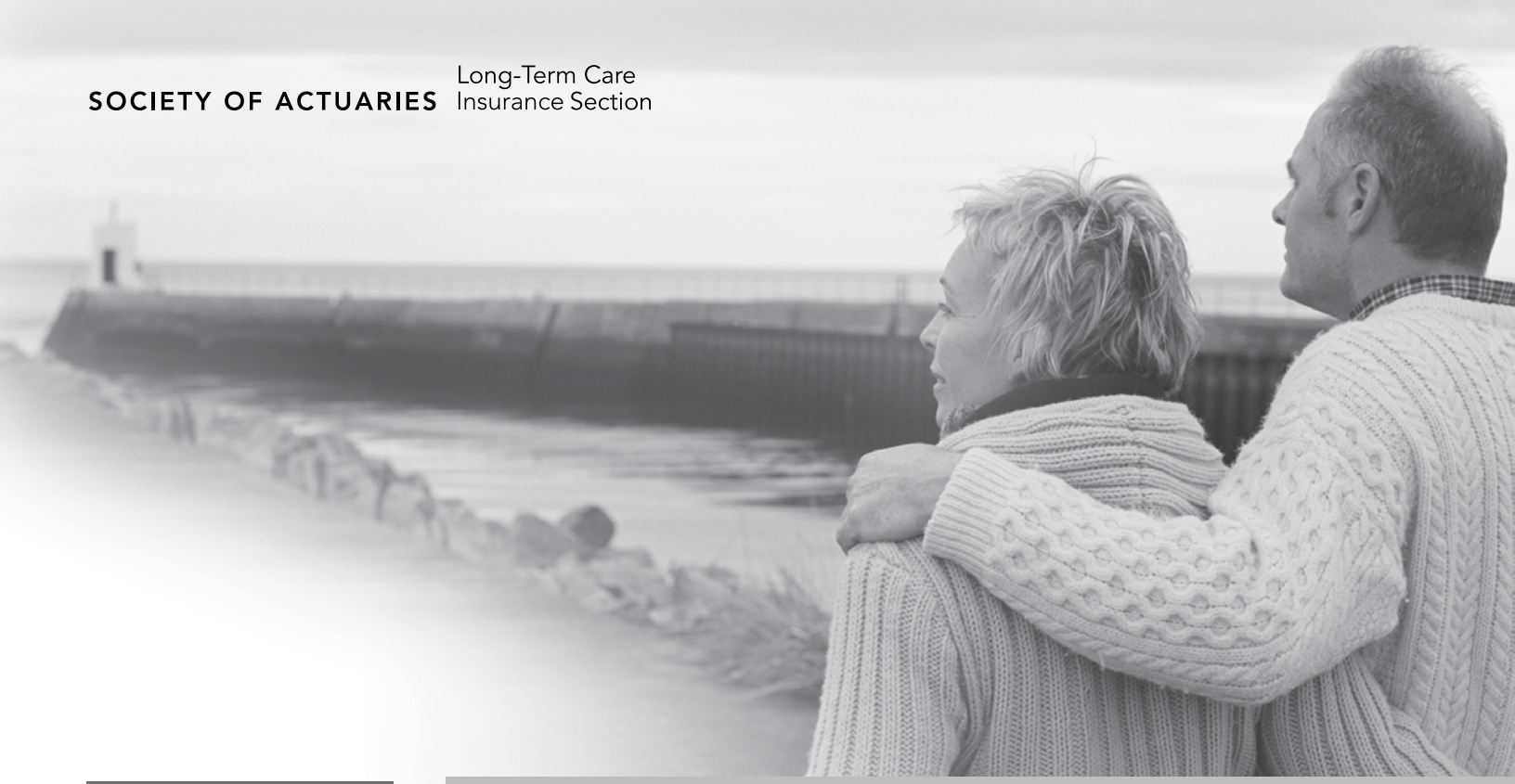
SOCIETY OF ACTUARIES Long-Term Care Insurance Section



Long-Term Care News

ISSUE 24 DECEMBER 2009

Actuarial Issues and Policy Implications

Presented by the American Academy of Actuaries and the Society of Actuaries

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July 22, 2009

U.S. Senate Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Re: Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program

Dear Senator:

To address increased expenses under state Medicaid programs and impending demographic changes that will further threaten these programs, proposals for the public funding of long-term care (LTC) services have been offered in recent years. This letter presents the comments of a joint work group of the American Academy of Actuaries[1] and the Society of Actuaries [2] on one of those proposals, the *Community Living Assistance Services and Supports Act* (CLASS Act). Our comments are based on an objective actuarial review of the version of this act included in section 191 of the *Affordable Health Choices Act*, which was introduced on June 9, 2009 by certain members of the Senate Committee on Health, Education, Labor and Pensions and passed with amendments by the committee on July 15, 2009. This analysis uses industry and population statistics, with scenarios derived from expected participant behavior under programs with elements of the CLASS Act design. Any subsequent

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The Time Is Now

by Brad S. Linder

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It is both an honor and privilege to announce to you that our Long-Term Care (LTC) Section has transformed itself in such a way as to include non-actuary member representation onto the LTC Section Council. There are three such representative seats. These seats will be identified as Affiliate Council Members. Additionally, we have a reorganization of the tracks along with new Track Chairs. Many thanks go to the new Council Members, to the Track Chairs and to the Council Members whose terms of service are expiring. We appreciate your service.

We will have some articles or columns written by our Track Chairs and members of Council. As we get their articles, we'll publish them in this newsletter. No, this does NOT let everyone off-the-hook for writing an article! We're constantly looking for articles of interest—but someone actually does have to write them.

At this writing of this issue, we are in the midst of a debate over the benefits and the costs of health care reform on a national scale. There are particular bills in Congress addressing proposals for change. The predominant bill appears to be the CLASS Act. The only possible way a person cannot have an opinion on at least some portion of this bill is if he or she has not read it or heard about it in the news. Although I am a little surprised that our readers have not voiced more opinions on this subject, perhaps we can present a few pros and cons on various provisions of the bill? What is your opinion? The time is now to voice your opinions!

To start you off, we present the Academy's presentation of the actuarial issues and policy implications. All of our readers should know of the analysis accomplished not only for the benefit of the members of Congress, but also for every one of us. Yes, into the soup mix we'll add quite a few dashes of viewpoints.

Also included in this issue is an interesting article addressing aspects of LTC versus Medicaid in Rhode Island. There are some serious recommendations presented.

There is a timely article alerting readers to LTC Experience Report changes. The time is now to make sure you'll be reporting correctly what is needed! For folks not in the financial reporting areas, you'll want to make sure you have an understanding of the changes.

Many thanks go to each of our esteemed authors. ■

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

This newsletter is free to section members. Current issues are available on the SOA Web site (www.soa.org). To join the section, SOA members and non-members can locate a membership form on the LTCI Web page at *www.soaltci.org*.

Industry Challenges/Challenges to the Industry

by Steve Schoonveld

Steve Schoonveld, FSA, MAAA, is the chief financial officer & actuary at LifePlans, Inc. in Waltham, Mass. He can be reached at *SSchoonveld@lifeplansinc.com.*

Whichever way the math is performed, there is little dispute that a high number of individuals choose to forgo health insurance even when they can reasonably afford coverage. In my home state of Massachusetts, where a mandate has been implemented, a significant portion of the uninsured population choose to pay a penalty instead of the cost of insurance. Many can indeed afford to purchase coverage. I don't intend to delve into this topic; however, I cannot help but make comparisons with the Long-Term Care Insurance (LTCI) industry:

- Do individuals feel they are too young and too healthy to need insurance?
- Is their impression that care will be paid by another source?
- Are there competing priorities that are being addressed?
- Is the insurance too expensive for the benefits received?

Affordability is indeed a strong reason for the lack of coverage in both industries and one that cannot be ignored. While there are similar reasons for not choosing an insurance solution, one can surmise that there are similar ways in which to demonstrate the value of each product. Such approaches range from noting personal experiences and scare tactics to financial modeling to a personal needs and goals assessment. Unless a product line can be elevated to the general no-brainer status enjoyed by home, auto and health insurance, such a demonstration is vital in order to reach markets.

While a mandate is a likely outcome of the recent reform efforts in health insurance, it is unlikely at this time for private LTCI. So absent the stick of an individual mandate or a social insurance solution, what is an industry to do? What is a section to do?

We began this recent section year with three goals: to build community, to support the educational needs and to invest in research on behalf of the industry. Indeed we are well down a solid community building path that can tackle the challenges we face internally as well as those received externally.

On October 1, the council welcomed three affiliate members to the LTCI Section Council as well as chairpersons for the five section tracks:

Affiliate Section Council Members

Winona Berdine
Ron Hagelman
Denise Liston

LTCI Section Track Chairpersons

Winona Berdine and **Denise Liston**, Underwriting & Claims Track Co-Chairs
Steve Pike, Marketing Track Chair
Jim Smith, Management & Operations Track Chair
Mark Whitford, Actuarial Track Chair
Ali Zaker-Shahrak, Regulatory & Compliance Track Chair

The addition of the above members and chairs will enable the tracks to take advantage of the resources that create industry wide participation and community. Such resources include a track specific section of the new and improved section Web site, webcast capabilities, the funding of

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research across the disciplines, and plenty of networking and educational opportunities. Sincere thanks to these volunteers who are breaking new ground for the section.

Also in October the council welcomed **Jay Bushey, Laurel Kastrup** and **Roger Loomis** as the three newly elected members of the LTCI Section Council. They join the affiliate members above and the six returning council members: **David Benz, Mark Costello, Roger Gagne, David Kerr, Amy Pahl** and **Al Schmitz**. Serving as council officers this year are **Mark Costello**, chairperson and **David Benz**, vice chairperson.

The CLASS Act would create a federal insurance program to help adults who develop functional impairments to remain independent and to stay a part of their community.

Please welcome the new council members by encouraging them with your suggestions to enable the section to better serve the industry.

One week in mid-July was quite active for the section. The first-ever section sponsored webcast was held entitled, "The Impact of the Economic Environment on Long-Term Care Insurance." Host and moderator **Malcolm Cheung** with presenters **Nyal Bischoff**, **Maureen Lillis** and **Ty Wooldridge** addressed the impact of the recession from a cross-section of marketing, claims and actuarial points of view. Attendance was very strong for the mid-summer scheduling of the webcast. Additional webcasts are planned with sponsorship by the tracks of the section.

