SOCIETY OF ACTUARIES Long-Term Care Insurance Section

Long-Term Care News

ISSUE 23 MAY 2009

An Ongoing Strategy to Boost LTCI Sales

by Don Grimes

A model exists for an effective, cost efficient national public LTC/LTCI education program that will increase LTCI sales nationwide and keep sales increasing. I developed and tested the model over the course of a yearlong program during 2007-2008 in cooperation with the State of South Dakota Department of Social Services. Many of the elements of this model LTC/LTCI education program are not new—what was new and notable in the South Dakota effort was the broad reach and length of the project and the leveraging of resources from LTC providers, LTCI agents, churches and community groups, the media and elected officials. The real sales impact of an ongoing community-based LTCI education campaign can be seen in the results of Gene Schmidt, the owner of SIA Marketing—a North Dakota-based LTCI MGA with many agents in South Dakota. Gene's firm worked aggressively to help their South Dakota agents, including many agents who are primarily P&C agents, leverage the SD public education effort. Gene reported a 75-percent increase in LTCI premium production from his agents in South Dakota, year-over-year, during the period I was conducting the public education effort in South Dakota.

In 2007 the State of South Dakota Department of Social Services began a yearlong statewide education effort to provide accurate and impartial information on LTC and the new SD Partnership LTCI plans that were just being offered. The funding for the effort came from a foundation grant.

My group was awarded the contract for the public education program, and I had three major areas of responsibility:

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The "Pure" Possibilities

by Bruce A. Stahl

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A friend who happens to be a member of the Democratic Party called me a purist when I told him I voted for Ron Paul in the Republican presidential primary. I took that comment as a compliment, because it seemed to me that being a purist meant I was hoping the three branches of the federal government might try a little harder to follow their respective roles as identified in the constitution.

Though the authors of the articles in this newsletter do not necessarily work within political circles, seeking to be a purist appears to be in vogue in LTC insurance today. David Hippen submitted an article opining that LTC actuaries have failed to be purists with regard to their own professional duties. I personally wrote a reply to this opinion, and David responded to my reply. (The editors hope that you will offer your own opinions in the debate.)

Other articles in this issue also seek purity in some fashion, or at least recognition when purity is not possible. Brad Linder pointed to the need for pure compliance with examples regarding policy provisions. Roger Loomis identified how actuaries may communicate the lack of purity as we price various demographic cells and policy options. Larry Pfannerstill submitted an article wherein he addressed the need for all stakeholders to be purists in addressing rate increases. Al Schmitz provided an update on reserving according to principles that are closer to actual experience or, we might say, with greater purity. Finally, Don Grimes describes his involvement in an LTCI educational effort with an aim to provide pure information: "In 2007 the State of South Dakota Department of Social Services began a yearlong statewide education effort to provide accurate and impartial information on LTC and the new SD Partnership LTCI plans that were just being offered."

So, with pure delight, we thank the authors for their contributions, and offer this issue to the readers and members of the LTC Section of the SOA. ■

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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.*

I Was an Audit Drop-In

by Steve Schoonveld

In the mid-80s, my college professor of Education, Dr. Cliff Schimmels, wrote a book titled, "I Was a High School Drop In." The book noted his experiences as a 47-year-old college professor who literally "dropped-in" a suburban Chicago high school. He went undercover and enrolled as a student by attending classes, completing the homework assignments, participating in gym activities, going to football games and pep rallies, and receiving grades. The intent of his experiment was to discover what really goes on as a high school freshman.

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Similarly, "I Was an Audit Drop In."

There are few within the LTCI Section who possess as unique a perspective as those who work within audit firms and state insurance departments. In the last six months, these individuals have been especially busy dropping in on their clients to perform their often lengthy and laborious reviews. That such reviews are most intense during the late fall and winter months perhaps make the countless hours spent, more palatable. I often joke that some of the 90 percent of the world's population may be living north of the equator just to avoid fiscal years ending in the middle of summer.

The intensity of an audit differs based on the purpose and the established materiality levels. Given recent financial performance such materiality levels are broadening the scope of audits and increasing the intensity of the review. As of the end of 2007, more than 100 companies have blocks of long-term care business on their books and somewhere, somehow, and at some level, someone is auditing each block. Long-term care pricing actuaries need to consider the underwriting and claim adjudication processes when establishing rates. Similarly, the actuaries who audit these blocks have to take into account these practices as they render their opinions on the underlying financial health of the block. To have the unique perspective that comes from annually reviewing many LTC blocks and working with many of our fellow section members is invaluable.

Now that I am no longer an audit drop-in, I thought I would share some general findings that come from such a perspective. Specific findings remain with the audit and of course are not discussed.

1. ALL BLOCKS ARE UNIQUE. THAT IS WHAT MAKES THEM THE SAME.

Long-term care has the advantage or disadvantage—depending on your leaning—of the year-to-year volatility and ambiguity of a health product with the necessity for a long duration view of a life product.

Start with the differences in product features, available riders, covered benefits and care settings. Add in the underwriting requirements, approaches and rigor. Include the distribution methods and market focus. Bring in the claims adjudication and administration approaches. Finish with the actual product experience and policyholder behavior, and there are many, many aspects which make one block completely different from another. When you top this off with valuation approaches that run across the conservative to aggressive continuum, it should not amaze anyone why there are such diverse carrier experiences with this product line.

2. THE SIZE OF A BLOCK MATTERS, BUT NOT NECESSARILY.

There are successful and unsuccessful carriers with as little as a thousand or as many as a million policyholders. Whether insurance is purchased through a regional health plan, a frater-

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nal benefit society, a large multi-line carrier, or under an employer-sponsored plan, there are plenty of policyholder and claimant success stories across the block size spectrum. Certainly there are volume requirements to support the essential infrastructure and a strong commitment to providing a well supported product is necessary. Once met, the talents of our fellow section members have enabled many carriers, large and small, to provide meaningful products to the market and provide real value to policyholders. As the industry continues to grow, so will these successes.

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3. ADEQUACY IS IN THE EYE OF THE BEHOLDER.

As my former professor likely experienced, one high school teacher can look upon a class and see a group of enthusiastic students while another sees rowdy chaos. Similar differences of views are present when looking at the reserves and assets supporting a block of long-term care policies. Such differences of opinion are fine if adequate support is demonstrated and the applicable accounting rules are followed. While we are in the midst of significant accounting methodology change in both statutory and GAAP approaches, such support will be of a greater necessity.

4. KNOWLEDGE BREEDS SUCCESS.

Any actuarial auditor of recent years would be remiss if he did not mention Sarbanes-Oxley. The implementation and support necessary for a sufficient internal control environment were onerous for some and even more onerous for others. However, the knowledge that comes from such a control environment along with a strong experience reporting and financial modeling framework has enabled carriers to succeed. The LTCI Section regularly supports research that brings knowledge to the industry. Two such research reports were released during the first quarter of this year.

At the ILTCI conference in Reno, the LTCI Section Council announced the initiatives that are underway to enhance the offerings that section membership brings. These initiatives help foster a community that educates one another, participates in industry research, and enables the industry to grow in the presence of the unique approaches, experiences and challenges.

I encourage each of you to find your role within the section and to participate in section-sponsored research, webinars and committees. The sharing of our unique perspectives, knowledge and expertise, plays no small part in the overall health of the industry and the products which make a difference in the lives of consumers. ■

1) Develop the PowerPoint and classroom materials.
2) Help develop outreach/education strategy.
3) Conduct the actual presentations.

I also provided advice and ideas on just about all parts of the program. All our work was developed in cooperation with and subject to the approval of South Dakota state officials.

The project goal was ambitious: to go to virtually every county in South Dakota and give live classes on LTC/Partnership LTCI. We scheduled classes one week a month over a 10-month period. I would conduct three to five classes per day with the first class scheduled to start anywhere from 7 a.m. to 9 a.m. The last class was typically scheduled to start at 6 p.m. or 6:30 p.m. Classes were typically 60 minutes in length—45 minutes of presentation and 15 minutes of questions. In the larger towns we made more than one visit over the 10-month period. We also conducted free telephone conference calls on a regular basis.

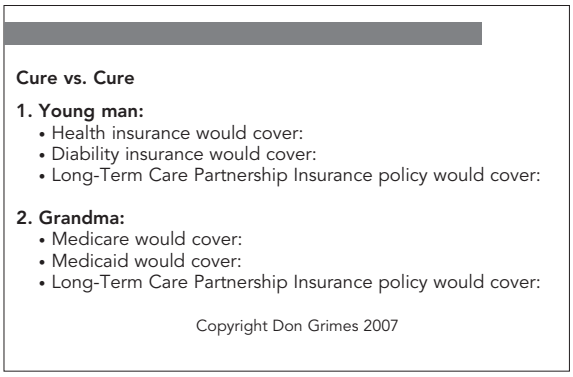
HERE ARE MY GUIDELINES FOR THE SOUTH DAKOTA EDUCATIONAL CAMPAIGN:

The key concepts must be broken down into simple English and given with examples. Examples help explain the concept and help the consumer better retain the information. When industry jargon like LMB, DMB, SNFs, ALFs and ADLs are used and not explained in simple ways the consumer tunes out.

For example, when explaining the difference between health insurance, disability insurance and LTCI and what each pays for I would say:

"Imagine that a 25-year-old, who is an assistant branch manager of a big bank in Sioux Falls (the major city in South Dakota and a major banking center), goes mountain biking in the Black Hills one Saturday with his grandma. They are having a great time going through the mountains looking at bison, eagles and turkeys. They are flying down a trail at high speed and hit a rock and lose control. They hit a big old tree and break their arms and legs. Fortunately, they are wearing bike helmets so they don't die, but they are both seriously injured. Let's see what insurance coverage would pay for what."

I then would show the following slide and lead the class in discussion:



The key concepts must be repeated in the presentation to help retention and you must test for comprehension in ways that are interesting or even fun for the audience. Our presentation and class materials repeated the key concepts throughout.

Leverage the resources and support that currently exist in communities from private and public sector. Having return visits to a community, planned out in advance, helped us to leverage community resources. We enlisted the support of civic groups, churches, LTC providers (SNFs, ALFs, Home Care), insurance agent groups, chambers of commerce, industry groups (e.g., state bankers association, wheat growers association, pork association, etc.), local media and local elected officials. We asked the groups to:

1) Endorse the educational meetings.
2) Use their existing member outreach channels to publicize the sessions.
3) Host sessions.

We were amazed at the response from many groups. In their own ways these groups had a stake in people learning about LTCI and in shifting the financial risk for LTC costs from consumers' pockets to the pockets of LTCI carriers.

