30	2.674
72	0.0050545	758.82	3.835
77	0.0124027	750.20	9.304
80	0.0199636	745.07	14.874
82	0.0274192	722.70	19.816
87	0.0516468	669.68	34.587
92	0.0783281	539.75	42.277

*Aggregate claim costs are equal to incidence times ALOS (e.g., 0.187 = 0.0002278 x 820.90); ALOS assumed constant under age 60.

FOOTNOTES

9 Society of Actuaries (SOA). *Long-Term Care Experience Committee Intercompany Study: 1984—2004*. (November 2007).

10 Society of Actuaries (SOA). *Long-Term Care Experience Committee Intercompany Study: 1984—2004*. (November 2007). Appendix D2-A is a pivot table that provides incidence by issue age, duration and other characteristics. Appendix E shows continuance by elimination period, region, diagnosis, and other demographic characteristics.

Using Appendix G5 of the SOA intercompany study, the aggregate incidence and length of stay were then adjusted to derive Alzheimer's and non-Alzheimer's claim costs.¹¹

Table 2: Incidence Distribution and Severity Relativities by Alzheimer's and Non-Alzheimer's Claims						
Attained Age	Incidence Distribution			Severity Relativities		
	Alzheimer's	Non-Alz	Total	Alzheimer's	Non-Alz	Total
0-64	7%	93%	100%	2.83	0.86	1.00
65-69	14%	86%	100%	2.43	0.76	1.00
70-74	18%	82%	100%	2.02	0.77	1.00
75-79	21%	79%	100%	1.74	0.81	1.00
80-84	21%	79%	100%	1.61	0.83	1.00
85-89	21%	79%	100%	1.43	0.89	1.00
90+	18%	82%	100%	1.39	0.91	1.00
Total	20%	80%	100%	1.71	0.83	1.00

Table 3: Claim Costs by Alzheimer's and Non-Alzheimer's Unisex			
Attained Age	Alzheimer's*	Non-Alzheimer's**	Aggregate Claim Costs***
42	0.037	0.150	0.187
45	0.045	0.183	0.229
47	0.052	0.209	0.261
52	0.072	0.292	0.364
55	0.088	0.356	0.444
57	0.106	0.428	0.534
60	0.140	0.563	0.703
62	0.165	0.667	0.832
67	0.542	1.038	1.581
70	0.958	1.715	2.674
72	1.414	2.421	3.835
77	3.328	5.977	9.304
80	5.205	9.668	14.874
82	6.833	12.983	19.816
87	10.335	24.252	34.587
92	10.499	31.778	42.277

* Alzheimer's claim costs are equal to Table 1 aggregate claim cost times Table 2 Alzheimer's incidence distribution times Table 2 Alzheimer's severity relativity factor (e.g., $0.037 = 0.187 \times 7\% \times 2.83$).

** Non-Alzheimer's claim costs are equal to Table 1 aggregate claim cost times Table 2 non-Alzheimer's incidence distribution times Table 2 non-Alzheimer's severity relativity factor (e.g., $0.150 = 0.187 \times 93\% \times 0.86$).