The day following the webcast the American Academy of Actuaries (The Academy) released a comment letter titled, "Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program." The letter was written by a joint work group of the AAA Federal Long-Term Care Task Force and the Society of Actuaries' Long-Term Care Insurance Section Council and is reprinted in this issue. The letter, sent to each member of both the U.S. Senate and U.S. House of Representatives, addresses a series of concerns regarding the proposed Community Living Assistance Services and Supports (CLASS) Act.

The CLASS Act would create a federal insurance program to help adults who develop functional impairments to remain independent and to stay a part of their community. The legislation, initially sponsored by the late Senator Ted Kennedy, has been on many tables since 2005 and in various forms. The comment letter provided an independent assessment of the design and features of the program and gave recommendations that may enable such a voluntary program to be sustainable. Inquiries received by the work group have included various members of the press, research firms, congressional staffers and the Congressional Budget Office. The comment letter has been well received by both the Academy and Society organizations such that further joint efforts are planned to address similar public policy matters. Great thanks go to my colleagues on this team for their countless hours to provide not only a public service but a solid approach for similar shared endeavors.

As you can see, the LTCI Section has been very active in the past year and is set up well to meet the challenges of the industry.

With apologies to a local band with a city namesake, is the "future coming much too slow" for the industry? Many in the section would point to the low market penetration and the high carrier concentration rates and agree. I submit to you that the initiatives such as the CLASS Act are efforts to provide affordable solutions to the long-term care uninsured and are gaining momentum for this very reason. As I finish my time on the Section Council, I challenge you to remember, this is **YOUR** industry, **YOUR** section, **YOUR** Community. I implore of you to participate, to lead and to share with one another so that we may progress expediently towards a solid future for this industry. ■

changes to the proposed legislation could alter the direction and interpretation of our comments.

This document is not intended to replace the actuarial analysis of the 75-year costs for the program called for in Senator Gregg's amendment to the June 9 legislation. Instead, it is intended to provide a summary of the issues that require consideration and a general analysis of the program provisions and their financial implications.

EXECUTIVE SUMMARY

Our actuarial analysis indicates that the proposed structure and funding approaches in the CLASS Act, as introduced on June 9th, will not only be unsustainable within the foreseeable future, but are unlikely to cover more than a very small proportion of the intended population. In the absence of an actuarially sound requirement, we project that the Fund will be insolvent as early as 2021, or within 11 years. The opt-out and guaranteed issue provisions of the plan pose a significant and likely risk that, in a relatively short time period, the program will either need increased premiums and/or significant reductions.

The version of the bill reported on July 15th includes an amendment requiring an actuarially sound program over a 75-year period. We commend this change in the legislation, with the caveat that the requirement may not be possible to achieve unless the issues explored in this letter are addressed. There is considerable risk of adverse selection, which could necessitate future increases in premiums or reductions in benefits to maintain a sustainable program. As these changes are introduced there is a significant potential for increased adverse selection, necessitating further changes, which may make the program unsustainable. The premium estimates suggested below are optimistic as they assume only a modest level of adverse selection.

Our principal analysis is performed assuming an average daily cash benefit of $75 increasing annually with the Consumer Price Index (CPI). We have also provided an analysis using the minimum average daily benefit of $50 called for in the legislation, increasing annually with CPI. Furthermore, we have reviewed two potential premium structures, an entry-age level premium and an annual increasing premium approach.

We estimate that the actuarially sound average monthly premium level would be $160 using an entry-age level premium approach and assuming an average daily benefit of $75. Under an annual increasing premium approach, the average monthly premium would be $125 per month increasing annually with CPI. Based on the originally proposed $65 average monthly level premium, the fund would be insolvent by 2021. Under the increasing premium approach the fund would be insolvent by 2022.

Using a $50 initial minimum average benefit, we estimate that an actuarially sound average monthly premium level would be $110 under the entry-age level premium approach and $86 using the annual increasing premium approach. Based on the originally proposed $65 average monthly level premium, the fund would be insolvent by 2027. Under the increasing premium approach the fund would be insolvent by 2032.

Each of these premium estimates is significantly in excess of the $65 monthly average initially proposed in the CLASS Act. These estimates were based on a series of scenarios, using actuarial assumptions, which we will detail later in our comments.

A voluntary federal LTC program can be developed so that the program is sustainable and minimizes the impact of adverse selection. Such a program would require the use of a stronger actively-at-work definition, an underwriting approach for the coverage of non-working spouses, stronger participant opt-out/opt-in restrictions, consistent eligibility definitions for benefits and potential program design changes that would result in more affordable premiums. These considerations, along

FOOTNOTES

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of 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.

[2] 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*.

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with a strong marketing and education effort, could enable the development of an actuarially sound voluntary federal program that encourages broad participation and a sufficient spread of risks.

ACTUARIAL ISSUES WITHIN A FEDERAL LONG-TERM CARE PLAN

As required premiums increase, there is a point at which premiums will be so high that fewer relatively healthy individuals will find program participation worthwhile.

The actuarial issues in designing a federal long-term care product have been outlined in a monograph published by the American Academy of Actuaries.[3] That review referenced issues with respect to access to the program; the impact of potential financing approaches; plan design components, including premium and benefit structures; and considerations for plan administration.

Public voluntary insurance programs have a number of interrelated factors that affect their viability and effectiveness: education, marketing, participation, underwriting criteria, access, and affordability. Critical to their success is a proper balance between these factors. The availability of private insurance, as either supplemental or alternative coverage, and the level of the public's awareness of the need to plan for future long-term care services both add to the complexity of these interrelationships. Any self-sustaining insurance program must adhere to certain principles of sound insurance systems, namely, premium affordability and a reasonable spread of risk within the insured group. A program stands to violate these principles if it is not properly designed or does not consider external influences.

Clearly, the higher the participation rate the more effective a voluntary program will be. A high participation rate is a tremendous challenge for voluntary programs because such programs compete with other needs of the potential participants for disposable income. Affordability and successful marketing are the main facilitators of participation. In order to make premiums affordable, the insured group must have a good spread of risk. If the underwriting criterion is minimal, a greater proportion of less healthy individuals will be attracted to the program. Higher premiums must be employed to accommodate these individuals. As required premiums increase, there is a point at which premiums will be so high that fewer relatively healthy individuals will find program participation worthwhile. However, a significant proportion of the less healthy would still be attracted to the program. Accessibility would be effectively confined to a few, and the program would collapse without external assistance.

A workable and actuarially sound public long-term care insurance program requires restrictions on eligibility to limit the significant impact of adverse selection to a manageable level. This is of critical importance with any voluntary-access provision where participants may opt in and/or out. Such restrictions might include underwriting, actively-at-work provisions, waiting periods, and appropriate penalties for initial opt out and re-enrollment after lapse.

Voluntary programs require the use of some type of underwriting mechanism, especially if participation levels are expected to be less than a majority of the eligible participants. There are many approaches that may be taken, ranging from a direct ineligibility for coverage approach, to an indirect benefit restriction approach. The fundamental underwriting issue for a federal LTC insurance program lies in a balance between the affordability of premiums and the desire for wide accessibility. A voluntary program means that coverage will not be elected by a typical cross section of the population representing a proportional range of the claim risk. When underwriting standards are removed, or set too liberally, a disproportionate number of less healthy individuals will find it more attractive to apply. As a result, per-participant benefit costs rise and premiums may need to be increased to a level that would also drive healthy individuals to choose not to participate, retaining those who are less healthy (and who are more predisposed to make claims), as participants. In addition, the perception by healthier participants of the value of the potential benefits compared with the increasing premiums will decline over time, prompting those healthier participants who elected to participate to then lapse their coverage. With a limited spread of risk initially and even less in subsequent years, the program could eventually become unsustainable at any price.

Conversely, more restrictive underwriting standards will generate a healthier group of insureds. This translates into lower claim costs, lower premiums, and coverage that is affordable to more people. However, those in poorer health will not be covered. The proper underwriting criterion thus becomes the mechanism for attracting the acceptable level of participation at the appropriate price.

FOOTNOTES

[3] *Long-Term Care: Actuarial Issues in Designing Voluntary Federal-Private LTC Insurance Programs, American Academy of Actuaries,* January 1999. *http://www.actuary.org/pdf/health/LTC.pdf.*

A fully guaranteed issue, voluntary plan would likely attract a disproportionate number of less healthy insureds. If a significant portion of all enrollees are not initially healthy, the insurance mechanism would not exist, as the correct premiums would be prohibitively expensive or underpriced initially, which would impair the long-term financial viability of the program. As an alternative, an approach that includes a long waiting period before benefits can be accessed (while premiums are paid) may be used to mitigate, but not eliminate, the adverse selection. Such a period would need to be long enough to discourage timely enrollment when a claim is imminent and therefore deter inappropriate early claims. Such a waiting period could be universally applied or apply only to those conditions in existence at the time of enrollment. Thus, the participants would sign up and pay premiums for 10 or 15 years before either any potential claim could be filed or before those based on pre-existing conditions could be filed. This approach could maximize participation while providing meaningful benefits with reasonable premiums.

The expected level of participation in the program and the costs to market the program can have a significant impact on the program's risk characteristics and its financial viability. In addition, the effectiveness of any marketing for a voluntary federal long-term care insurance program will have a significant impact on the attained risk pool characteristics. Sufficient efforts (and expenses) are required to ensure that a diverse assumption of risk across the morbidity curve is attained. While there are many challenges related to providing a sufficient level of education and to marketing to such a large and widely dispersed eligible population, such efforts are necessary to provide for sufficient participation to enable an effective program with a good spread of risk. A key component of these education and marketing efforts is the ability to discuss the need to plan for potential LTC expenses and explain program features in group meetings with the eligible population.

Private voluntary group long-term care insurance plans issued by private industry typically achieve less than 10 percent participation rates. These plans make use of the actively-at-work approach for underwriting employees and have, at a minimum, a simplified underwriting approach for spouses of employees and certain additional levels of coverage. Furthermore, private plans typically require some form of medical underwriting for reinstatement of lapsed coverage. The federal long-term care insurance program, which is a voluntary large group where employees and spouses are subject to simplified underwriting, began to offer coverage in 2002. A Government Accountability Office (GAO) report issued in December 2006 summarized the many challenges the program faced with respect to marketing efforts.[4] Currently the participation rate for the federal employee program is estimated to be at approximately 5 percent.