LTC provider groups would send out e-mail blasts to their members each month, LTC facilities would send out e-mails to the families of their residents, YWCA would host events and publicize, churches

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would host sessions in their buildings and publicize events to their members and to other churches, elected officials would use their extensive contacts to drive attendance and media outlets ran PSAs and did stories. Some cities in South Dakota that have city-owned utilities would include information on the upcoming sessions in their billing.

The presentations/ education outreach is most effective when it is scheduled with an understanding on local needs and repeated with at least a two-week period between presenting days.

We had many insurance agents who would leverage our classes to sell LTCI. They would invite all their existing non-LTCI clients to attend the events. We would provide the accurate and impartial information and the agents would follow with their clients. I recall that one day in Huron, S.D., a local insurance agent spent all day outside the meeting room I was presenting in and he was greeting many of the folks attending the session. He had seen too many of his clients suffer when an older loved one needed LTC and he worked hard to get people to attend. That same day a member of the State Legislature attended a session and he had worked his phone and e-mail list to encourage people to attend. In another town the local bank president spent considerable time and effort promoting the educational events in his town. He told me the reason was that he had seen many of his older, long-time clients have to pull out all their savings and sell their land to pay for LTC and his small bank definitely felt the withdrawal of tens of thousands of deposits to pay for LTC. The dollars removed from the bank to pay for LTC could never again be loaned out to another farmer or rancher, so the negative ripple effect to the local community was great.

The presentations/education outreach is most effective when it is scheduled with an understanding of local needs and repeated with at least a two-week period between presenting days.

I was surprised at how often influencers in the community—ministers, business leaders, insurance agents, etc.—would want to first attend a session themselves before they would be willing to support them and reach out to their customers. At one meeting, on the very first day of the program, I spoke before a full room in Sioux Falls. In the back there were two tables—all seats filled—populated by a group of men who looked very serious. At the end of the session I went to the back of the room and introduced myself. They turned out to be insurance agents who wanted to see the sessions first before they were willing to reach out to their clients to promote it. One told me, "We needed to make sure the class was good before we promoted it to our clients and friends. Well, you did a very good job— the class will help our clients!" I took that as very high praise for my skills as a presenter!

We also had times when people would attend a second public presentation months after they attended the first class. The second time they would have their spouse with them.

Here are some of the project's goals for understanding. These were key topics that we hoped the public would learn, understand and retain as a result of attending the educational events. If the majority of the attendees could not answer these questions at the end of the class, then we failed as educators:

- Is long-term care just for older folks?
- Is long-term care always received in nursing homes?
- Does the government pay for long-term care in my home?
- Does health insurance pay for long-term care costs?
- Does disability insurance pay for long-term care costs?
- Can I save money and pay for my long-term care costs?
- Is LTCI expensive?
- How do I know my LTCI policy will pay for care when I need it?

Pre- and post-session surveys were used to measure effectiveness.

Over the course of the South Dakota project we conducted over 200 public sessions in every corner of the state. Some days we had audiences as large as 60 people at each of three sessions—very impressive in a city with a population of 40,000 people. At the end of the test project, the State of South Dakota provided another example of leadership by creating a staff educator position within the DSS to continue the statewide public LTC/LTCI program throughout 2008 and into 2009.

We are implementing a national version of this LTC/LTCI public education program in 2009 in the top 40 markets in the United States. We will be leveraging the wide spectrum of existing community resources as was done in the South Dakota project. ■

Measuring Subsidization in LTC

by Roger Loomis

PREVALENCE OF SUBSIDIZATION IN LTC

The long-term care insurance industry has made the decision to use unisex premium rates, despite the fact that females have much higher claim costs. According to various studies, at some ages female claim costs are over 100 percent greater than those of a corresponding male. Unisex rates result in significant subsidization across gender. Given the fact that females are the ones receiving the subsidized premium rates in LTC, one would expect that more females than males would purchase LTC policies, and this is in fact the case.

It could be argued that unisex rates are good for society and the industry, and this article isn't intended to advocate change. However, the acceptance of subsidization across something as fundamental as gender sets a precedent for broad subsidization that may find its way into other cell characteristics such as rating class, age and even policy options. That being the case, good risk management stipulates that the subsidization and inherent risks be understood and monitored. Otherwise, an unfavorable mix of business sold under a subsidized pricing structure may come as a surprise.

When there is deliberate subsidization across pricing cells, *subsidization risk*[1] is created. The 2000 LTCI Model Regulation requires that the initial premium rate schedule be sufficient to cover anticipated costs under moderately adverse experience and that it be sustainable over the life of the policy form. In the context of subsidized pricing structures, whether a rate structure is in fact sustainable can hinge on whether a favorable business mix is sold and remains in force. Thus, selling an unfavorable business mix should be considered adverse experience, and the actuary must consider moderately adverse experience in this context. Furthermore, ASOP 18 Section 3.5 stipulates that actuaries should perform sensitivity testing on reasonable variations in assumptions. With subsidized pricing structures, the business mix is in fact a key assumption, and thus should be analyzed with sensitivity testing.

The balance of this article will explore the hazards of subsidization risk and give some insights into how subsidization risk can be analyzed to comply with the 2000 LTCI Model Regulation and ASOP 18.

HAZARDS OF SUBSIDIZATION RISK

When rating structures are subsidized, antiselection forces emerge, which could cause your business mix to turn unfavorable. Antiselection has been informally described as "that annoying tendency people have of doing what's best for themselves."[2] Whenever you have one cohort subsidizing another, you create multiple opportunities for others to do what's best for themselves—to your detriment. First, you are giving your competitors an opportunity to profitably beat you on price. Second, assuming one of your competitors takes advantage of that opportunity, you are giving your most profitable potential clients an incentive to go with your competitor.

Sales forces and management teams have arguments for the specific subsidizations that they champion. However, subsidization can be dangerous. Companies that can correctly assign risk and minimize subsidization better than their competitors will have a significant competitive advantage. Regardless of whether your objective is to justify or to minimize subsidization, the actuary needs a clear understanding of how much subsidization exists in a given pricing structure so that it can be effectively monitored and managed.

HOW SUBSIDIZATION CAN BE MEASURED

Whenever different cohorts are priced with different anticipated profit margins, there is a degree of subsidization present.[3] When analyzing subsidization, there are three fundamental components:

1. Profit measures by pricing cell.
2. Assumed sales distribution.
3. Actual sales distribution.

When the business is being priced, the first and second items are combined to calculate target profits, and the anticipated subsidization can be measured. After a block of business is sold, the expected profits can be recalculated using the first and third items, and the actual subsidization can be measured. To the extent that profits can be different solely due to the difference between the actual sales distribution and the assumed sales distribution, subsidization risk exists that should be quantified and managed.

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The easiest way to begin analyzing subsidization is simply to look at the profit margins by pricing cell. As a simplified example, see Exhibit A.

Exhibit A: Profit Margin By Cell		
Age	Female	Male
45	25%	35%
55	-5%	30%
65	-15%	25%
75	-25%	20%

By looking at this type of table, cells that project losses can be easily identified and the range of returns can be observed. Of course for a real block of business with multiple ages, classes and benefit elections, such a table would become unwieldy and difficult to readily grasp. One way to summarize the data would be with a histogram that would show the number of pricing cells in different profit ranges.

Exhibit B: Assumed Sales Distribution		
Age	Female	Male
45	15%	10%
55	15%	10%
65	15%	10%
75	15%	10%
Total	60%	40%

However, this type of analysis ignores the sales distribution. The actual risk we are trying to analyze is the uncertainty of the sales distribution, not varying profit margins across cells. A first attempt at incorporating the sales distribution is simply to use the distribution assumed in pricing. Continuing with our simple example, see Exhibit B.

Exhibit C: Expected Cumulative Return						
Cell	Premium	Profit	Profit Margin	Cumulative Premium	Cumulative Profit	Cumulative Return
75F	$15.00	$(3.75)	(25.0%)	$15.00	$(3.75)	(25.0%)
65F	$15.00	$(2.25)	(15.0%)	$30.00	$(6.00)	(20.0%)
55F	$15.00	$(0.75)	(5.0%)	$45.00	$(6.75)	(15.0%)
75M	$10.00	$2.00	20.0%	$55.00	$(4.75)	(8.6%)
65M	$10.00	$2.50	25.0%	$65.00	$(2.25)	(3.5%)
45F	$15.00	$3.75	25.0%	$80.00	$1.50	1.9%
55M	$10.00	$3.00	30.0%	$90.00	$4.50	5.0%
45M	$10.00	$3.50	35.0%	$100.00	$8.00	8.0%

Knowing this sales distribution, it is a straightforward weighted-average exercise to see that the expected profit margin for the entire block will be 8.0 percent. However, when this is done the subsidization becomes camouflaged into the total return. Furthermore, this approach subtly creates the impression that the actual returns would be normally distributed around 8.0 percent (e.g., selling a higher-than-expected concentration of the ultra-profitable cells is just as likely as selling a lower-than-expected concentration).

In order to illustrate the amount and effect of subsidization in a given set of pricing assumptions, consider the following. First, make a table with a row for each pricing cell. Include in the table the profit margin and its underlying components (present value of premium and present value of profits), weighted according to the sales distribution. Then, order the table by profit margin. Finally, add columns that accumulate the premium and profit by row, and calculate the cumulative return (Exhibit C).

It may be easy to sell unprofitable, under-priced cells—the more profitable a cell, the more challenging it will be for the agent to sell his quota. Thus, the reason this exhibit should be ordered by profit margin is because that is the order in which sales would be the easiest to make. Note that the bottom number in the cumulative return column is the 8.0 percent you get from the weighted average of the pricing cells.

When the expected cumulative return is graphed as a function of the cumulative premium, you get a curve named the Subsidization Signature, shown in Exhibit D on page 9.

INTERPRETING THE SUBSIDIZATION SIGNATURE

The subsidization signature illustrates how much subsidization is taking place in order to achieve the 8.0 percent expected return. Hypothetically, if only one pricing cell were to be sold, it would most likely be the 75-year-old female's, resulting in a negative 25 percent profit margin. If one more cell were to be sold, it would likely be 65-year-old female's, resulting in a combined profit margin of a negative 20 percent. Following the line up, if you were to make all of the sales *except* the two most profitable cohorts, the combined profit margin would only be 1 percent—barely breaking even. In order to get the 8 percent profit margin that was hoped for in pricing, you are heavily reliant upon making sufficient sales in the most profitable—and hence least likely—cells.