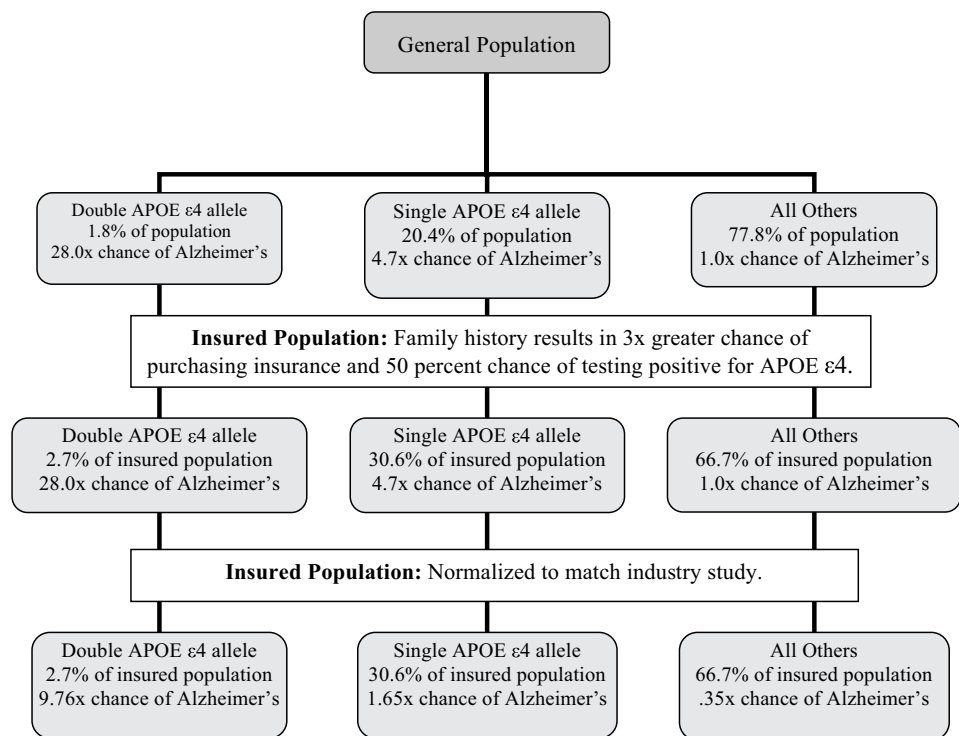
*** Aggregate claim costs are equal to Table 1. They may not equal the Alzheimer's plus non-Alzheimer's claim costs due to rounding.

FOOTNOTES

¹¹ Society of Actuaries (SOA). *Long-Term Care Experience Committee Intercompany Study: 1984—2004*. (November 2007). Appendix G describes how claims were mapped into diagnosis categories.

We know the underlying insured population consisted of a mix of APOE ε4 positive and negative insureds. Based on a study published in the *Journal of Clinical Psychiatry*,¹² 20.4 percent of the control population tested positive for the presence of one APOE ε4 allele, indicating they have a 4.7 times greater likelihood of developing Alzheimer’s Disease than those without APOE ε4. Of the control population, 1.8 percent tested positive for the presence of two APOE ε4 alleles, which corresponds to a 28.0 times greater likelihood of developing the disease. In addition, the *Risk Evaluation and Education for Alzheimer’s Disease (REVEAL)* study, conducted between 2000 and 2003, indicated that individuals with a family history of the disease were 3 times as likely to purchase LTC insurance.¹³ In addition, the presence of a family history of Alzheimer’s was associated with a 50 percent chance of testing positive for APOE ε4.¹³ Data from elderly controls in the Swedish Kungsholmen Project indicated that the probability of a family history of dementia-related symptoms was approximately 18.6 percent (46/247).¹⁴

Using the above research results, we estimated that 2.7 percent of the LTC insured population would test positive for two APOE ε4 alleles and that 30.6 percent of the LTC insured population would test positive for one APOE ε 4 allele.¹⁵