An alternative underwriting standard would require every participant who is actively at work to enroll, regardless of current health status. A program with this mandate would eliminate the impact of participants waiting until an immediate need for long-term care benefits arises and would enable program coverage of a full cross section of the risk.

It is in the nature of long-term care insurance that the average annual costs of benefits increase by age and increase sharply at advanced ages. Thus, insurance premiums, computed on a level premium lifetime basis, are significantly lower for policies issued at younger ages. Due to this relationship of level premiums and sharply increasing costs, there is significant prefunding in the earlier years of coverage and sufficient assets must be accumulated in the Fund to provide for future benefits. A critical component to effectively funding long-term care benefits from the amounts contributed by participants is to maximize investment returns on the accumulated assets. The earlier the funding begins, the greater the proportion of the total costs that will be earned from investment income. The success of a federal long-term care program may well hinge on this ability to successfully attract a high percentage of younger participants.

DETAILS OF THE CLASS ACT AND ACTUARIAL CONSIDERATIONS

Enrollment Eligibility

The requirements of the plan to be implemented, as initially drafted, must include an average monthly enrollee premium that is no more than $65. The amended version of the legislation, however, requires an actuarially sound premium over a 75-year horizon. Premiums may increase annually with CPI for subsequent enrollees and late entrants.

FOOTNOTES

[4] *Long-Term Care Insurance: Federal Program Has a Unique Profit Structure and Faced a Significant Marketing Challenge*, United States Government Accounting Office, December 2006, GAO-07-202, *http://www.gao.gov/new.items/d07202.pdf.*

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This premium must provide for minimum average benefit payments of $50. A nominal monthly premium of $5 will be offered to individuals with income below the poverty line and to working students under age 22. Premiums may be adjusted for program solvency with stated exceptions including those older than age 65 and who have paid premiums for 20 years and are not actively at work. Premiums are attained-age adjusted for delaying enrollment and lapse with reenrollment.

Individuals are eligible to enroll in the CLASS program if, at time of enrollment, they are actively at work, self-employed with income that is subject to the Social Security tax, or the spouse of an eligible individual. In addition, at enrollment individuals may not be a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or may not be confined in a penal institution or correction facility. Underwriting may not be used to determine the monthly premium for enrollment in the program or to prevent an individual from enrolling in the program. Individuals may waive enrollment under the CLASS program or enroll during periodic enrollment periods. Participants may drop enrollment during an annual specified period. Participants must pay premiums for five years before they are eligible for benefits.

The program as detailed is voluntary and offers guaranteed issue to willing enrollees. Insurance products offered in this manner require an adequate level of protection from adverse selection by enrollees. Without such provisions the product cost is virtually certain to spiral out of control, as increased claims will require premium increases which, in turn, discourage healthier participants from purchasing or continuing to pay premiums.

The use of an actively-at-work provision in a guaranteed issue program is an underwriting approach that is common within the private group long-term care insurance industry for certain employer groups when the carrier believes it can market adequately and achieve a reasonable level of participation. Such coverage is typically only provided to a plan sponsor's employees, working a minimum of 20 to 30 hours per week. However, spouses of these group enrollees are typically only provided coverage after they pass some form of an underwriting screening. This level of underwriting provides for some protection from anti-selective choice among participants.

The presence of the five-year waiting period will not be sufficient to reduce the risk associated with the guaranteed issue to employees and spouses. Those with pre-existing health conditions can begin to receive benefits immediately after the five-year waiting period if conditions persist. The potential magnitude of such a provision may put the viability of the entire program at risk.

In general, the lower the participation rate the greater the opportunity for adverse selection and, therefore, a level of claims above that anticipated within the pricing basis. In particular, the participation rates of those receiving a subsidy, either initially or in subsequent years, presents a challenge to the pricing of the program. At $5 per month, the participation rates may be greater among those eligible for the subsidy. Approximately 5 percent of the current working population, who are at least 18 years old, earn incomes below the poverty level.

The requirement that premiums are fixed for participants who have attained age 65, have paid premiums for at least 20 years, and are no longer actively at work limits the effectiveness of premium increases that may be necessary should experience dictate. (Current programs typically pass along premium increases equally to all policyholders.) This provision would need to be adjusted for in the pricing of the initial premiums in order to avoid unduly affecting future enrollees and subsequently affecting the Fund's solvency. Moreover, when a premium increase is necessary, those who will be subject to the increase will subsidize these participants. This could potentially entice more participants to opt out of the program.

Eligibility for Benefits

Benefits are available only to active participants who have paid premiums for at least 60 months. Benefit triggers mirror the Health Insurance Portability and Accountability Act of 1996 (HIPAA) long-term care insurance benefit triggers, which require determination that an individual has a functional limitation expected to last more than 90 days due to an inability to perform at least two or three (as defined by the CLASS Act) of the following six activities of daily living (ADL): eating, toileting, transferring, bathing, dressing, and continence; cognitive impairment; or a level of similar limitation prescribed by the Secretary of Health and Human Services (HHS).

Benefit eligibility under the legislation is determined within 30 days of receipt of an application for benefits and requires that an application that is pending after 45 days is deemed approved. Eligibility is deter-

mined by state-based disability determination services. Presumptive eligibility is assumed if an enrollee has applied for and attests eligibility for the maximum cash benefit; is a patient in a hospital (for long-term care reasons), a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases; and is in the process of planning to discharge from the hospital, facility, or institution, or is within 60 days of such a discharge. Beneficiaries are expected to periodically recertify (by submission of medical evidence) their continued eligibility for benefits and to submit records of expenditures attributable to their aggregate daily cash benefit received in the preceding year.

Approaches in the private long-term care market to determine benefit eligibility include the use of independent clinical functional and cognitive assessments, often performed face-to-face in the claimant's home, and the receipt of a plan of care developed by a licensed health care provider. Recertification is typically annual and often more frequent based on condition and the type of care received. The expenses for the assessment work can range from 3 percent up to 7 percent of paid claims, depending on the amount of benefit, with the higher 7 percent amount typical for lower benefit amounts such as $75 per day.

Presumptive eligibility will increase morbidity levels as the necessity of two or three of six ADL requirements will not be determined through the assessment process for some enrollees. Enrollees may apply for benefits and receive them without an assessment after many types of hospital stays. The lack of a uniform assessment that applies to all eligibility requirements will subject the program to increased claim incidence.

Benefit Levels

The program provides eligible beneficiaries with a cash benefit for the lifetime of the claim. Benefit levels are set initially at a minimum average of $50 per day and must have at least two tiers based on the beneficiary's level of disability. Benefit levels increase annually with the CPI for both currently eligible beneficiaries and future claimants. Cash benefits may be paid daily or weekly and may be used to purchase nonmedical and support services that beneficiaries need to maintain their independence at home or in another residential setting of their choice in the community (e.g., home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, and home care aides and nursing support). Benefits commence beginning with the first month in which an application for benefits is approved.

An average benefit of only $50 per day is inadequate for the vast majority of participants, and results in considerable out-of-pocket expenditures and continued stress on the Medicaid program. There is a risk that many participants may assume that they have adequately covered this risk since they are enrolled in the federal plan. As such, it is important that a strong public awareness campaign is utilized to encourage the purchase of supplemental coverage as the federal benefit may be inadequate to cover the significantly higher expected LTC costs. According to a July 2009 *Broker World* survey[5] of the long-term care private insurance market, the current average private long-term care insurance daily benefit is approximately $165 per day (although this varies geographically from $120 up to $400 or more). Long-term care insurance is not in the same category as Medicare supplement—most individuals recognize the need for medical insurance as it is more commonly used. Long-term care services, on the other hand, may not be needed by all participants and is more often decades away for most people of working age.

Administrative Expenses

Administrative expenses during the first five years of the program established by the CLASS Act are restricted to no more than 3 percent of premium. After the first five years of operation, the administrative expenses are restricted to 5 percent of the total amount of expenditures.

The administrative expenses for benefit assessment activities alone can readily use up the 5 percent of claims available for administrative expenses. The addition of enrollment and premium collection activities makes it highly unlikely that the administrative expenses will be within the 5 percent limit. Furthermore, the necessity to adequately market a guaranteed issue product to attain a sufficient spread of risk will add further to these administrative expenses. A successful offering within the private group long-term care market requires a significant education component so that employees may make informed enrollment decisions. Such intensive marketing to eligible insureds is essential to reduce the adverse selection risk to a predictable level.

During an open enrollment period, a guaranteed issue federal program would require much of the

The lack of a uniform assessment that applies to all eligibility requirements will subject the program to increased claim incidence.

FOOTNOTES

[5] Thau, Claude and Robert Darnell, *The 11th Annual Individual Long Term Care Survey*, Broker World, July 2009 (Table 5: Distribution of Sales by Maximum Daily Benefit).

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same educational initiatives to reach all working individuals and their spouses in the country. Such a campaign may need to include employee meetings at the worksite and mailings to the homes of all eligible participants. To effectively market a guaranteed issue plan would add 2.5 percent to the required premiums. We estimate total administrative expenses for similar private programs to be between 10 percent and 15 percent of premium. This expense includes the marketing costs, the cost of premium collection and billing, and the costs associated with the assessment and payment of claims. This should be further adjusted for the level of enrollees with subsidized premiums.

Trust Fund Mechanism

The Act establishes a trust fund called the CLASS Independence Fund (Fund) with the Treasury Secretary serving as the managing trustee. The Act directs the premiums paid by enrollees, as well as the recoupment of unpaid and accrued benefits, into the Fund from which benefits are paid. The Secretary of the Treasury would invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund.