Of course the real likelihood of achieving the business mix assumed in pricing depends upon how that business mix assumption was made: if your assumed business mix is based upon credible data with a suitable antiselection model and conservative assumptions, then it could actually be quite likely that you'll achieve a favorable business mix. However, as long as subsidization exists, antiselection pressures could persist that may eventually cause things to

shift against you. As William Bluhm said, "antiselection seems to reflect human nature. It's annoying to those who work in this industry, however, because it keeps sneaking up to bite us in the nose when we least expect it."[4] That being the case, and however unlikely it may seem, it is prudent to remain vigilant about how much subsidization is present and what the downside risk is.

By measuring the amount of subsidization this way, you can set up quantifiable objectives to limit the amount of subsidization. For example, you could set the criteria that your pricing structure won't have *any* cells with negative profit expectations. Or, for another example, you could set the criteria that by 75 percent of the cumulative premium, the cumulative return would be equal to the risk-free rate of return.

The previous example of the subsidization signature was based upon the business mix that was assumed in pricing. After a cohort is sold, its expected profits can be re-calculated, and a subsidization signature of the actual business mix can be created. Exhibit E compares the expected subsidization signature with the actual subsidization signature.

In this example, the actual cohort that was sold had fewer sales in the profitable cohorts, and more sales in the unprofitable cohorts, leading to a subsidization signature where the total return builds up to only 1.3 percent. As a minor consolation (with tongue in cheek), because the range of the actual business mix is smaller than the range in the expected business mix, there is less subsidization taking place than was assumed in pricing.

The subsidization signature gives you a framework to assess the sustainability of a proposed rating structure in compliance with the 2000 LTCI Model Regulation. In this example, if failing to sell the most profitable 25 percent of cells assumed in pricing was determined to be moderately adverse experience, then this analysis demonstrates that even with moderately adverse experience the company would still be projected to get a 1 percent profit margin. Furthermore, this gives you a way to speak to the sensitivity of the business mix assumptions in the spirit of ASOP Number 18. In this example, you could say that if you removed the most profitable 10 percent of pricing cells, the profit margin would decrease by 3 percent. ■

Exhibit D: Subsidization Signature

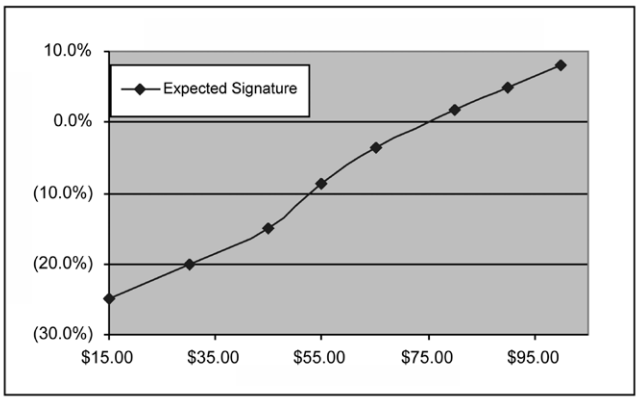
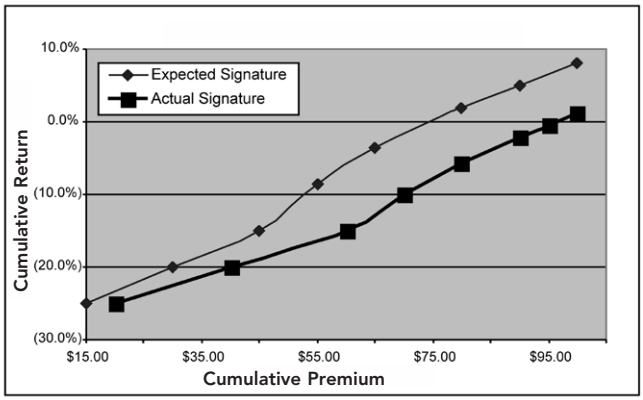


Exhibit E: Subsidization Signature



FOOTNOTES

[1] "Subsidization risk" is sometimes called "distribution risk." See "The Cross-Subsidization Risk" by David N. Wylde in December 2004 *The Messenger* newsletter published by Transamerica Reinsurance *http://www.transamericareinsurance.com/Media/media_associateArticle.aspx?id=184*

[2] William Bluhm, *Individual Health Insurance,* Actex 2007, pg. 83.

[3] This is assuming that each cohort is equally risky. A sophisticated player might determine that some pricing cells are riskier than others and hence are deliberately priced at a higher return to compensate for the higher risk and not to subsidize other cells. If that is the case, then risk-adjusted returns should be used in this analysis.

[4] Ibid

Society of Actuaries

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AG VACARVM/AG 43 Seminar

Tuesday, May 19 and Wednesday, May 20

Jointly sponsored by the Academy and the SOA, this seminar will provide an in–depth discussion of several "hot topics" and specific implementation challenges related to the proposed Principle–Based Approach (PBA) for variable annuity products.

Including presentations focused on technical aspects of implementation and a review of the updated Variable Annuity Practice Note, set to be released in spring 2009, as well as any questions you may have as you work towards the Dec 31 effective dates and updates to C3 Phase II.

Learn more about the Spring meeting and seminars at ***www.soa.org/meeting-and-events.***

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Conflicting Perspectives on LTC Rate Increases

by Larry J. Pfannerstill

Guaranteed Renewable with level premiums anticipated for the life of the policy. Those are provisions included in almost every individual long-term care (LTC) policy contract sold since the early stages of the product. However, it's become common for companies in the industry to recognize that the original anticipation of level premiums throughout the life of the policy cannot always be maintained. Premium rate increases on LTC products have become more common and have brought increased scrutiny to the industry by agents, regulators, current policyholders and potential purchasers.

There has been relatively little discussion of rate increases in trade publications, although everyone involved in the LTC industry is aware that this practice is occurring. So, let's acknowledge the elephant in the room by examining the different viewpoints of three stakeholders in a LTC insurance contract; the insurance company that issued the policy, the policyholder that purchased the policy, and the insurance department that approved and continues to regulate the policy. Each of these stakeholders has very different, and often conflicting, opinions on the appropriateness of rate increases on individual LTC policies. One thing I believe each party would agree on is that when the policy was issued, none of them anticipated that premium rates would increase in the future.

JOE THE POLICYHOLDER

Joe purchased his individual LTC policy back in 1999 at age 60. He was in good health at the time and was issued at a preferred rate. (The insurance company had no underwriting restrictions regarding unique middle names). Joe's comprehensive policy benefits included compound inflation and carried an unlimited, or lifetime benefit maximum. He bought top-of-the-line coverage available at the time and considered himself a responsible person for purchasing coverage for his long-term care needs.

It's now 2009, and just after his 70th birthday, Joe received a notice that his premiums were increasing by 25 percent on the next renewal date. The following thoughts randomly cross his mind:

- I thought the premiums were level for life. Now the insurance company says it can raise my rates! I'm complaining to the insurance commissioner.
- What do I have to show for the 10 years of premiums I paid without collecting any benefits?
- I'm on a fixed income while everything I purchase keeps getting more expensive each year. I'm not sure I can afford to keep paying these premiums.
- The company is offering not to increase my premiums if I reduce my lifetime benefits down to five years. Is that still a valuable benefit to cover my needs?

Joe's situation is hardly unique. Seniors who bought policies years ago are generally less healthy and unlikely to qualify, or even find comparable benefits in the market at a price similar to what they are paying. It's difficult not to feel a level of remorse for policyholders in this tough situation.

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THE DEPARTMENT OF INSURANCE

Protection of the policyholders in their respective state is the utmost priority of the Commissioner of Insurance. Their department is responsible for monitoring the practices of insurance companies to ensure that the companies are compliant with the regulations of the state that were established in the interest of all Joe T. Policyholders. The regulations, in most cases, are based on the National Association of Insurance Commissioners (NAIC) model regulations but with state specific modifications. Joe's policy was issued prior to the state's adoption of the NAIC Rate Stabilization Model Regulation. Therefore, the regulations governing rate increases are likely the same regulations that were used as guidance when the Department originally approved the policy form for sale. These regulations rely on minimum loss ratio standards to prove that proposed premiums are reasonable in relation to benefits.

There is a wide variation of interpretations by states in granting a rate increase based on those regulations. However, there is often additional information the department is forced to consider in the process of evaluating a rate increase filing. For example, Joe's complaint to the insurance commissioner will likely not be the first if the department has approved rate increases on other LTC companies. Based on my discussions with regulators on rate increases filings, most departments are keenly aware of the policyholder complaints that will be generated by a rate increase on LTC policies. This is even more of a significant concern in those cases where the policy form has been granted an increase in the past. Along with policyholder complaints, increased scrutiny on the industry from the media and higher levels of government, including federal, have influences on whether or not rate increase filings are approved. These influences have become more intense over the past few years as the number of companies filing for rate adjustments has increased.

In some states, the maximum percentage increase that can be approved is now limited by regulation. This limitation is viewed by regulators as a method to protect the policyholders from excessive rate increases. If Joe's policy was issued in one of these states, his increase in any one year will be less than or equal to the regulated maximum, but he may receive further increases in subsequent years. The regulations in other states give the commissioner discretionary power to limit rate increases "if the proposed increase is deemed excessive." In summary, the department governing Joe's policy now has multiple factors it must consider when deciding on the appropriate future rate levels, besides the actuarial justification submitted in the rate increase filing. This has been very plainly explained to me in discussions with staff at the department of several states.

THE COMPANY

Looking in a rear view mirror, the industry as a whole did not price appropriately for the risks accepted in the early stages of LTC products. The products were evolving and there was little historical data on which to base assumptions. Right around the turn of the century, companies began to realize that pricing assumptions were not being realized, and the profits were not emerging as expected. Benefit designs were changed, new issue premiums increased and there was a general improvement in risk management through advancements in underwriting selection. This left many companies with an older block of business that was performing below expectations. There are different strategies employed by companies to regain profitability on older LTC policies. Some companies use experience on better performing segments of their business—LTC or other product lines—to offset losses on older LTC policy blocks. Others have used extensive claim management programs to delay or mitigate the need for premium increases. However, the most prudent management decision for some companies was to exercise the contractual provision of the guaranteed renewable

product and increase premiums. Unfortunately for Joe, his company may have tried other options, but they still ultimately increased premiums.