FOOTNOTES

- 12 Coon, Keith D., et al. "A High Density Whole-Genome Association Study Reveals That APOE is the Major Susceptibility Gene for Sporadic Late-Onset Alzheimer's Disease." *Journal of Clinical Psychiatry* (April 2007; 68:4, pp. 613-618).
- 13 Zick, Cathleen D., et al. "Genetic Testing for Alzheimer's Disease and its Impact on Insurance Purchasing Behavior." *Health Affairs* (March/April 2005; 24:2, pp. 483-490)
- 14 Fratiglioni, Laura. "Risk Factors for Late-Onset Alzheimer's Disease: A Population-Based, Case-Control Study." *Annals of Neurology* (March 1993; 33:3, pp. 258-266).
- 15 The 2.7 percent estimate represents the conditional probability of having two APOE ε4 alleles, given that the person actually purchased LTC insurance; the 30.6 percent estimate represents the conditional probability of having one APOE ε4 allele, given that the person actually purchased LTC insurance. In making these estimates, we reduced the 18.6 percent family-history estimate from Sweden to 16.6 percent for the U.S. to reflect, in part, reports that APOE ε4 allele frequencies are lower at mid-latitudes than at high latitudes (such as in Sweden); see Eisenberg et al. "Worldwide Allele Frequencies of the Human Apolipoprotein E Gene: Climate, Local Adaptations, and Evolutionary History." *American Journal of Physical Anthropology* (2010; 143, pp. 100-111).

Combining these distributions resulted in the following claims projections:

- Those insureds who are positive for two APOE ε4 alleles will have a claim cost 9.76 times that of the aggregate Alzheimer’s claim cost (9.76 is equal to $28.0 / (2.7\% \times 28 + 30.6\% \times 4.7 + 66.7\% \times 1)$ —values are rounded).
- Those insureds who are positive for a single APOE ε4 allele will have a claim cost 1.65 times that of the aggregate Alzheimer’s claim cost (1.65 is equal to $4.7 / (2.7\% \times 28 + 30.6\% \times 4.7 + 66.7\% \times 1)$ —values are rounded).
- In contrast, those insureds who are negative for the APOE ε4 allele will have a claim cost 0.35 times that of the aggregate Alzheimer’s claim cost (0.35 is equal to $1 / (2.7\% \times 28 + 30.6\% \times 4.7 + 66.7\% \times 1)$ —values are rounded).

The following table applies the above assumptions and calculates Alzheimer’s claim costs as well as the non-Alzheimer’s claim costs and shows the total based on the presence or absence of APOE ε4.

Table 4: APOE ε4 Specific Claim Costs Unisex				
Attained Age	Double APOE ε4 Positive*	Single APOE ε4 Positive**	APOE ε4 Negative***	Aggregate Claim Costs****
42	0.512	0.211	0.163	0.187
45	0.627	0.258	0.199	0.229
47	0.716	0.295	0.228	0.261
52	0.997	0.411	0.317	0.364
55	1.217	0.501	0.387	0.444
57	1.462	0.602	0.465	0.534
60	1.925	0.793	0.612	0.703
62	2.279	0.939	0.725	0.832
67	6.333	1.931	1.228	1.581
70	11.066	3.292	2.049	2.674
72	16.226	4.749	2.915	3.835
77	38.455	11.454	7.138	9.304
80	60.464	18.236	11.485	14.874
82	79.674	24.231	15.367	19.816
87	125.122	41.264	27.858	34.587
92	134.248	49.061	35.442	42.277

* Double APOE ε4 positive claim cost is equal to Table 3 Alzheimer’s claim cost times 9.8 plus Table 3 non-Alzheimer’s claim cost (e.g., $0.512 = 0.037 \times 9.8 + 0.150$). Number may differ slightly due to rounding.

** Single APOE ε4 positive claim cost is equal to Table 3 Alzheimer’s claim cost times 1.6 plus Table 3 non-Alzheimer’s claim cost (e.g., $0.211 = 0.037 \times 1.6 + 0.150$). Number may differ slightly due to rounding.

*** APOE ε4 negative claim cost is equal to Table 3 Alzheimer’s claim cost times 0.35 plus Table 3 non-Alzheimer’s claim cost (e.g., $0.163 = 0.037 \times 0.35 + 0.150$). Number may differ slightly due to rounding.

**** Aggregate claim cost remains equal to Table 1. It is the sum of the three APOE ε4 statuses with each weighted by the portion of the insured pool that each status represents.