The interest credited to the Fund and the method for determining the interest rate play a critical role in establishing the actuarial balance of the Fund and the long-term adequacy of the premiums. It is the real interest rate, the discount rate net of the assumed consumer price index, which is of most importance. However, both the real and nominal rates have an impact. Instead of a risk-free real interest rate,[6] the Social Security Advisory Board recommended in an October 2007 report a stronger weight on the forward-looking information in recent Treasury yield curves for nominal and real interest rates and for discounting the actuarial balance using risk-adjusted rates. Current long-term expectations following the approach given in the 2009 Federal Supplementary Medical Insurance Trust Fund trustees' report would provide for a nominal interest rate of 5.7 percent and a CPI rate of 2.8 percent.[7]

Understanding the sensitivity to interest rates of the level of premiums necessary to ensure a positive long-term trust fund balance is critical in order to limit the need for significant premium increases.

[6] Report to the Social Security Advisory Board, October 2007, *http://www.ssab.gov/documents/2007_TPAM_REPORT_FINAL_copy.PDF*.

[7] 2009 Supplementary Medical Insurance Trust Fund trustees report.

AN ASSESSMENT OF THE FINANCIAL VIABILITY OF THE CLASS ACT

With the use of a simplified financial model to project expected enrollees, annual premiums, claims costs, and the trust fund balance, scenarios were run to evaluate the CLASS Act plan as described above and to determine sensitivities to changes in assumptions and provisions. The model is intended to produce rough estimates only. To set proper premiums with greater precision, a more sophisticated model will be required.

Baseline assumptions were developed from the expectations of an insured and underwritten population and are as follows:

Table 1: Baseline Assumptions

Assumption	Source
U.S. Population – (Actively at work and spouses)	U.S. Census Bureau of the working population – 2009 Statistical Abstract
Mortality	Social Security 2005 table with mortality improvement, 50 percent male/50 percent female
Lapse	1.5 percent per year
Morbidity	Adjusted National Long-Term Care Survey data
Mortality and Morbidity Improvements	0.5 percent per year for 30 years
Expenses	3 percent of premiums in the first 5 years of the program and 5 percent of claims thereafter
Interest Rate	5.7 percent
Consumer Price Index	2.8 percent annually
Program Implementation	2011
Daily Benefit Amount	An average of $75 per day growing with CPI annually
Benefit Eligibility	Inability to perform at least 2 of 6 activities of daily living or cognitive impairment for all claimants

Our assumption of an initial $75 average daily benefit level considers the current costs of home-based care, how enrollees will value the benefits in relation to premium levels, the burden of per policy administration costs relative to benefits and recent expectations for the implementation of the program. The Congressional Budget Office[8] assumed an initial $75 per day average benefit level in combination with a $65 average monthly premium. The analysis below also includes the use of the minimum average daily benefit of $50 called for in the Act.

From these assumptions, adjustments based on the described plan provisions and considerations for participation rates were selected.

Using the current working population, non-working spouses and estimated participation rates by age group, the model projects the participant population in future years by using assumed opt-out rates and a population table. Premium, claim rates and benefit utilization (on an incurred basis) are applied to the future participant population to derive the net flow of funds. The Fund is credited with interest each year. Premiums are assumed to be issue-age based. The required average premium is determined by ensuring fund solvency through the end of 2086. A portion of the working population is assumed to be working poor and its premiums are restricted according to the provisions of the Act. The claim assumptions are derived from the National Long-Term Care Surveys, adjusted for the CLASS Act program structure and benefit design. These surveys provided longitudinal data representative of long-term care usage for the entire U.S. population. The benefit trigger is selected as an inability to perform two or more activities of daily living or severe cognitive impairment with no elimination period during which no benefits are paid. Based on trend data, we applied annual improvement factors for both claim and mortality rates.

The participation proportions by age group came from similar private insurance programs from one insurer. The overall participation rate is assumed to be 6 percent. The model uses a simplifying assumption that the 6 percent participation occurs at program inception. We observed that the participation rates in several large voluntary private insurance group programs are less than that. We believe it is appropriate to further adjust the data from the National LTC Surveys to account for the anticipated adverse selection with such a level of participation, as well as for the adverse selection arising from the lack of underwriting for spouses or for reentry into the program.

Retirees are assumed to continue to pay the same level of monthly premium as when they retired. Expenses are as described above and are not adjusted for the marketing effort required to attain this level of participation. No benefits are paid during the first five years of enrollment. In order to focus on the premium level for the majority of the participation, we assumed that the premiums for new and returning entrants are self-supporting and do not affect the premiums of the current participants. Other modeling simplifications were also utilized. In the aggregate, we believe their impacts on the results are not overly conservative or aggressive.

Measurement and Program Approaches

Two measurement approaches for evaluating the feasibility of the program are considered. First, the original CLASS Act provision of an average initial monthly premium of $65 across the anticipated enrollment is used to determine the year in which the Fund is expected to become insolvent. Second, we determine the initial average monthly premium that is necessary so that the Fund remains solvent. Solvency is defined as the Fund having enough assets to pay future benefits on claims that have already been incurred.

The two measurement approaches are used to demonstrate program design and scenarios in which the program may be administered. First, premiums are assumed to be level after enrollment unless the HHS Secretary deems the need for a premium rate increase following benefit reductions. Second, premiums paid by all program participants would increase with the CPI rate annually. In each case, premiums vary by enrollment age, the year of enrollment, and the use of subsidized premiums and limits on premium increases are maintained.

The Level Premium Approach

Based on the original premium provisions of the Act, it is anticipated that the Fund would become insolvent by the year 2021. No future increase in premiums other than the annual CPI increase for new enrollees is assumed, nor are future benefits decreased.

The average initial premiums would need to increase by $95 to $160 per month under the level-premium

FOOTNOTES

[8] Congressional Budget Office, Additional Information on CBO's Analysis of the Community Living Assistance Services and Supports Act, July 6, 2009, *http://www.cbo.gov/ftpdocs/104xx/doc10436/07-06-CLASSAct.pdf.*

CONTINUED ON **PAGE 12**

approach for the Fund to maintain solvency over the 75-year horizon and to maintain the benefit levels described in the Act. It is critical to note that this premium level is only estimated to be actuarially sound under the assumed participation level of 6 percent. If lower participation is realized (which is possible and perhaps likely given the size of the premiums), the $160 premium will be inadequate.

The required premiums by age group are shown in the table below:

Table 2: Required Level Premiums by Age at Enrollment

Age at Enrollment	Initial Monthly Premium – Level Basis
18-29	136
30-39	136
40-49	144
50-59	152
60-69	231
70-79	277
80+	305
Average Premium	160

The Increasing Premium Approach

We also modeled a $65 initial average monthly premium, increasing annually, at the same CPI rate that is assumed for the benefits modeled. Under this approach it is anticipated that the Fund will become insolvent by the year 2022. No additional increases are assumed nor are future benefits decreased in this scenario.

The average initial premiums would need to increase by $60 to $125 per month under the increasing premium approach for the Fund to maintain solvency over a 75-year horizon and to maintain the benefit levels described in the Act. Again, it is critical to note that these premiums are only estimated to be sufficient under the assumed participation rate of 6 percent.

The required premiums by age group are shown in the table below:

Additional Analysis

In order to maintain program solvency, benefit decreases and premium increases may be applied to all enrollees subject to the provisions of the Act. The timeliness of these benefit decreases and premium increases will have a significant impact on the solvency of the program. Using the two premium approaches above, which began with a $65 average monthly premium, projections were developed to determine the impact on solvency of the timing of benefit decreases and premium increases.

Under the level premium approach, the Fund is expected to be insolvent in 2021. A decrease in benefits from the initial $75 average to the minimum $50 average for all levels of impairment (adjusted for CPI) in 2019 and a premium increase of 184 percent to $185 would be necessary for the Fund

Table 3: Required Increasing Premiums by Age at Enrollment

Age at Enrollment	Initial Monthly Premium – Increasing Basis	Monthly Premium in 2031
18-29	106	184
30-39	106	184
40-49	112	195
50-59	119	207
60-69	180	313
70-79	216	375
80+	238	413
Average Premium	125	217

to remain solvent until 2086. Likewise, under the increasing premium approach, a decrease in benefits to the minimum $50 level and a premium increase of 77 percent in 2019 would be necessary to maintain solvency. The average monthly premiums in 2019 would increase to $144, inclusive of the premium increase and the annual CPI increases.

The $185 premium would remain level during 2019–2086; the $144 premium would continue to increase with CPI during the same period. These premium estimates do not account for the large adverse selection lapse that would occur with such large premium increases.

The CLASS Act requires a minimum average daily benefit of $50 in the first year of the program. Using this minimum, we estimate that an actuarially sound average monthly premium level would be $110 under the entry-age level premium approach and $86 using the annual increasing premium approach. Based on the originally proposed $65 average monthly premium, the fund would be insolvent by 2027 under the entry-age level approach and by 2032 under the increasing premium approach. This analysis is based on the baseline assumptions described in Table 1 and is not adjusted for any potential differences in participation rates, morbidity levels or changes in benefit utilization as a result of the lower benefit amount and lower actuarially sound premiums.

The CLASS Act allows for a benefit trigger using either a minimum of two or three of the six activities of daily living, or cognitive impairment, for benefit eligibility. The above analysis includes the use of at least two of six ADLs. With the use of three of the six ADLs, a sustainable average monthly premium may decrease by up to 6 percent, assuming that there would be no impact due to claim adjudication differences which may occur.

CONCLUSION

Our actuarial analysis demonstrates that the proposed structure and the premium requirements within the CLASS Act plan are not sustainable. Due to its design and the high level of required premiums, the program is unlikely to cover more than a very small proportion of the intended population or achieve its goal of broad participation. There are significant concerns that the program's design may limit the ability of the program to be both sustainable and affordable for participants:

- The voluntary nature of the program coupled with the absence of any underwriting at enrollment would very likely result in significant adverse selection, especially among spouses of active employees. Program participants would not represent a uniform spread of health risks and premiums would need to be increased to reflect this.

- The ability to enroll or drop enrollment in the program after initial eligibility with no underwriting and with relatively limited restrictions would compound the potential for adverse selection.

- The use of a five-year waiting period may produce significant adverse selection that could be substantially mitigated by using a 10–15-year waiting period for non-working spouses.

- The use of a guaranteed issue approach for spouses of participants who are actively at work would enable those with existing chronic conditions to enroll and subsequently apply for benefits as early as possible. This level of adverse selection would significantly affect the actuarially necessary premiums, especially given the anticipated lower participation rates.