As mentioned in the prior section, there is a wide range between states on the level of acceptance or reluctance on granting rate increases. From the viewpoint of a company that is operating in several states, this can be frustrating for several reasons including the following:

- The company has a contractual right to increase premiums to cover the cost of benefits covered by the policy. As a business, they have a right to earn a profit.
- Insurers have taken on increased and unforeseen risks as long-term care services have evolved since the policies were first issued. An example is the increased use of assisted living facilities.
- Denial of actuarially justified rate increases shifts additional risk to the company without compensation.
- More states are disapproving or severely limiting increases based on seemingly political arguments.

The management teams at companies I am familiar with did not take the decision to increasing premiums rates lightly. They reviewed other financial options, claim management alternatives, and also considered the impact of increases on the policyholders as well as the reputation of the company. I suspect the same decision process goes on in other companies before rate increases are filed.

Companies typically offer alternatives to reduce or eliminate the increase in rates. In Joe's case, the company is offering him the opportunity to continue paying the same premium by reducing the maximum lifetime benefit to five years. This option my also require approval by the state if there is a new rate schedule for the five-year benefit option or other elections. The policyholder has the right to change benefits at any time, but presenting different options to manage the premium level is helpful to all parties at the time of a rate increase. Such a compromise reduces the level of frustration of the policyholder, helps avoid complaints to the department, and reduces the ultimate risk of the company.

Recently, some states are taking additional steps in the interest of protecting their policyholders. Some are requiring the company to offer a paid up benefit if the policyholder lapses, in order for the state to approve a rate increase. This is similar in concept to the NAIC contingent non-forfeiture model, but the implementation is achieved by compromise, rather than by regulation. One state requires that the company offer to roll the policyholder over to a newer product with comparable benefits, that is subject the Rate Stabilization Regulation, commonly referred to as an MAE (Moderately Adverse Experience) regulation. In both scenarios, the company is being required to offer additional benefits and potentially assume greater risk without additional compensation.

MY ADVICE FOR JOE AND OTHERS

In Joe's situation, my advice would be to accept the reduction in the maximum benefit period (or adjust other benefit options) and maintain the current premium level. The five-year benefit is still a valuable long-term care benefit. He will have much greater benefits by maintaining the premiums he has been able to afford in the past, and presumably in the future, than he would by letting the policy lapse and taking the paid up option. However, Joe should be mindful that additional premium increases could happen in the future. The value of 25 percent could be an indication that a higher percentage was originally requested but the full amount was not approved. There may be some indication in the renewal letter he received. There may be additional information on the practices of the company regarding rate increases on other forms. Information can be found on most states' Department of Insurance Web sites. The California Web site below includes all approved rate increases on LTC policies in any state.

http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/ltc-rate-history-guide/index.cfm

Joe's scenario is an example of the rate increase actions that are actually occurring in the LTC market with policies priced prior to the introduction of MAE regulation. In many states, compromises are made in order to gain approval of some level of rate increase, which is usually less than the percentage requested and justified from the viewpoint of the insurer. These compromises may not be in the best long-term interest of the current or future policyholders as they may eventually lead to the need for even higher ultimate rate increases.

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Departments of Insurance must continue to protect their policyholders from abusive practices but also recognize the need to keep LTC companies viable in order to pay future LTC benefits, and approve appropriate premium increases in a timely fashion.

Without some correction, it is easy to visualize the direct progression of the following steps:

1. An insurer unintentionally issuing an underpriced LTC policy.
2. Departments denying, delaying or limiting the needed rate increase.
3. Failure and liquidation of the company.
4. Policyholder benefits being reduced to the limits of each states' guarantee fund.
5. Increased cost to all taxpayers as more long-term care costs are paid by the general funds of each state through Medicaid benefits.

Granted, this is a "doom and gloom" scenario, but it is still a *plausible* scenario. If the private LTC market is to survive, each stakeholder must do their part to support that survival. Companies must first use appropriate, responsible pricing assumptions and effectively monitor their experience. Then, if unforeseen events occur that are beyond "moderately adverse," the company should file rate increases as soon as possible to control the amount of increase needed. Departments of Insurance must continue to protect their policyholders from abusive practices but also recognize the need to keep LTC companies viable in order to pay future LTC benefits, and approve appropriate premium increases in a timely fashion. Blanket denial of rate increases will hurt both the companies and policyholders in the long run.

The industry is challenged with finding a solution to the financial losses attributable to the pricing mistakes of the past. With the current regulatory structure, the options are limited. Unfortunately for all the Joe T. Policyholders, the LTC uninsured population, and the LTC industry, I expect that it will take the failure of one or more LTC companies to gain the attention of our regulators that the current structure is not working. At that time, we in the LTC industry must take up the cause to educate and steer any change in an appropriate direction.

The intent of this article is to spark discussion within the LTC industry regarding rate increases. The opinions expressed or implied, are solely my own based on eight years of filing rate increases for different LTC companies and periodic discussions with staff members at several Departments of Insurance. The opinions are not intended to reflect those of my associates or the companies which I have assisted. ■

A Kind of Quality Assurance

by Brad S. Linder

At this particular time in our global financial crisis, we're looking for ways to restore our collective faith in the underlying financial systems. The abuses uncovered so far have done much to shake our confidence in the systems of checks and balances as well as other protections that are currently in place. A short list of the abuses range from inappropriately underwriting mortgage debt on high-risk clients to the Ponzi investment schemes to paying out super-bonuses to executives whose companies receive TARP money. Even the deaths and sicknesses of the recent salmonella poisoning via the peanut processing demonstrate a pattern of behavior that harms our best interests and shakes our confidences in the food supply. When pundits ask how our collective confidences can be restored in systems that appear to be failing, the answer starts with improving on a kind of quality control. We seek significant improvements in quality controls. Fairness needs to be restored. Further abuses need to be ferreted out. Can we really be assured that a particular job has been done and that it has been done well? We expect a kind of quality assurance.

From the perspective of those of us who work with long-term care (LTC) insurances, I believe that there are a number of things that we can each do to help improve our collective confidences. Consider what happens on your own job. Examine all of your own job responsibilities—both those responsibilities that are stated as well as the unstated ones. Examine if you are actually able to accomplish all of the details of your own job in a timely fashion. That means placing tight controls on any financial numbers you are in contact with or responsible for. How do you know/prove they are right? Do the calculations rely on data that is considered faulty? Does it ever happen that someone gives you information and you are supposed to read and understand, but you don't happen to get to it? Or do you assume that others who get the same information are reading it to pick up and report any mistakes appearing in it? If you rely on others, there is a danger.

Remember that in this day, employers are cutting back on the number of jobs. If the same functions and responsibilities still need to be covered, that means that the surviving employees inherit the responsibilities of those voted off the island. If there is no inheritance of duties, then dangerous results can happen. Loss of experience and technical expertise is bad enough. Loss of monitoring duties is a serious mistake. My best piece of advice to those who are in this situation is to report these facts to your bosses. Document it. Keep a safe copy of that document backed up on your computer network. Report it appropriately.

This article is actually a compliance test with questions designed to generate further discussion on a range of issues. Please remember that there are a number of wonderful people who have a large amount of collective knowledge about LTC. I encourage the newer readers to ask questions of them too. Learn more by entering into discussions with the more knowledgeable people. Ask yourself if there are ways to improve the quality of the job responsibilities you perform.

To illustrate how job cutting affects our industry, consider a real life example of understaffing in an assisted living facility (ALF). The basic example is from an actual nursing home, but I am changing the setting to an ALF because I would like more focus on the consideration of imposed inability to perform activities of daily living (ADL) as a problem for claims adjudication. To proceed, the proper staffing ratio—the nurse to patient (N2P) ratio—is unique for each ALF. Indeed, that N2P ratio is unique to each wing of the ALF. Often, cognitively impaired patients are grouped together and they require different care levels and monitoring. Therefore, it's easy to see that the N2P ratio is made up of a number of different factors that the administration staff monitors. Those factors include the type of care at the time that care is needed by the ALF residents. They also include the type of care able to be provided in the ALF by the trained staff. Please remember that there is a distinct shortage of care providers in a number of areas in this country. And, it is important to note that the job burnout rate for the care providers in an ALF (and nursing homes) is rather high.

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It might be fair to say that there has already been a serious shortage of care providers in the LTC industry. That being said, we ask the question of what happens when that N2P ratio drops. As the ratio drops, the wait time for needed care services increases. Yet, those services still need to be provided. Let us focus on the resulting effects on toileting since that area appears to be one of the simplest ways to compensate for staffing cuts. Examine the effect on the aspect of being able to self-toilet. If the individual starts out with only the inability to walk to the toilet or that they have become a slower un-dresser, then the increased wait times would cause more toileting accidents to happen. To combat this extra work, the remaining nursing staff depends on absorbent undergarments. Certainly, there's a lot less time-critical work involved by having the residents wear these simple undergarments. Unfortunately, it forces a resident to rely on using the undergarments when they can actually maintain control over their bodily function. By virtue of the understaffing, the staff cannot help all of the residents needing to use the restroom on a timely basis. Despite the complaints of the resident, a resident is taught to rely on the new method of using the undergarments. A resident must wait to use the restroom. And, you would expect that for the resident their inability to perform an ADL count increases automatically by two. Neither the resident nor the nursing staff is at fault for this unfavorable result. Is this a true observation? If the resident didn't previously qualify for benefits in their LTC policy, they probably would appear to now. So, as an insurer of that LTC policy, do you pay benefits or deny benefits? Is the answer documented as a written procedure in the insurer's claims adjudication manual? Why or why not?

Compliance audits should be used as an ongoing tool to test for quality and provide assurance that procedures are followed as expected.

USING THE COMPLIANCE DEPARTMENT AS A QUALITY ASSURANCE TOOL

It used to be that when someone uttered the word compliance in a crowd, there were a lot of different reactions. Imagine back in the 1990s, a world where the reaction was mostly negative. Compliance was viewed as impeding the ability to do business. When compliance found that there was a rule that needed to be followed, a procedure that needed to be changed, the correction was viewed as personal tarnish against the area-manager affected.

Compliance audits should be used as an ongoing tool to test for quality and provide assurance that procedures are followed as expected. Not just a financial audit nor just an internal audit, they are designed to also directly test elements of complying with each and every one of the state insurance laws and requirements that the insurer does business in. Most of the states contain a simple compliance certification that appears in the policy form filings documents. That certification process clearly states that the signatory is responsible for and has knowledge of the underlying state rules, regulations and statutes as they apply to the subject LTC insurance. It's interesting to note that there are a lot of different LTC requirements that do vary by state.

So, ask yourself what you would do if you found that the LTC policy language does not match the procedures you are following? What do you do?