CONTINUED ON PAGE 18

From Table 4, double APOE ε4 positive claim costs are 274 to 423 percent of the aggregate claim costs, and single APOE ε4 positive claim costs are 113 to 124 percent of the aggregate claim costs. As has been noted, this history can be priced for in current premium rates. If LTC insurance is purchased by 10 percent of the population, and if we have a population of 1,000, the required premium (using claim costs as a proxy) could be viewed in the following manner:

Table 5: Claim Cost Relativities by APOE ε4 Presence		
	Number of Policies	Relativity to Aggregate*
Double APOE ε4 Positive	2.7	3.904
Single APOE ε4 Positive	30.6	1.214
APOE ε4 Negative	66.7**	0.784
Aggregate	100.0	1.000

* Relativity to aggregate equals the sum of the relativities by age from the data in Table 4 multiplied by the weight of the number of claims at each age to the total number of claims in the 2004 Intercompany Study.

** Balancing item equals aggregate (10 percent of 1,000 population) minus 2.7 percent of insured population testing double APOE ε4 positive minus 30.6 percent of insured population testing single APOE ε4 positive.

If genetic testing were to become widely available without insurers having access to the same information, the risk pool will worsen by 28 percent from the APOE test alone. This would occur with the likelihood that the remainder of the APOE ε4 positive lives will buy insurance but the penetration rate of APOE ε4 negative lives will remain unchanged.

Table 6: Claim Cost Relativities by APOE ε4 Presence 100% Purchase by APOE ε4 Positive Population		
	Number of Policies	Relativity
Double APOE ε4 Positive	18*	3.904
Single APOE ε4 Positive	204**	1.214
APOE ε4 Negative	67	0.784
Aggregate	289	1.283

* 18 = 1.8% of 1,000 population

** 204 = 20.4% of 1,000 population

According to a Forbes Consulting report, “a 20-25% increase in premiums is associated with a 30% decline in sales.”¹⁶ Those who have tested positive for the APOE ε4 allele, however, are not likely to change their

FOOTNOTES

¹⁶ *Price Elasticity and Optimization*. Forbes Consulting (2004).

purchasing behavior, causing further deterioration in the purchasing pool to be 32 percent worse than today.

Table 7: Claim Cost Relativities by APOE ε4 Presence 100% Purchase by APOE ε4 Positive Population, 30% Reduction in APOE ε4 Negative		
	Number of Policies	Relativity
Double APOE ε4 Positive	18	3.904
Single APOE ε4 Positive	204	1.214
APOE ε4 Negative	47*	0.784
Aggregate	269	1.320

*67 x 70% (30% reduction in APOE ε4 negative purchasers)

As testing improves and becomes more readily available, those who purchase LTC insurance will become more heavily weighted toward the 3.9 cost relativity. As the lower-risk population determines that it no longer is willing to bear this price and leaves the insured pool, the required premium rates will continue to increase. As such, only the very highest-risk individuals would purchase LTC insurance, which would shrink the market drastically, causing more individuals to rely on public programs such as Medicaid.

CONCLUSIONS

The analysis performed by this work group serves to emphasize some of the actuarial implications of extending GINA regulations to the LTC insurance market. GINA would prevent an LTC carrier from being able to underwrite its potential risk appropriately. It would promote anti-selection as more high-risk individuals would apply for coverage at the same time low-risk individuals potentially would leave the market due to increasing premiums. This likely would lead to rate spirals and a significant contraction of the LTC market. It would threaten the financial stability of LTC market, potentially resulting in carriers' inability to pay their customers' claims. One important result would be more pressure on the already strained public programs such as Medicaid.

We urge you to carefully consider the actuarial considerations outlined above. Extending GINA to LTC insurance has the potential to disrupt the financial stability of an insurance market of vital importance by preventing proper assignment of risks to homogenous premium rate pools.

We would welcome the opportunity to speak with you in person about our concerns. If you have any questions or would like to discuss these comments further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org). ■

Sincerely,

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P.J. Eric Stallard, MAAA, ASA, FCA
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