- The expenses included in the CLASS Act do not allow for the type of meaningful educational and marketing efforts that are required to drive reasonable participation.

- The use of a presumptive eligibility approach without a benefit assessment provision is likely to increase claim incidence when services are not truly needed.

- Under our assumptions, the originally proposed average level premium of $65 is just over 40 percent of the actuarially appropriate premium for a $75 initial average daily benefit, and just under 60 percent of the corresponding premium for the $50 benefit. If either premium is set at the actuarially appropriate level, it would be difficult to enroll enough healthier and unsubsidized lives to keep the program sustainable.

- If future rate increases are necessary, the amount of such increases will be magnified by the combined effects of loss of interest, lapse, and mortality, thus creating an increased burden on those who continue. This is even more severe for any rate increases after 20 years, when most of the initial enrollees are retired and thus excluded from such increases.

CONTINUED ON **PAGE 14**

A sustainable voluntary federal LTC program should have provisions that address many of the concerns expressed in this analysis. Such a program could include the following:

- An actively-at-work definition with a requirement of a minimum of 20–30-hours of scheduled work or a comparable requirement.
- The use of an underwriting approach for the coverage of spouses who are not actively at work.
- Restrictions on the ability to opt-out and subsequently opt-in with the use of either a second waiting period for benefits or an application for reinstatement with health questions.
- The use of a benefit elimination period, a benefit period duration that is less than lifetime, and/or benefits that are paid based on a reimbursement provision rather than on a cash basis.
- An initial premium structure that provides for scheduled premium increases for active enrollees at either a CPI or alternative lower rate.
- A consistent definition of eligibility for all benefits and benefit levels with use of the HIPAA defined ADL triggers and cognitive impairment definitions.

These provisions, along with a sufficient marketing effort to ensure the desired participation and concentration of risk, may enable the development of an actuarially sound voluntary federal program. We recommend that the final version of the Act permits implementation of the design features described in this letter.

We thank you for the opportunity to present this analysis. Members of the joint AAA/SOA work group are available to assist Congress as it considers proposals to address the issue of long-term care. If you have any questions or would like additional information or assistance, please contact Heather Jerbi, the Academy's senior health policy analyst, at 202.223.8196 or Jerbi@actuary.org. ■

Sincerely,

P.J. Eric Stallard, MAAA, ASA, FCA
Chairperson
Federal Long-Term Care Task Force
American Academy of Actuaries

Steven Schoonveld, MAAA, FSA
Chairperson
Long-Term Care Insurance Section Council
Society of Actuaries

cc: Members of U.S. Senate
Members of U.S. House of Representatives

This analysis was performed by a joint work group of the American Academy of Actuaries' Federal Long-Term Care Task Force and the Society of Actuaries' Long-Term Care Insurance Section Council. The initial draft of this brief was developed by Steven Schoonveld, MAAA, FSA; James Glickman, FSA; and Malcolm Cheung, MAAA, FSA. The analysis and modeling work was performed by Robert Yee, MAAA, FSA and Allen Schmitz, MAAA, FSA. Academic research and guidance was given by P.J. Eric Stallard, MAAA, ASA, FCA. Staff support was provided by Sara Teppema, MAAA, FSA, FCA of the Society of Actuaries.

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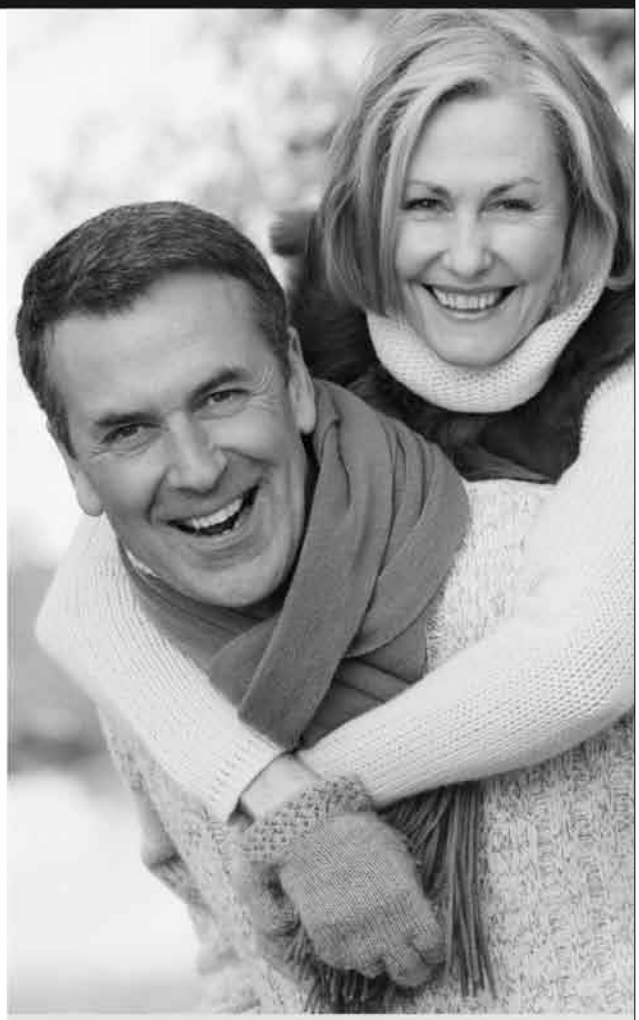

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Impact of CLASS or "Son-of-CLASS" Act

by Jesse Slome

Jesse Slome is executive director of the American Association for Long-Term Care Insurance He can be reached at *jslome@aaltci.org.*

Even if we were not based in Los Angeles, my crystal ball comes up cloudy when trying to predict the ultimate outcome of health care (insurance) reform and any impact it will have on long-term care.

But one thing I strongly believe. Even if the CLASS Act does not make its way into final legislation, we will inevitably see son (or daughter) of CLASS. That is inevitable. Thus to ignore the obvious is ... well, even actuaries know what happens when you ignore the obvious.

While the American Association for Long-Term Care Insurance does not lobby or take political positions, as part of our role as advocates for the industry and our members, we certainly take a position. So, am I positive or negative in terms of the impact of CLASS. My answer is an unequivocal "yes." That's partly due to a belief that the current legislative destiny of the United States will result in an ever increasing series of government programs (long-term care included).

On the positive side, CLASS will provide the opportunity for long-term care insurance to redesign policy provisions. No one has taken the bold step of declaring level premium policy pricing antiquated and inappropriate for a product targeting 50-year-olds. CLASS could allow significant redesigns and it would be a missed opportunity not to. Secondly, LTCI suffers from a split public persona. We try to give the impression that "it's for everyone" but that really doesn't sit well when you consider the cost. Medicare Supplement Insurance is a better role model that a post-CLASS LTCI world will emulate (smart folks in corporate marketing departments are likely already trademarking LTC Supplement Plan names).

On the negative side, any federal plan won't be priced properly. The American Academy of Actuaries report goes into this in great detail. The framers of CLASS smartly offer a "voluntary" plan but the voluntary function will, I suspect, be short-lived. Ultimately, we will see a new entitlement plan funded by future generations with a new addition to Medicare taxation. Secondly, the real risk is media coverage and consumer complacency. The media doesn't always get it right and 15-second soundbites of new federal long-term care insurance could result in consumers saying "got that covered." A shrinking marketplace will force smaller insurers out of the arena resulting in fewer producers marketing the product. This is the opposite of what it takes to build a strong and vibrant marketplace.

That said, long-term care is a problem the United States must deal with. That we know is obvious. It's just the outcome that remains unclear. ■

Why I Support the CLASS Act

by Scott A. Olson

I admit that I was against the CLASS Act initially. After reading it, I came to the conclusion that it would dramatically *increase* private LTCI sales for at least three reasons:

1) By raising awareness of the need to plan for long-term care through the mandated "you're included unless you opt out" provision,

2) By allowing Section 125 plans to be used to pay LTCI premiums on a tax-favored basis, and

3) By demonstrating how good private LTCI is when compared to the CLASS Act (see points A, B, C and D below.)

Human nature is that we don't appreciate what we have until we have something to compare it to. Similarly, I don't think consumers appreciate how marvelous private LTC insurance is because they have nothing else to compare it to.

A. No LTC insurer states that your premiums could increase four-fold (200 percent) in the next 20 years; but the CLASS Act states that. (To my knowledge, only one LTC insurer has had increases that approached those percentages and that insurer has been taken over by the PA DOI.)

B. No LTC insurer could decide to decrease your benefits at any time (without your consent) in order to maintain financial viability; but the CLASS Act states that the Secretary of HHS must do that to keep the program fiscally sound.

C. No LTCI policy would deny all claims within the first five years you pay the premium; but the CLASS Act will do that.

D. No LTC insurer requires that you work for three of the next five years in order to keep your coverage; but the CLASS Act requires that.

EVEN IN TERMS OF COST, THE CLASS ACT IS NOT CHEAP

Every article I've read about the CLASS Act states that it is cheaper than private LTCI; but it's NOT cheaper when you do an apples to apples comparison. I've run the numbers and a healthy married person, under the age of 65 can get $50 of Daily Benefit, a CPI Automatic Inflation Benefit, and a Lifetime Benefit Period, for LESS than the average projected $65 per month that the CLASS Act will charge.

The only downside to the CLASS Act is if people assume "that they are covered" and don't realize that they'll need at least a supplemental LTCI policy to cover the full cost of care. But, most people think they are covered for LTC expenses already anyway. I believe that the positive results of the CLASS Act will outweigh this potential downside.

I support the CLASS Act and I hope that it becomes law. ■

Scott A. Olson can be reached at *LTCPro@Verizon.net.*

LTC Bullet: Baucus Means Bupkus for LTC

by Stephen A. Moses

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

[Editor's Note: This article is reprinted with the permission of the author.]

Tuesday, September 22, 2009

Seattle—

LTC Comment: High hopes the Baucus health reform bill might help LTCI won't be realized. Our analysis and prediction after the ***news.***

LTC BULLET: BAUCUS MEANS BUPKUS FOR LTC

LTC Comment: The long wait for Senator Max Baucus (D, MT) to unveil his Senate Finance Committee's health reform proposal is over. Debate in the committee begins today. It promises to be an entertaining spectacle, if you like political bloodbaths.