Compliance audits should be routine. The time periods for the routine should be explicitly defined for everyone. If there are available resources, the compliance audits should be cycling through each of the states' requirements. They should positively confirm where procedures are being handled correctly. If they happen to find something wrong or incorrect, it is good to get it corrected. Understanding and correcting what went wrong is always an opportunity to improve the quality of the procedures. Improving quality assurances is a major strength possible for any compliance department.

WHERE CAN WE LOOK?

Since I have seen and reviewed a large number of LTC policy forms, rate filings, and actuarial memoranda, I have often been asked what are the most common areas of LTC for the language to mismatch actual practice and mismatch what has been priced. I know that my understanding of these (and all of the other) policy provisions are a great way to improve on the quality assurance of what I do. I encourage each of you to find out more about policy language and statutory requirements! My list of areas where I find the most problems are:

1. *The Inflation Protection Options.* OK, everyone should first understand the basic idea of the required offer of the 5 percent Compound Inflation Option. The intent is to have a meaningful increase to the underlying available LTC benefits. The benefits get increased by 5 percent each year. Sure, that means that you have to manage on-anniversary increases to benefits as well as the normal billing for premium. No,

billing for premium should not be changing for this inflation option. It is priced as a part of a levelized premium product package. I use the term levelized carefully because it is meant to describe the calculation method where the premium is intended to provide for the benefits over the life of the policy. It's possible to have the intended premium-paying period of the policy shorter than the life of the policy. By way of another common example, the idea is similar to a whole life insurance policy where there is a serious amount of prefunding that is set up for future benefits. The prohibited term level-premium policy is considered misleading to consumers because of the implication of never needing a rate increase.

If the contract has a pool of available benefits, make sure that the daily benefit maximums are not the only element to increase. If the policy has a pool of days available, make sure the value of those days increases. Mismatches in contract language versus company procedures versus the actuarial memorandum have occurred. Keep a very clear understanding of the financial elements that get incremented in your electronic census listings (master files). It is critical that the claim files are completely accurate to the policy language. Companies have chosen from two very distinctly different ways to keep track of these options when policy benefits are paid out. Method 1 is the bank account method, where the policy terminates when the bank account first hits a zero balance. Method 2 is the hit-the-limit method, where the policy terminates when the limit for the total benefits payable equals the total benefits actually paid. The correct method for a given policy is only the one that exactly matches the claimant policyholder's contractual language. Would you consider other language correct?

Other inflation options have additional concerns. Simple interest versus compound interest? Three percent versus 5 percent versus CPI indexed inflation offers? Inflation addition offers could be timed to a particular policy duration—which does not have to be consecutive policy years. Those offers could be offered up to a certain cutoff attained age, or offered up until a certain number of refusals of the offers. The offers of inflation additions usually come with an increased premium price tag. Therefore, there's a need to make sure the billing dates, the premium, the coverage issue dates are all monitored.

It's easy to see that the increased complexity adds to the possibility of errors, and hence the need for excellent quality assurance. If you have found an error in how inflation is handled, can you get it corrected easily?

2. *Return of Premium (RoP) Options.* These are complex options that are most often trigger-based upon the death of a named insured. However, some companies have designs that are based upon survival of the insured. RoP may have an offset based upon claims already paid under the contract. Also, the stated return of premium percentage may decrease as the policy duration increases. Be careful to spot that an RoP claim should be hitting a claim account and not reversing entries in any premium account! It can be surprisingly common for non-LTC savvy folks to misunderstand this particular point.

3. *Restoration of Benefits (RoB).* These provisions reset the available policy benefits. There needs to be clear guidelines in the claim administration procedures that include verifications. Be watchful of claimant apparent recoveries just before benefits run out. The RoB reset is a significant temptation.

4. *Benefit Eligibility.* Understanding of the benefit triggers is a source of confusion, particularly

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at the time of claim. And, if a care plan document is required, then the document had best be a part of the claim file. If requiring the document is waived for any reason, there had best be documented written reasons matching the claim administration written procedures that allow the waiver.

5. *Waiver of Premium (WoP).* The complexity of this provision comes from when the provision triggers on as well as when it shuts off. While some companies use only generic language like, "… waive premium on a monthly basis," the provision usually needs to describe how premiums are due to be paid when the provision turns off. If it's pro rata, those details need to be stated. If it's going to change the billing mode to a monthly billing, it needs to be stated. It is very important that the consumer know how much and when that premium is due to be paid—particularly when they have just recovered from a claim!

   If the contractual language waives the modal periodic premium as they fall due, it may be easier to administer, but it has anti-selective possibilities. Your claim management system needs to monitor claims as they approach what would be the next premium due dates. Temptations depend on mode, but they still increase the closer to due date it is.

6. *The 60-days Limit of Back Premium for Reinstatements on Levelized Premium Contracts.* When I first saw this as a provision in an LTC contract, I questioned why this was included in the sample contracts. It did not make financial sense. A reinstatement is supposed to return to policy to the point as if there was not a lapse. For a contract that has a serious pre-funding of benefits, the restriction makes no sense. I know of two regulatory provisions—one in Georgia and one in Pennsylvania—that are pointed to as part of the LTC policy form filing gauntlet that companies are tested on. The last time I researched these two states' requirements, they were both not applicable to LTC insurances designed as I've stated. And, it makes no sense to not collect that back premium.

   To correct this flaw, make sure that the written procedures clearly state that no reinstatements will be made beyond that 60 days window. Caution: please note that there is a separate provision appearing on some LTC contracts for a six-month automatic reinstatement window for those insureds who are demonstrably cognitively impaired. Do not confuse these two different provisions! Writing a procedure for just the former provision might accidentally cause a problem when complying with the latter provision.

7. *Rate Increases.* Are the increases made by state-of-issue or are they to be made according to the current state-of-residence of the policy holder? Some contracts have made this language very explicit as to which rule is followed. So have some states! If the LTC contract is not explicit, what is correct? If your company has filed for an LTC rate increase, did it explicitly detail which method to follow in the filing to the insurance department(s)? If the method is not stated, are the insurance departments expecting insurers to apply rate increases in a particular way? Why?

If your company has filed for an LTC rate increase, did it explicitly detail which method to follow in the filing to the insurance department(s)?

In summary, there are a number of areas where WE can impact quality assurances. Don't assume that there is nothing wrong in areas previously thought to be OK. Substantial back checking should be made in all areas. If you think that it is someone else's job to check on it, that's actually a point where errors happen. Remember the bottom line, the people whom we serve depend on us to get it all right! We can't do it all by ourselves, but we—all of us—can help. ■

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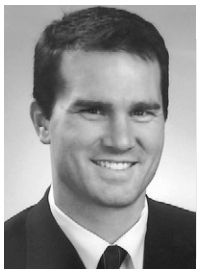
Principle-Based Reserves and LTC Insurance Innovation

by Al Schmitz



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Is a principle-based approach to reserves for Long-Term Care (LTC) insurance getting closer to reality? Discussion and analysis of principle-based reserves for LTC has been going on for some time. The Academy of Actuaries Long-Term Care Principle-Based Work Group (LTCPB Work Group) has been around since 2005. While the movement toward principle-based reserves for LTC has been relatively slow, it may start to accelerate and be pulled along as the life insurance industry gets closer to implementing principle-based reserves.

As the LTC insurance industry looks to develop (or gets pulled into developing) an innovative approach to reserves, it would do well to recall past innovations in the evolution of LTC insurance. While innovation often comes from the nearest adjacent space—in this case, other product lines—care must be taken since the nearest adjacent space can sometimes lead down the wrong path.

In LTC insurance, the nearest adjacent space has not always led to positive innovation, and as a result, the industry has sometimes had to learn the best avenue for its product the hard way.

For example, early LTC products used the nursing home eligibility definition from the adjacent Medicare space that included a three-day prior hospitalization requirement. It was not until much later that this was determined to be an ineffective and overly restrictive approach. Another example is lapse rates. Early lapse assumptions were taken from experience with other life and health products. However, in the United States, lapse supported products did not exist and the nearest adjacent space mislead pricing actuaries. Interestingly though, the Canadian product term life to 100, was lapse supported and would have provided a better benchmark to develop LTC insurance lapse assumptions. Yet another example of following the lead from another product was some carriers' cavalier treatment of LTC insurance to be like an inflationary health product that is expected to have increases. There was inconsistency in the industry as to how LTC should be priced and managed—at least until rate stabilization was passed.

Other adjacent spaces have and will continue to define LTC insurance. Items such as investment income strategy, shared care (first-to-die life), and combination products that link LTC with life and annuities all borrow ideas from other product lines. However, as we have learned along the way, LTC insurance can be a unique animal and approaches and innovations need to be well thought out and tailored to the unique aspects of the LTC insurance product.

So it goes with applying principle-based reserves to LTC insurance. While life and annuities are relatively far down the path toward principle based reserves, LTC insurance is still determining the best path to take. What can we learn from life and annuities—the nearest adjacent space—to appropriately and effectively apply principle-based reserves to LTC?

PRINCIPLE-BASED RESERVES

What are principle-based reserves? Principle-based reserves, or more broadly, a principle-based approach (PBA) is an effort to create a new framework for reserves and capital for U.S. life insurers. The American Academy of Actuaries (Academy), particularly within the Life and Health Practice Councils, has several work groups dedicated to this charge and has been working closely with the National Association of Insurance Commissioners (NAIC) and the industry to bring the project to fruition. The life insurance and annuity product lines have been leading the charge on PBA, followed closely by health and financial reporting practice areas.

PBA is based upon a conceptual framework published by the Academy's Life Practice Council in March 2007 and then updated by the Academy's Life Consistency Work Group (CWG) in September 2007.[1] This framework, taken from the updated CWG document, is as follows:

*A **Principle-Based Approach** of statutory Risk-Based Capital and minimum contract/policy reserve requirements for Life, Health and Annuity products incorporates the following common statements when considered together and not in isolation from one another. Further, these statements should be interpreted in the context of the value being calculated (i.e., reserve or RBC component).*

1. *Captures the benefits and guarantees associated with the contracts and their identifiable, quantifiable and material risks, including the 'tail risk' associated with the contracts, and the funding of those risks.*

2. *Utilizes risk analysis and risk management techniques to quantify the risks and is guided by the evolving practice and expanding knowledge in the measurement and management of risk. This may include, to the extent required by an appropriate assessment of the underlying risks, stochastic models or other means of analysis that properly reflect the risks of the underlying contracts.*

3. *Incorporates assumptions, risk analysis methods and models and management techniques that are consistent with, those utilized within the company's overall risk assessment process. The inclusion of the risk analysis methods and models should consider the original purpose of that analysis. Risk and risk factors explicitly or implicitly included in the company's risk assessment and evaluation processes will be included in the risk analysis and cash flow models used in the PBA. Examples of company risk assessment processes may include economic valuations, internal capital allocation models, experience analysis, asset adequacy testing, GAAP valuation and pricing.*

4. *Utilizes company experience, based on the availability of relevant company data and its degree of credibility, to establish assumptions for risks over which the company has some degree of control or influence.*

5. *Incorporates assumptions that, when viewed in the aggregate, reflect an appropriate level of conservatism and, together with the methods utilized, recognize the solvency objective of statutory reporting.*

6. *Reflects risks and risk factors in the calculation of the PBA minimum statutory reserves and statutory RBC that may be different from one another and may change over time as products and risk measurement techniques evolve, both in a general sense and within the company's risk management processes.*

This framework for PBA will continue to evolve and move forward. PBA will drive insurers to analyze their future liabilities in greater detail (and with more freedom) than before which ultimately give better protection for the insurer and their customers.