Amendments to Baucus already introduced? 564 and counting. There are so many ideological and policy cross-currents in the country's current health reform conversation that it's very hard to see how anything of consequence gets passed. That is the main reason I don't think very much will happen, good or bad, for long-term care financing.

It looks like the CLASS Act has fallen by the wayside as one of its advocates laments here (*http://www.mcknights.com/CLASS-Act-might-be-left-out-of-final-healthcare-reform-bill/article/149384/?DCMP=EMC-MCK_Daily*). CLASS would have created another multi-billion dollar slush fund, I mean "trust fund," for politicians to rob. That's one bullet dodged, at least for now.

On the positive side, Baucus includes the long-elusive proposal to include LTC insurance in "cafeteria" plans. Jesse Slome of AALTCI (*www.aaltci.org*) explains the benefits of that idea here (*http://www.healthleadersmedia.com/content/239265/topic/WS_HLM2_LED/Baucus-Bill-Calls-Attention-to-LongTerm-Care-Insurance.html*). But AHIP says it would reduce federal tax revenues by $3.6 billion over 10 years here (*http://www.ahipiwire.org/HealthInsurance/News/Default.aspx?doc_id=406402&utm_source=9/21/2009&utm_medium=email&utm_campaign=HiWire_Newsletter&uid=TRACK_USER*). Is it a real proposal or just a sop to insurers now to be dropped later to reduce costs? You decide.

On the other hand, that flexible spending proposal sure isn't "above-the-line" tax deductibility, the LTCI industry's real holy grail. Nobody's dreaming that dream anymore. (I do know exactly how to make real LTCI tax deductibility a reality by paying for it with Medicaid savings and improvements, but that's a story for another Bullet.)

Looking at the bigger picture, the best thing LTC providers and insurers have going for them in this health reform fight is gridlock. Their most hopeful outcome is to dodge big negatives, not to win small positives. Here are some of the cross-currents to watch.

LTC providers breathed a sigh of relief last week when the Baucus bill backed away from billions of dollars of cuts to the nursing home industry. But how long will LTC providers sustain their optimism (See *http://www.mcknights.com/Bill-protects-nursing-home-market-basket/article/150179/*) with Medicare and Medicaid on the chopping block as sacrificial lambs offered up to support bigger health reform?

How about that plan to fund health reform with cuts to Medicare and Medicaid? Last time I checked, Medicare had an $89 trillion infinite-horizon unfunded liability and Medicaid was bankrupting state budgets. Governors and state Medicaid directors are screaming "hold your horses" on that one (*http://www.kaiserhealthnews.org/Daily-Reports/2009/September/18/Governors.aspx*) and elsewhere.

If the most likely outcome for health reform is to hit a wall of political gridlock and emerge as minor incremental changes, these "flaws" of the

Baucus proposal (see *http://fixhealthcarepolicy.com/research/seven-fatal-flaws-of-baucus-bill/*), as articulated by Nina Owcharenko of the Heritage Foundation, will be its downfall.

Seven Fatal Flaws [by Nina Owcharenko of the Heritage Foundation]

1) Middle Class Tax Hike: The Baucus bill would impose a new sales tax on drugs and medical devices and a new federal excise tax on insurance plans that exceed $8,000 for an individual and $21,000 for a family. These taxes will ultimately be passed down to the consumer, putting many middle class families on the receiving end of a tax hike.

2) An Individual Mandate: In 2013, almost everyone would be required to purchase health insurance that complies with new federal standards. Those making more than three times the poverty level would face a tax penalty of $950 (maxing out at $3,800 per family) and $750 (maxing out at $1,500 per family) for those below 300 percent poverty. This penalty could apply to individuals with incomes as low as $10,831 a year.

3) No Privacy: In order to enforce the tax penalty provisions, the government would be forced to collect detailed health insurance information on Americans, reducing patient privacy and adding significant administrative costs to employers and insurers.

4) A Pay-or-Play Employer Mandate: Employers with more than 50 employees that don't offer health coverage would have to pay a penalty for each employee who qualifies for new federal subsidizes under the bill. Inevitably, low-income workers will be hurt the most as employers would simply downsize or cut wages.

5) A Thinly Disguised Public Option: The Baucus bill invites indefinite federal control of a "co-op" by providing an unnecessary $6 billion in federal funding for startup loans and grants and it gives broad latitude to the HHS Secretary to regulate co-ops and promote them. The co-op created in this bill is literally an acronym for a new government-run health plan.

6) Medicaid Expansion: Under the Baucus bill, millions of Americans would end up on Medicaid. The current Medicaid program is unsustainable

and poorly serves the needy and indigent now. Taxpayers will pick up the new costs of Medicaid, and states will have little flexibility for real reform.

7) Medicare: The Baucus bill establishes value-based purchasing, requiring compliance with government guidelines on the delivery of medical services. Hospitals and physicians who don't comply would get lower Medicare payments. This approach could bias or compromise doctors' decisions and contradict U.S. law on the federal interference in the practice of medicine.

The President needs to lead by meeting with key leaders of both parties and seek bipartisan reform around two key themes: 1) instead of a one-size-fits-all federal solution, Congress should let the states take the lead on reform, and 2) reform the tax treatment of health insurance to give all taxpayers tax relief for purchasing private insurance and extend assistance (through spending offsets) to low-income families to purchase private insurance instead of expanding government care.

If you still harbor any doubt that LTC reform is dead for now, read this piece (*http://www.kaiserhealthnews.org/Columns/2009/September/091409Gleckman.aspx*) by an advocate of more government financing and an enemy of private LTC financing alternatives. Even he's discouraged.

Finally, if you really want to know what's happening, pull back from the microscope of current affairs and take a telescopic look at the larger historical trend. That's what I did last November when groundless optimism seemed to point toward massive health and LTC reform. ■

The Age Wave, the Ocean State, and Long-Term Care

Presented by the Center for Long-Term Care Reform "Dedicated to ensuring quality long-term care for all Americans". In cooperation with The Ocean State Policy Research Institute "Free Market Answers in Rhode Island" (September 2, 2009)

by Stephen A. Moses

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

[Editors' Note: This article is reprinted with the permission from the Center for Long-Term Care Reform and the Ocean State Policy Research Institute as well as the author.]

Executive Summary: Rhode Island's unique "global Medicaid waiver" pursues a potentially dangerous national policy trend: long-term care (LTC) rebalancing without strong eligibility controls. Given the state's already grave budget crisis, potentially explosive increases in Medicaid costs incidental to the global waiver could seriously damage Rhode Island's social safety net. Policy makers can maximize the global waiver's opportunity, minimize its danger, and become a LTC financing model for the country. To do so, they will need to recognize the issues discussed in this report and pursue the recommended additional research and analysis.

Background: In early May 2009, Bill Felkner, president of the Ocean State Policy Research Institute (OSPRI, *www.oceanstatepolicy.org*) contacted Stephen Moses, president of the Center for Long-Term Care Reform (CLTCR, *www.centerltc.com*) about the possibility of conducting a study of Rhode Island's unique "global Medicaid waiver." As no funds were otherwise available to support the project, CLTCR invited its individual and corporate members to sponsor a very limited study intended to identify the key issues and the need for further research. Donors who made this work possible are identified and thanked in the Appendix.

During the week of July 6-10, 2009, Stephen Moses visited Providence, Rhode Island and interviewed a large number of public officials and related professionals about the global waiver, Medicaid eligibility policy, long-term care service delivery and financing, and private financing alternatives for long-term care. A list of respondents and interviewees is included at the end of this report.

CLTCR thanks OSPRI president Felkner and his staff for their invaluable assistance in reaching the right people and facilitating this work in many other ways. We also want to thank Mr. Gary Alexander, Secretary of the Rhode Island Executive Office of Health and Human Services, who met with us and graciously authorized our interviews with staff of his organization.

Overview: Rhode Island (RI) has a "global Medicaid waiver" that is unique in the country. For the first time ever, the Centers for Medicare and Medicaid Services (CMS) has permitted one state wide latitude to experiment with policies not otherwise allowed under federal law and regulations in exchange for the state's accepting a cap on federal Medicaid matching funds that would otherwise be open-ended. The global waiver provides RI a great opportunity (for experimentation) but it comes with a huge danger (of cost over-runs). The state's success or failure is critical to the issue of long-term care service delivery and financing at the state and at the national level. Because of the challenge of aging demographics, exploding health and long-term care costs, and the enormous unfunded liabilities of existing entitlement programs, how Rhode Island deals with this issue under this waiver at this time is a touchstone for the country's future prospects.

Rhode Island intends to use its global Medicaid waiver to pursue a policy of long-term care rebalancing that is sweeping the country. LTC rebalancing involves diverting chronically ill or frail elderly people from expensive nursing home care to less expensive home and community-based services (HCBS). The objective of rebalancing is to save money while providing more desirable services to a larger number of RI residents. Many other states have pursued the same policy with mixed results but under severe federal restraints. With its global waiver, RI may pursue the policy relatively unrestrained for better or worse.

But long-term care rebalancing is highly problematical. Research shows that diverting the frail and infirm elderly from nursing homes to home care does not save money. Home care delays nursing home

care, but does not replace it, resulting in total costs across lifetimes and populations that exceed nursing home care only. Furthermore, Medicaid financial eligibility criteria are so generous and elastic in Rhode Island and nationally that most people who qualify medically also qualify financially with ease for the program's extensive benefits. Consequently, Medicaid LTC benefits already crowd out a market for privately financed HCBS and severely reduce demand for private LTC financing alternatives such as home equity conversion and private long-term care insurance.

Bottom line: by offering more LTC services people want (HCBS) and fewer services they don't want (nursing homes) without controlling already wide-open program eligibility, Rhode Island runs the risk of exploding LTC expenditures, increasing public dependency on government-financed LTC, and reducing the use of private funds and market-based products for financing long-term care. Our purpose with this report is to show how the state can keep costs under control, encourage the public to plan responsibly and pay privately for long-term care, and promote the use of private LTC financing alternatives. If successful in Rhode Island, similar policies could become the model for national long-term care reform in a way analogous to what happened with welfare reform in the 1990s. Wisconsin's public assistance waiver under then-Governor Tommy Thompson became the model for national reform in 1996 that diverted millions away from welfare dependency and saved taxpayers billions of dollars.