Recent discussions surrounding the PBA framework for life insurance include a floor reserve definition, and the use of a common set of interest rate scenarios (rather than allowing each company to generate and use their own) to be used for PBA calculations.

PRINCIPLE-BASED RESERVES FOR LTC INSURANCE

While the NAIC's PBA initiative has focused primarily upon life insurance and annuities, it is expected to eventually include health (including LTC) and property/casualty products. The Academy's LTCPB Work Group is monitoring and responding to regulatory developments with respect to reserve regulations, with a goal of ensuring that any changes made include reasonable accommodations for LTC products.

In addition to monitoring the progress at the NAIC, the LTCPB Work Group has been making progress in an effort to address how PBA will work for LTC. Key discussions and issues addressed by the subgroups include:

1. Discussion on stochastic review.
The LTCPB Work Group has discussed which variables should be reviewed stochastically for LTC. In contrast to life products, many of the LTC liability assumptions, including morbidity and mortality, should be analyzed stochastically. The life/annuity work to date applies stochastic modeling to interest rates and equity returns only. Different approaches to developing an LTC model that handles liability assumptions on a stochastic basis have been analyzed. The Work Group has settled on one approach to be used in a model prototype.

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2. Address potential premium rate increases. The LTCPB Work Group has decided to address the potential for including future premium rate increases in the modeling of future LTC cash flow. Rate adjustments are part of the product risk profile, and therefore, the capability to model this contingency is needed. Determining what premium rate increase levels, if any, should be reflected in PBA will require significant modeling analysis and open discussions with all interested parties, including the NAIC.

3. The need for a standardized morbidity table. Currently, LTC insurance does not have a standardized morbidity table. Such a table may prove to be important, as movement is made towards developing appropriate benchmarks. It would also be vital in providing a baseline for companies that do not have credible experience to develop their own assumptions. To date, the life insurance working groups involved with principle-based approaches have struggled to develop a reasonable method for recognizing company mortality experience to the extent it is relevant and credible, while satisfying regulator concerns regarding auditability.

An update of the progress of the LTCPB Work Group was presented at the December 2008 NAIC meeting. The update included a discussion of the above items and other issues surrounding LTC under PBA, including a discussion of the stochastic modeling approach to LTC. Regulators at the meeting reacted very favorably to the direction of the work group, noting the importance of the work and encouraging continued progress.

The potential implications of a PBA for LTC are far reaching. It will not only influence reserves, but also product development, pricing and strategic decisions.

WHAT CAN INSURERS DO TO PREPARE?

What will PBA do to the LTC insurance product? Will it increase reserves, decrease reserves, and/or do as its name suggests and result in a more appropriate principle-based approach? The answer is unknown and may vary from company to company and depend on upcoming decisions with respect to the framework of PBA for LTC. Many of the innovations with respect to PBA for LTC may be drawn from the adjacent spaces of life and annuity products, or be influenced by International Accounting Standards. It will be important to analyze these innovations with respect to the resulting implications for LTC to ensure effective innovation. Three important steps LTC insurers should take toward this end include:

1) Ensure experience analysis systems are in place to monitor results. Currently, for reserve calculations, companies generally use their own assumptions of morbidity and persistency assumptions based on either their own data, data from reinsurers and consultants, or some combination thereof. Under a PBA regime, the use of a company's own data will become even more critical as it may potentially influence the reserve calculation more directly.

2) Review the company's position with respect to actuarial projection systems. The basic framework of PBA as adapted by Academy's Life CWG requires utilization of "risk analysis and risk management techniques to quantify the risks and is guided by the evolving practice and expanding knowledge in the measurement and management of risk." A company's ability to effectively implement risk management techniques and PBA in general can be enhanced by the actuarial projection systems.

3) Monitor and participate in the ongoing discussions of PBA and its potential implications for LTC. While implementation of PBA for LTC may be years away, critical intermediate decisions are being made today. Important issues and questions are being discussed and addressed by the Academy's LTCPB Work Group. These discussions and resulting opinions have the potential to leave lasting implications on LTC reserves. Updates of progress can be found on the Academy[2] and NAIC[3] Web sites.

The potential implications of a PBA for LTC are far-reaching. It will not only influence reserves, but also product development, pricing and strategic decisions. Your increased participation and awareness in the development of a PBA framework for LTC will help ensure that careful consideration is given to the future implications for LTC. This will ensure that innovations created by adapting ideas and approaches from other product lines will result in the best long-term course of action for LTC. ■

FOOTNOTES

[1] The Academy's Life Consistency Work Group report to the NAIC's Life and Health Actuarial Task Force, dated Sept. 5, 2007. *http://www.actuary.org/pdf/life/consistency_sept07.pdf*

[2] *http://www.actuary.org/*

[3] *http://www.naic.org/*

Unfair Discrimination and Individual Health Policies

by David J. Hippen

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Zeno, ancient Greek genius, is credited with creating calculus. According to history, he began by realizing that to travel from point A to point B, one must first cover half the distance. He then realized that one must travel half of that (1/4), and half of that (1/8), and so on to infinity.

Legend says that Zeno carried his logic a bit too far. Awakening one morning, he realized that to reach the door from his bed, he must first traverse half the distance, but first must get halfway there, and so on to infinity. He reasoned that motion is therefore impossible, and died in bed.

We actuaries must also guard against extrapolations that extend to infinity without considering the consequences. If we aren't careful, others might sense nonsense instead of wisdom, and stop listening to us. (My wife does that to me on occasion.)

Many Medicare Supplement (Med Supp) and long-term care (LTC) policies offer a discount for married couples, partners or multiple-resident households. Claims seem lower for couples living together. This lower claims rate could be due to living together (i.e., caring for one another), or could also be affected by gender mix.

In both, most rates are unisex. Some carriers report more single sales are to females, which might make claims rates higher (at least on LTC). Most couples include one of each gender, so gender might be a contributing factor to lower rates for couples.

In 1980, the American Academy of Actuaries issued "Statement 1980-19: Risk Classification Statement of Principles." This became the basis for Actuarial Standard of Practice 12 (ASOP 12—which did not supersede Statement 1980-19). ASOP 12 is the professional standard on risk classification for all practicing actuaries.

State laws all define unfair discrimination and rebates. ASOP 12 reinforces those laws by guiding actuaries to charge equal rates for insureds in the same class. Market conduct examiners and consumer services reps are often the only state watchdogs for these laws, because it is difficult to catch in policy filings or financial exams.

Therefore, actuaries are generally considered the guardians of risk classification. Because actuarial standards are self-administered, appropriate administration of actuarial principles is largely dependent upon the rating actuary's integrity in adhering to professional actuarial principles. The Code of Professional Conduct requires, "An Actuary shall not provide Actuarial Services for any Principal if the Actuary has reason to believe that such services may be used to violate or evade the Law."*

Suppose ABC Co. offers to sell Joe a Med Supp policy at a discount, but will only give Joe the discount if his wife Jane also buys an ABC Med Supp policy. If Joe's wife is only 60, or already has a policy from another company, she doesn't need it, so she doesn't buy. This doesn't change Joe's risk; Joe is cheated out of the discount.

To increase the likelihood that Joe and Jane will be able to care for each other, some carriers require that both pass underwriting before Joe gets the discount, which seems acceptable if the carrier doesn't require both to buy individual contracts. Other carriers only offer the discount if both buy individual policies from the same company, which seems unfair. Some cancel the discount on the remaining policy if one policy is terminated, which seems to be inappropriately re-underwriting the risk.

In addition, suppose the company barely meets the 65 percent loss ratio requirement (including those who get the discount). They don't meet 65 percent for the nondiscounted class. Married people whose spouses don't buy a policy are charged excessive rates.

Suppose Jane initially buys a policy, so Joe gets the discount. If Jane later decides to drop it, Joe might lose the discount. Despite the entire contract provision, Joe's contract has been improperly changed by changes in Jane's individual contract.

In addition, the discount could be a rebate, an illegal inducement for Joe to buy a policy. It might even be characterized as an improper agent's commission to (unlicensed) Jane, as she would be enlisted in the effort to sell the coverage to Joe. She would be paid via the discount on her policy.

If married people should get a discount, then Joe should. It shouldn't matter whether his wife buys from the same company. We need to protect Joe's rights.

Discounts to individual insureds are not appropriate on individual forms unless the (legal) discount is based upon the reduced risk of that individual. It should not be based upon application for, issuance or continuance of a policy on a second person. If credible actuarial data indicates a reduced risk, discounts seem acceptable on joint policies, or on individual policies where the living arrangement, e.g., marriage, reduces the risk.

The Long-Term Care Model Regulation requires an actuarial certification: "A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits."** This implies that only reasonable differences in benefits are acceptable as justification for a difference in premium rates for equal risks.

Some insurers discount rates for individual long-term care or Medicare supplement policies for individuals who are employed by the same employer, or are part of an association, or can be list-billed. The discounts are commonly described as due to commission, expense and/or processing savings. Differences in expenses and/or commissions cannot be used to justify differences in individual insurance rates. That would be unfairly discriminatory and illegal.

If the same individual applied for the same contract directly, e.g., through an agent, the rate for the same benefits would be higher. Changing the purchase source does not change the hazard. The discount is a rebate resulting in unlawful unfair discrimination.

Charging different rates for the same coverage is unfair discrimination. Unfair discrimination under the Unfair Trade Practices Act is based upon actuarial risk classes. An individual with the same risk factors must be charged the same for the same benefits.

"Unfair discrimination" [NAIC Model Unfair Trade Practices Act, Section 4.G.]