FINDINGS:

Issue 1: **Rhode Island's Medicaid long-term care financial eligibility rules allow most people to qualify for LTC benefits without spending down significant assets.**

Recommendation: Conduct the additional research suggested below and pursue corrective action under the global waiver to target scarce Medicaid resources to people most in need.

Facts:

1. Anyone (over 65 and medically qualified) with income below the cost of a nursing home ($7,777 per month) qualifies for Medicaid LTC benefits in RI based on income. *The state has only twice ever denied LTC eligibility to an applicant because of excess income.*

   Research needed: Identify ways under the global waiver to target benefits more cost-effectively to lower income people.

2. Applicants qualify for Medicaid LTC benefits with, and recipients may retain, unlimited exempt assets, *e.g.* home equity up to $500,000 and, without any dollar limit: one business including the capital and cash flow, one automobile, prepaid burial plans, term life insurance, home furnishings and other exempt assets.

   Research needed: Identify ways under the global waiver to target benefits more cost-effectively to genuinely needy people.

3. Medicaid estate planning (artificial impoverishment of affluent seniors to qualify them for Medicaid's LTC and other benefits) is rampant in Rhode Island. State eligibility staff report half of Medicaid LTC recipients have done some form of Medicaid planning to qualify.

   Research needed: Identify the Medicaid planning methods used and quantify the costs to the state and federal government from techniques like "reverse half-a-loaf," purchase of "life estates," irrevocable income-only trusts, legal (beyond the 5-year look back) and illegal (fraudulent) transfers of assets, purchase of exempt assets and many other less common practices.

4. Rhode Island permits "mail-order" Medicaid eligibility so that 60% of all applicants are not seen face-to-face and 85% of all applications are completed by someone other than the applicant, often by an attorney with a financial interest in the case.

   Research needed: Examine this practice and estimate the savings to the state of closer and stronger eligibility monitoring.

5. Rhode Island intends to use the same eligibility criteria and methods of determination under the global Medicaid waiver for HCBS (which people want) as it uses for nursing home care (which most people prefer to avoid).

   Research needed: Examine the potential increased costs this practice will likely entail and propose initiatives to reduce them.

Issue 2: **Rhode Island's Medicaid program does not fully recover benefits correctly paid from liens or estate recoveries. To that extent, the program is defacto free inheritance insurance for heirs against the risk of their parents needing long-term care.**

CONTINUED ON **PAGE 22**

Consequently, Medicaid LTC benefits already crowd out a market for privately financed HCBS and severely reduce demand for private LTC financing alternatives such as home equity conversion and private long-term care insurance.

Recommendation: Identify, document and quantify methods by which Rhode Island can discover, secure, and recover the cost of LTC benefits paid to people with exempt (sheltered) assets out of their estates or from liens on real property. Propose corrective actions allowable under the global waiver.

Facts:

1. Rhode Island does not pursue TEFRA liens, so the state is unable to track and secure recipients' largest exempt asset, home equity, during the period of their Medicaid LTC eligibility.

   Research needed: Explore the potential savings for RI from the use of property liens as authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) and examine potential expansion under new authority granted by the global waiver.

2. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) required state Medicaid programs to pursue recovery of program benefits correctly paid to anyone 55 years of age or older out of the person's estate or the estate of the person's last surviving, exempt, dependent relative (usually a spouse.) *RI does not pursue this non-tax revenue source aggressively having cut staff and collected only $2 million in the past year*.

   Research needed: Examine estate recovery programs in other states (especially Oregon) to show how *Rhode Island can recover at least $15 million per year* from this source. By so doing, the state should be able to achieve even greater savings from cost avoidance as consumers plan more responsibly to pay privately for LTC in order to stay off Medicaid and avoid estate recovery.

3. Besides not utilizing TEFRA liens and underutilizing estate recovery, Rhode Island has no uniform probate code law, no enhanced definition of "estate" as authorized by OBRA '93, no way to track deaths and estates systematically, no method to ensure recovery of recipients' "nursing home accounts" (up to $4,000), and no recoveries at all from home care benefits which are likely to explode under the global waiver.

   Research needed: Research and propose a combination of state legislative initiatives and program changes to address these specific deficiencies and improve RI's non-tax revenue from these sources.

Issue 3: **As Rhode Island's Medicaid long-term care program rebalances from heavy coverage of institutional services (nursing home care) to vastly more home and community-based care (HCBS), total program costs may increase rapidly.**

Recommendation: Identify, explore and quantify the risks and cost of rebalancing. Consider why measures to reduce excessive program eligibility may be critical to maintain cost-effectiveness under this global waiver initiative.

Facts:

1. Rhode Island's global waiver proposes to reduce nursing home dependency by providing services in the community (HCBS) to more people at less cost.

   Research needed: Find, enumerate and elucidate the extensive literature that demonstrates HCBS will not save money. Use this information to develop ways that total costs can be reduced while funding less nursing home care and more HCBS by controlling eligibility, maximizing estate recovery, and encouraging private financing of long-term care.

2. RI Medicaid historically and currently provides LTC benefits mostly in nursing homes (90%) and much less in HCBS (10%). The state plans under the waiver to expand HCBS vastly and reduce nursing home care. Yet nursing homes have already lost 1200 beds statewide; seen their occupancy decline from 97% to 90%; and suffered reimbursement cuts so that current Medicaid payments are now $16.21 per bed day (12 percent) less than allowable costs, while their Medicaid census has increased to 73% and their private-pay census has plummeted to 10%.

   Research needed: Explore these problems and propose solutions that avoid further damaging an already fragile service delivery system.

3. The Rhode Island global waiver contemplates assisted living facilities (ALF) and home care providers picking up the extra care recipients who will no longer qualify for nursing home care due to increased acuity of care requirements. Yet few ALF beds are available in the state and home caregivers are in very short supply. ALF and home care providers say Medicaid pays too little to enable them to provide services to the kinds of higher-need recipients under the global waiver who otherwise would have received care in nursing homes.

Research needed: Examine and quantify these problems and suggest ways to eliminate them by improving Medicaid eligibility, estate recovery and public education programs.

Issue 4: **Medicaid is the dominant payer for long-term care in Rhode Island because easy eligibility, almost nonexistent estate recovery, and a lack of positive incentives for private financing alternatives has left the public largely unaware of the need to plan, save, invest or insure for long-term care risk and cost.**

Recommendation: Develop a plan to implement, integrate and publicize stricter income and asset eligibility rules, stronger lien and estate recovery policies, and the need for consumers to plan early and save, invest or insure for long-term care. Use some of the resulting savings to educate the public about long-term care planning and private LTC financing options.

Facts:

1. Despite widespread home ownership and high property values in Rhode Island, reverse mortgage lenders report that borrowers rarely (perhaps 5%) use the proceeds of home equity conversion to pay privately for home care and related medical and custodial services.

   Research needed: Determine to what extent Rhode Island's $500,000 home equity exemption encourages Medicaid use and discourages home equity conversion as a means of financing LTC privately. Estimate potential savings to the state of limiting the home equity exemption and incentivizing the use of reverse mortgages to fund home care. (See especially the National Council on the Aging's study titled "Use the Home to Stay at Home.")

2. Long-term care insurance producers in Rhode Island report that too few policies are in force; the market is flat or down; the state has no tax incentives to encourage the purchase of LTC insurance; Medicaid planning after the insurable event has occurred is commonplace; and, although RI has approved a "long-term care partnership" program, no policies are being sold.

   Research needed: Carefully examine and consider implementing policies to encourage early LTC planning, utilize tax incentives for the purchase of private insurance for long-term care, and eliminate Medicaid eligibility policies that have the effect of anesthetizing the public to the risk and cost of LTC.

SUMMARY

Rhode Island's current plan under the global Medicaid waiver to expand home and community-based services while reducing nursing home use without controlling the state's wide-open LTC eligibility system is, however unintentionally, highly likely to increase costs and undermine private-sector LTC financing sources.

Careful study and further review of the issues raised in this report will identify corrective actions that can reduce costs by targeting Medicaid benefits under the global waiver to people most in need and by encouraging private, market-based solutions based on savings, investment and insurance to fund long-term care. ■

Careful study and further review of the issues raised in this report will identify corrective actions that can reduce costs by targeting Medicaid benefits under the global waiver to people most in need and by encouraging private, market-based solutions based on savings, investment and insurance to fund long-term care.

ADDITIONAL RESOURCES

1. Center for Long-Term Care Reform's extensive Web site and "LTC Blog" are here: *www.centerltc.com*

2. The Ocean State Policy Research Institute's Web site is here: *www.oceanstatepolicy.org*

3. The primary researcher's professional biography is here: *http://www.centerltc.com/steves_bio.pdf*

4. An electronic handout with links to many of Stephen Moses's published articles, speeches and reports is here: *http://www.centerltc.com/Handout-print.pdf*

5. See especially the Cato Institute monograph titled "Aging America's Achilles' Heel: Medicaid Long-Term Care" here: *http://www.cato.org/pubs/pas/pa549.pdf*

6. See reports for HCFA (1985) and the federal DHHS, Inspector General (1988) that resulted in federal statutory changes in 1993 (OBRA '93) and laid the groundwork for 2005 legislation (DRA '05) on Medicaid and LTC financing issues here (*http://www.centerltc.com/mer_study.pdf*) and here (*http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf*), respectively.

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APPENDIX

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A Word from … the Underwriting & Claims Track

I am honored to have the opportunity to serve as an Affiliate Council Member and co-chair of the Underwriting & Claims Track for the LTCI section. I believe that this section of the SOA plays an integral role in the leadership, research and education of actuaries and many other professionals involved with the development, sales, management and future of the LTC insurance industry. I am pleased to have the opportunity to foster the direction and initiatives of this section as well as act as a liaison for the broad base of members from all functions and disciplines within this market. I look forward to the upcoming year! ■

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A Suggestion to do a Postmortem Analysis of the Work Done by LTC Pricing Actuaries Over the Last Quarter Century

by Ali Zaker-Shahrak

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In this note, after a lengthy introduction, I suggest we do a postmortem analysis of the work of the Long-Term Care (LTC) pricing actuaries.

It is well known that the pricing of any insurance product is as much an art as it is a scientific endeavor. In developing premium rates, we use well-known actuarial principles, but, in addition, we take into account many other factors, not least of which is whether our company can market the product, and, what the competition is doing. There is always a danger of following the crowd—herd mentality—and arriving at low premium rates when others do the same. Of course, there is no free lunch, not even for the actuaries. Low premium rates resulted in low profits (losses) and many subsequent red faces in the years that followed the introduction of initial prices. Pricing an actuarial product becomes especially challenging when the product is new and little is known about historical, industry wide claims experience for the product in question. Looking back, this was the case during the 1980s, when insurance companies started pricing and marketing the first generation of LTC products.

As is well known, in the beginning, some actuaries came up with premium rates for LTC products that have turned out to be woefully inadequate. Did they use very optimistic assumptions? And perhaps, part of the problem was because everybody else was employing similar assumptions? Perhaps too, *there was too much reliance on the minimum required LTC policy provision statement that the product was* ***guaranteed renewable?*** Guaranteed renewability meant that insurers could increase the premium rates if the assumptions turned out to be off-the-mark. That is what has happened. Over the last quarter century, most insurance companies selling LTC products have implemented significant rate increases (many repeatedly). There still seems to be no end in sight for how many more rate increases are to follow.

It goes without saying that individuals who had bought LTC policies do not appreciate such repeated rate increases, and in many instances have vociferously complained to state insurance regulators regarding such increases.

To combat the inadequacy of initial LTC premium rates, the National Association of Insurance Commissioners (NAIC) came up with a model law—referred to as "rate stability law"—at the beginning of this decade which has since been enacted into law in many states, including my home state of California. The new law emphasizes adequacy of initial rates. For example, California Insurance Code, Section 10236.11(a) states,

"*No approval for an initial premium schedule shall be granted unless the actuary performing the review for the commissioner certifies that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated*."

Also, in Section 10236.11(b) we read,

"*The insurer shall submit to the commissioner for approval a rate filing for each policy form that includes at least all of the following information: ...* ***(2) An actuarial certification consisting of … the following: (A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.***"

It was hoped that with the enactment of rate stability law, rate increases for policies sold following the enactment would happen relatively rarely and only when the experience turned out to be more than moderately adverse. Unfortunately, we are seeing rate increase filings for "post rate stability" policies more frequently than the authors of the new law would have hoped for.

It is, therefore, appropriate and timely that we look back and analyze LTC pricing over the last three decades. We should do this so that we can identify the shortcomings of former and current practices and recommend ways in which pricing of LTC products can be improved in future years. ■
(October 2, 2009)

Get Ready for New LTC Insurance Experience Forms!

by Al Schmitz and Chris Giese

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Long-Term Care (LTC) insurers are coming under increasing scrutiny. Many different stakeholders want to better understand the business and financial picture of LTC insurers, such as:

- Insurance company investors that want to understand how companies are performing financially,
- Rating agencies and regulators that want to understand the adequacy of reserve levels,
- Regulators and consumers that want to understand the adequacy of current rate levels, including evaluating rate increase requests,
- Competitors that want to understand each others' financial experience in terms of where they are performing well and where they might be struggling, and
- Auditors that want to understand how assumptions are materializing relative to actual experience.

Beginning with statement year 2009, companies reporting LTC experience are required to file New LTC Experience Reporting Forms ("New Forms"). The New Forms will greatly aid those who want to scrutinize LTC insurers more closely by offering greater transparency of LTC insurers' reserve levels and policy form experience.

Information regarding company experience is difficult to obtain from the prior Forms A, B and C for the following reasons:

- Forms A, B and C ("Prior Forms") were based on the original pricing distribution of business and not the distribution of business actually sold. This is a critical point. The Prior Forms often demonstrated strange actual to expected (A:E) ratios, driven by the use of the original pricing distribution.
- Over time, these strange A:E ratio results on the Prior Forms caused many in the industry to pay little attention to these forms. Consequently, insurers occasionally took high-level shortcuts in preparing the Prior Forms.
- The Prior Forms focused on loss ratio results. The New Forms more directly examine the critical component assumptions of morbidity and persistency.
- Many companies combined policy forms for experience reporting under the Prior Forms, making it difficult to isolate experience. The New Form 2 requires each base policy form to be reported separately.

The New Forms attempt to address some shortcomings of the Prior Forms. They also reflect the rating rules in the current version of the *NAIC LTC Insurance Model Regulation,* which has shifted away from a loss ratio focus. The resulting transparency to all interested parties will likely result in increased focus on the New Forms.

The remainder of this article provides some background and potential pitfalls of the New Forms, as well as some tips on preparing for them.

BACKGROUND

The American Academy of Actuaries worked with regulators to develop the New Forms. The New Forms were completed and approved more than four years ago. On its Web site, the National Association of Insurance Commissioners (NAIC) provides the following reasons for the development of the New Forms:[1]

> *"The revisions will allow regulators to track the experience of Long-Term Care insurance and compare the actual experience to the projected experience. This will provide long-term profitability measures and help identify areas where solvency may be an issue. As an additional benefit, this will assist regulators with evaluating requests for premium increases on long-term care insurance."*

The New Forms are required for statement year 2009. They are due by April 1, 2010. *For the 2009*

FOOTNOTES

[1] *National Association of Insurance Commissioners, October 5, 2009. http://www.naic.org/documents/committees_e_app_blanks_adopted_2007-49BWG_Modified.pdf*

statement year only, both the Prior and New Forms need to be submitted to ensure the inclusion of calendar year 2008 experience. The reason is the Prior Forms had a one-year lag for reporting calendar year data. Form A from statement year 2008 showed experience for calendar year 2007. The New Forms, however, primarily require reporting starting with calendar year 2009, so 2008 calendar year data may not have been reported under either set of forms (Prior or New). The New Forms completely eliminate the Prior Forms starting with statement year 2010.

The New Forms are intended to track claims and persistency against expected, calculate a ratio of an "experience" reserve against an expected reserve, and examine the adequacy of claim reserves over time.

WHAT IS CHANGING

There are five entirely new forms (Forms 1 – 5) that replace the prior Forms A, B, and C. The Prior Forms were primarily loss ratio focused. They used pricing assumptions to develop expected morbidity and persistency based on the original assumed distribution of business. Conversely, the New Forms focus on pricing and reserve adequacy. They use valuation assumptions to develop expected morbidity and persistency based on the actual distribution of business.

Table 1 lists each form along with a brief description for both the Prior Forms and the New Forms. Table 2 includes additional details on the new Forms 1 – 5.

TABLE 1
Listing of Prior and New LTC Experience Forms

Prior Forms
- Form A: Claim Experience by Calendar Duration (One Calendar Year)
- Form B: Cumulative Claim Experience
- Form C: State Specific Form B
New Forms
- Form 1: Actual Claims and Persistency vs. Expected
- Form 2: Ratio of Experience Reserve to Reported Reserve
- Form 3: Test Adequacy of Claim Reserves
- Form 4: LTC Acceleration Benefits Under Life/Annuity
- Form 5: State Specific Data

TABLE 2
New LTC Experience Forms – Key Components and Requirements

Form 1
- Tracks Actual Claims and Persistency Against Valuation Expected
- Reports Open and New Claim Counts
- Reports Individual and Group Business Separately
- Summarizes Experience Into Three Policy Categories:
• Comprehensive
• Institutional
• Non-Institutional
Requires Policy Form Detail to be Retained
Form 2
- Calculates Ratio of Experience Reserve to Reported Reserve • Experience Reserve calculated on retrospective basis using prior year reserve, valuation net premiums and interest rates, and experience claims and premiums.
- Captures Actual Loss Ratio Experience
- Displays Net-to-Gross Premium Ratio
- Reports Individual and Group Business Separately
- Shows Data by Policy Form
- Requires Calendar Duration Detail to be Retained

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TABLE 2 (continued) New LTC Experience Forms – Key Components and Requirements
Form 3
- Tests Adequacy of Claim Reserves
• Tracks runout for eight years
- Reports Individual and Group Business Separately
- Similar to Schedule O – But LTCI Only
- Requires Individual Claim Data
- Consistent with Actual Incurred Claims in Form 1
Form 4
- Tracks Life/Annuity Products with LTC Acceleration Benefits
- Summarizes Policies, Claims, and Non-claim Reserves
- Reports Individual and Group Business Separately
- Shows Last Three Years and Total Since Inception
Form 5
- State's Portion of Earned Premium, Incurred Claims, and Lives Inforce
- Reports Individual and Group Business Separately

Learning how to navigate the forms, properly fill them out, and understand some of the nuances will take time.

POTENTIAL PITFALLS

The New Forms require a fair amount of effort to complete. Learning how to navigate the forms, properly fill them out, and understand some of the nuances will take time. In addition, companies and their actuaries should be prepared to explain counterintuitive or unusual results that may potentially show up in these New Forms. For example:

- Some difference between the incurred claims reported in Form 1 and Form 2 is to be expected, but a large difference may send up a red flag and require further explanation.
- Persistency experience relative to expected is shown for each year, and not on a cumulative basis. Therefore, the long-term impact of missing the persistency assumption is not readily apparent by only examining the actual to expected lives from Form 1.
- A comparison of the reported reserve with the experience reserve may be counterintuitive. Deviations in morbidity and persistency have different timing impacts on the experience reserve.

The approach and specific calculations a company uses to populate a form need to remain consistent for all subsequent years for that form. For example, the method used to account for waiver of premium must be consistent over time. Therefore, companies should give proper consideration to the long-term impact of technical decisions made in the first year of filing the New Forms.

START PREPARING NOW!

It is important for companies to begin understanding the way the forms work and their nuances as early as possible. If time permits, a dry run can help determine whether results are accurate and consistent with internal business analysis results. In addition, it will be necessary to tie form data to financial statement items as required in the instructions.

LTCI is a complicated product. The New Forms do a better job capturing the drivers of LTC experience, but they will not account for all the intricacies affecting financial results. In the event unusual or counterintuitive results arise, companies must be prepared to explain these results. Remember that these forms will create greater transparency and results may be ranked and analyzed closely by many different stakeholders (regulators, rating agencies, investment analysts, competitors, etc).

A thorough understanding of what the experience forms are communicating about a book of business is critical. ■

SOCIETY OF ACTUARIES Long-Term Care Insurance Section

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