> (2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

State insurance departments don't often check for potential unfair discrimination when they review rates. Some don't want to reject a filing on that basis, and market conduct exams often ignore such issues. People who get discounts almost never complain, and those who miss out on discounts usually don't know they're available.

Insurance regulators have largely relied upon actuaries to determine appropriate actuarial risk classes. Attorneys are often uncomfortable venturing into this actuarial arena, or arbitrating actuarial arguments. Actuarial professionalism and adherence to Actuarial Standards of Practice should suffice to appropriately administer the law.

Besides unfair discrimination, basing the discount on application, issuance or continuation of another individual contract conflicts with the entire con-

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tract provision. It also creates separate rate classes. Minimum loss ratios must be met, which could be impossible for both rate classes while keeping the original discount percentage.

Company commission or expense savings are no defense to unfair discrimination. Class of risk depends upon the insured's tendency to incur losses, not the risk that the carrier will have higher costs. Company expenses have no effect on the insured's risk of loss, so they can't switch people to different risk classes.

If you drive 75 in a 65 zone, even if a police officer has you on radar but doesn't stop you, it's still breaking the law. Drivers can't presume that not getting a ticket means it's legal. Actuaries are required to abide by the law, whether or not a regulator catches it.

People who lose due to unfair discrimination pay extra premiums even though they're buying the same insurance. If the carrier charges them more, buyers are often unaware that they're being cheated, and usually feel powerless to stop it. Actuaries must take responsibility for assuring that premium-paying policyholders are fairly treated.

If actuaries don't rely upon facts instead of appearances, and demonstrations instead of impressions, others might stop relying upon us. Actions taken on race-based pricing, credit scoring, and community rating have at times resulted from actuarial arguments not being sufficiently supported by fact (even when they could have been). If attorneys are handed the job of determining and defining unfair discrimination, all actuaries will lose. ■

This article represents my personal observations, and not the position of my employer.

* Code of Professional Conduct, Professional Integrity, PRECEPT 1.ANNOTATION 1-2., Effective 1/1/01

** NAIC Long-Term Care Insurance Model Regulation, Section 10.B.(2)(e)(i)

Equitable Discrimination and Long-Term Care Insurance

by Bruce A. Stahl

The speedometer on my 12-year-old Beemer has not worked regularly for a couple of years. Sometimes it works fine, and sometimes it swings from 0 to 120 mph and back within half of a second, and may lock at either 0 or 120. Two dealerships could not repeat the problem in the shop, and it would have been costly in terms of time and money just to have the problem identified. While I do not always have the benefit of a speedometer, I can still drive safely. Rather than spend a large sum of time and money, I drive with the flow of traffic.

Often actuaries do not always have a speedometer to help them with risk classifications. In order to classify risk characteristics safely, actuaries can follow the flow of traffic by following Actuarial Standard of Practice (ASOP) #12, Risk Classification.

The first paragraph of ASOP #12 provides the ASOP's purpose. "This actuarial standard of practice (ASOP) provides boundaries to actuaries when performing professional services with respect to designing, reviewing, or changing risk classification systems." Pricing or certifying rates may involve all three, "designing, reviewing, or changing risk classification systems." Yet, in my opinion, pricing or certifying rates *requires* one—reviewing the systems. My opinion is based upon language in the Scope of ASOP #12. "Risk classification can affect and be affected by many actuarial activities, such as the setting of rates. …" and "This standard also applies to actuaries when performing such activities to the extent that such activities directly or indirectly are likely to have a material effect, in the actuary's professional judgment, on the intended purpose or expected outcome of the risk classification system."

Section 3.2.1 of ASOP #12 helps us understand how rate classifications may be reviewed. "Rates within a risk classification system would be considered equitable if differences in rates reflect material differences in expected cost for risk characteristics."

In an environment where the actuary knows all of the relationships within or among a multitude of risk characteristics, it may be possible to price with every possible risk characteristic in mind. Yet the pricing or certifying actuary generally finds that such an environment is merely a future hope, and not yet a present reality.

The Rate Classification ASOP, #12, again recognizes that the actuary does not always have a speedometer, and provides further guidance to the actuary. Four relevant examples:

1. *"Objectivity.* The actuary should select risk characteristics that are capable of being objectively determined."
2. *"Practicality.* The actuary's selection of a risk characteristic should reflect tradeoffs between practical and other relevant considerations." Such considerations may include "the cost, time, and effort needed to evaluate the risk characteristic."
3. *"Industry Practices.* When selecting risk characteristics, the actuary should consider usual and customary risk classification practices for the type of … system under consideration."
4. *"Business Practices.* When selecting risk characteristics, the actuary should consider limitations created by business practices related to the … system."

When the pricing or certifying actuary heeds the standard of practice, it keeps him from exceeding the speed limit. For example, the actuary may consider whether a married applicant, applying without the spouse, should be classified the same for setting premium rates as a married applicant applying with his spouse. For long-term care insurance, an actuary may have followed any of the four items above in deciding against doing so. Objectively, the impact from the presence of a spouse in insured experience is often only known when both apply and are issued coverage. Practically, it is costly and difficult to underwrite a spouse who does not apply for coverage. And for many years, industry and

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business practices have been contrary to classifying business based merely upon being married, and to do so would require that an actuary alter the system rather than classify risk characteristics according to the existing system.

ASOP #12 also provides actuarial considerations when establishing risk classes. They include Adverse Selection and Credibility. Using the same example of the married applicant applying without the spouse, the *credible* insured experience has generally been from married individuals who applied together, relative to single individuals and to married individuals who did not apply with their spouse (think objectivity again). The historical data has generally not been identified otherwise (think business practices again.) Furthermore, actuaries have generally not believed the industry practice of granting discounts to spouses to be antiselective. To the contrary, granting a discount to spouses separately may encourage adverse selection.

However, if charging a different premium rate is contrary to statute or regulation, the Actuarial Standards of Practice is not the actuary's standard. Rather, the statute or regulation is.

Similarly, members of a particular association or individuals who are list-billed may actually be part of a different morbidity risk classification, simply because the members of the association, or individuals associated enough to be list-billed, may have characteristics that make them less costly risks. For example, they may tend to have social activities of some kind, and perhaps this implies a way of life that makes the participants less apt to need or seek benefits.

Yet, even if there were no difference in the morbidity risk in association discounting, there is certainly a demonstrable difference in the cost of distributing or administering the business. The objectivity of the category is clear from an expense standpoint. ASOP #12 says, "Rates within a risk classification system would be considered equitable if differences in rates reflect material differences in expected cost for risk characteristics." It defines Risk Classification System as, "A system used to assign risks to groups based upon the expected cost or benefit of the coverage or services provided." Smaller distribution expenses contribute to a different expected cost.

However, if charging a different premium rate is contrary to statute or regulation, the Actuarial Standards of Practice is not the actuary's standard. Rather, the statute or regulation is.

Pricing or rate-certifying actuaries should be familiar with the NAIC model act on Unfair Trade Practices. This model act defines unfair trade practices as consciously disregarding or frequently "making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner."

The definition refers to "unfair discrimination between individuals of the same class and of essentially the same hazard." If the definition referred only to the latter, individuals of essentially the same hazard, an insurer might not legally charge different premium rates for policies which provide the same benefits. Yet the definition did not isolate the hazard, but specifically included the notion of the "same class." In so doing, the regulation refers us back to the concept of risk classifications, and the actuaries to their standard of practice, ASOP #12.

The model act on Unfair Trade Practices appears to have been designed with the confidence that actuaries will be able to drive the pricing and rate certification processes without a speedometer, without being able to precisely measure all the risks. In other words, the model act seems to anticipate that actuaries will heed ASOP #12. Therefore, the act seems to maintain ASOP #12 as the standard. Those who satisfy the principles of credibility, avoidance of adverse selection, objectivity, and practicality, all within the limitations of business and industry practices, should be driving below the maximum speed, setting risk classifications within the boundaries of the state regulations and laws. ■

ASOPs and Unfair Discrimination

by David J. Hippen

Actuarial Standards of Practice (ASOPs) provide principles in broad terms to leave liberal leeway for actuaries operating under those standards. In contrast, The Code of Professional Conduct requires, "An Actuary shall not provide Actuarial Services for any Principal if the Actuary has reason to believe that such services may be used to violate or evade the Law." Each actuary is individually responsible for all services provided—regardless of the "flow of traffic," ignorance of the law is no excuse.

When the law addresses classes of risks, it is talking about the risk of loss to the insured, not the carrier. Risk classes must be developed indifferent to the carrier's costs and commissions. Actuaries must be able to defend risk classes according to the risk of the insured's loss, based upon statistical evidence and sound actuarial judgment.

Sales, marketing and underwriting folks aren't bound by—and often aren't aware of—actuarial standards. Actuaries often provide services for them and naturally want to give the best service possible. That sometimes means not giving them everything they want.

I recently discussed marital discounts with the actuary from a large LTC insurer who signed the rate demonstration. His company wanted to only discount a married person's individual policy if the spouse also bought a policy. When I asked why the insurer didn't simply issue joint policies with a two-person rate, his response was interesting.

He said the carrier sold joint policies in the past, but agents complained that they would rather sell individual policies. He reported they could more easily sell to the wife, and then solicit her help in persuading her husband that they could both get a discount if the husband would buy one. This ploy is reflective of Eden's snake, who got Eve to bite the apple first, then had her talk Adam into sharing her fate.

Actuaries who claim that the married two-policy stats are sufficient to justify higher rates for one-policy marrieds may make marketers merry, but might overlook major flaws in that argument. Some have opined that the non-buying spouse is likely a poorer risk. This conflicts with the time-honored and experience-supported principle of anti-selection.

Those who buy are more likely to anticipate higher claims, not less. Further, it would be virtually impossible to demonstrate that the nonbuyers are worse risks, as nobody gathers statistics on the uninsured spouses. Actuaries should be suspicious of serpentine suppositions that support sales instead of ASOPs and Professional Conduct. ■

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Highlights of the 9th Annual ILTCI Conference

by Sandra Latham

Sandra Latham is the chief administrative officer and a principal at LTCI Partners, LLC. As an active member in the ILTCI Conference, she has been the Operations Track chair and co-chair. Most recently, Latham has served as the conference co-chair and this year's chairperson. She can be reached at *Sandra.Latham@LTCIPartners.com*.

The 9th Annual ILTCI Conference was held in Reno, Nev., March 29-April 1, 2009. The event was kicked off by keynote speaker, Dan Buettner. Buettner is a worldwide explorer, *National Geographic* writer and *New York Times* best-selling author. He has unlocked some of the secrets to living younger and better and has led the teams that found the longest-lived pockets in the world, called Blue Zones.

Following are the tracks at the conference and highlights from the various sessions.

ACTUARIAL TRACK

Chair: Peter Sutton
Co-Chair: Laurel Kastrup

This track focused on stochastic pricing, product viability, litigation, experience analysis, projections, in force risk management and the value of the product. "Advanced Topics in Actuarial Pricing" highlighted trends in mortality and claims continuance, and also showed how stochastic pricing models can provide additional insight into effects of assumption variability. "Can LTCI Really Work?" emphasized learning from the past to overcome a tarnished reputation. Speakers focused on trends in claims, consumer satisfaction, company stability, regulatory oversight, the financial resources required and the failure of current systems. "Ask an Actuary" addressed morbidity and mortality improvement, rate increases and premium rate subsidization. "Litigation/Compliance" provided examples of court cases; the legal process, emphasizing actuarial roles and professional conduct were discussed. "Experience Analysis & Future Expectations" highlighted how financial statement forecasts change as business mix, lapse and morbidity unfold. Experience analysis as a process was reviewed, highlighting the need to ask appropriate questions and collaborate with other business professionals to form a support network. "Enterprise Risk Management" emphasized the need to manage claims and map out investment plans. The final session reviewed the growing need, wellness and disease management, payment models and the role of government.

CLAIMS TRACK

Chair: Lane Kent

The Claims Track sessions were well attended. "Assessing Benefit Eligibility" described best practices for initial assessment of benefit eligibility and the necessary requirement gathering. "Managing Independent Providers" discussed the challenges associated with using independent providers and the effect of state mandates. The "Dementia" session was rated as outstanding as the panelists volleyed the discussion of operational metrics and clinical progression back and forth. This dynamic created interactive discussions as case studies were reviewed. "Addressing Claims Fraud" reviewed tips for investigating suspicious activity and how to get results and report claims fraud.

COMPLIANCE TRACK

Chair: Karen Smyth

"Trial by Jury" was entertaining and educational, featuring a mock trial with a claimant suing her insurance company. The "jurors" learned the value of aligning marketing material with contract language, agent training and claim procedures. "Emerging Challenges & Solutions in Implementing Partnerships" identified key challenges in implementing state partnership programs. The speakers examined opportunities for bridging gaps with state regulators. "LTC & the Elderly—the Legal and Regulatory Landscape" discussed the scrutiny by federal and state legislators and regulatory review of LTCI carriers' rate increase requests and claims handling practices. Several best practices were shared for LTCI carriers to employ given the 50 different sets of regulations governing rate increases and claims handling. "Interstate Compact" examined the progress being made in both development and implementation standards for LTCI policies, rates and advertising. Finally, "The Genetics Debate" looked at the current emotional environment associated with genetics as it relates to personal privacy, where genetics appears in the public domain and the implications for insurance underwriters.

FIELD MARKETING TRACK

Chair: Lisa McAree
Co-Chair: Louis Brownstone

This track shook things up this year bringing new and relevant information to the conference attendees. "Creating and Marketing a New LTCI Policy" was a fascinating discussion on the intricacies of creating an LTCI policy starting with obtaining buy-in from top management, organizing and potentially outsourcing various functions, developing marketing materials and building distribution. When it came to "Linked Benefit Products," all agreed that the Pension Protection Act will open up this market. The session on "Starting, Selling or Buying a LTC Brokerage Firm" featured a panel sharing their extensive experience in each of the three phases. One of the more innovative sessions, the brainstorming session, "How to Sell More LTCI," brought together some of the brightest members of our industry. Attendees were randomly divided into groups and given one topic. At the end of an intense 20-minute session, each group presented their best idea and the entire group voted. "Brokerage Distribution versus Career Distribution" offered a spirited debate while the "Simplified Sales" session provided presentation options for both the individual and multi-life sales scenario. An interactive session, the Distributors Roundtable, had five successful panelists share their thoughts and responded to audience's questions.

GROUP TRACK

Chair: John Sherman
Co-Chair: Scott Beck

This track started with "What Makes Some Plan Sponsors Better than Others," which reported on a recent qualitative survey. Questions were posed to 29 LTCI plan sponsors prior to the conference. Respondents ranged in employee size from 1,000 to more than 100,000, and were headquartered in 16 states. The purpose was to determine what factors made some LTCI plans more likely to succeed than others in terms of employee participation. "Is It All or Nothing: an Industry at the Extremes" explored the differences in the amount and type of coverage consumers tend to purchase in the group and individual markets, determining which segment is better meeting the needs of LTCI buyers. "Multi-Life in the Large Group Market" explored the growing use of multi-life in the large group market. Traditionally, true group has been considered the only solution. However, recent experience from at least one large carrier in the industry suggests that large groups will embrace a multi-life solution. "The Role of the Web: Today & Tomorrow" gave perspectives from the carrier, agent, employer and employee on using the internet to do business. "Should Insureds Pay Less for Group LTCI?" explored the methodology around the pricing of individual and group LTCI in an attempt to answer the question of whether buyers who purchase group LTCI should pay less. "The Challenge: Finding the Group Path to Qualified LTC Partnership Insurance" explored the unique challenges presented by the group market to the new partnership programs.

HOME OFFICE MARKETING TRACK

Chair: Laurel Wooster
Chair: Scott Williams
Co-Chair: Linda Skelly

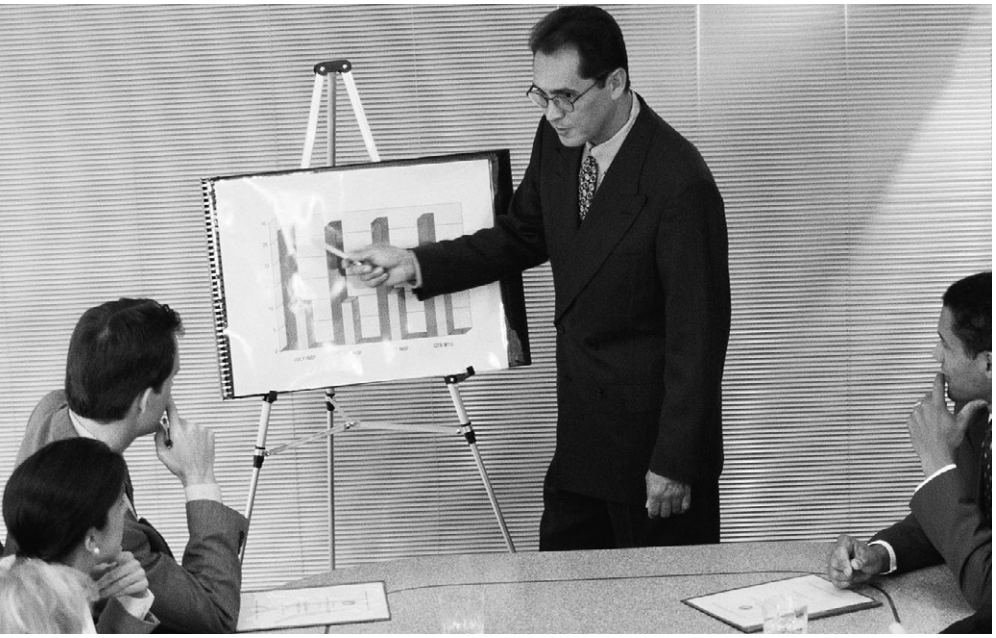
The Home Office Marketing Track sessions presented this year were: "LTC Awareness and Action Campaigns" (AHIP Campaign and Own Your Future), "Psychology of the LTC Sale," "LTCI National Partnership Opportunity," "Pension Protection Act Impact to LTC Products and Marketing," "Evolution of Marketing and Distribution," and "Positioning LTCI as a Financial Protection Product." Many of the sessions featured distribution perspectives affording important insights to home office marketers, vendors and other attendees. Common trends and topics included:

- Partnership programs can be used to raise awareness, but keep client discussions simple and to the point.
- The increased use of Web marketing and social media by producers.
- The importance of cultivating centers of influence to get referrals.

The impact of the current economic crisis on marketing suggests that advisors mine their existing client base for referrals; go back to those who declined to purchase first time and to those who thought they could self insure. Everyone noted the need for increased consumer awareness initiatives across the board, and the positioning of LTCI as a sale for income protection, versus asset protection, made for an interesting session. With 2010 fast approaching, the question of the future of stand-alone LTC products in the wake of the Pension Protection Act made for a timely session. The question of the impact of combo annuity/LTC

One of the more innovative sessions, the brainstorming session, "How to Sell More LTCI," brought together some of the brightest members of our industry.

and life/LTC products overtaking stand-alone LTC is an important issue and made for an interesting session.



MANAGEMENT TRACK

Chair: David Kerr
Co-Chair: Mark Costello

This track explored the outlook for LTCI with the session "Luck of the Draw: Where Will LTC/LTCI Be in 5, 10, 15 Years," discussing the potential for increased regulation, likely developments in product design, workplace versus retail and changes that will emerge in care delivery. The session entitled "Rolling the Dice: Winning Despite Uncertain Assumptions" session addressed the gap between industry experience and pricing expectations leading management concerned with morbidity. The session "LTCI Wheel of Fortune—Consumers/Investors/Carriers" provided information on The Partnership Program's issues for consumers, carriers and investors; substandard opportunities; and cash and combo products. "LTC Issues and Opportunities: Time to Go All In!" was a lively and informative discussion covering marketing, product development and regulatory and pricing issues. We were reminded that we can learn from the past or we can repeat old mistakes with the session "Counting Cards: Win by Learning from the Past." Managing closed blocks was the focus of "Playing the Cards You're Dealt—Managing Closed Blocks to Win." AHIP's recent campaign was the focus in "Bad Flops: Controlling the Damage of Negative Publicity."

OPERATIONS TRACK

Chair: Beth DeMartino

"We're in this Game Together" included both sales and operations staff and focused on the tools and practices that leading carriers use to ensure that sales and operations stay on the same page throughout the year. The common theme of the discussion was two sided: sales need to understand what operations can commit to delivering; and operations needs to keep an open mind to changes to accommodate specific customers. "Operations Metrics—How to Make Your Numbers Work for You" focused on the common measures in operations, sales, finance, at the customer level, that measure how we say yes, go fast and be right. "Best Practices of Implementing a Rate Increase" featured panelists from both ops and actuarial backgrounds. During the session they shared lessons learned and provided guidance from filing, through implementation, to results. It was clear by the number of and types of attendees that rate increases are on everyone's minds.

POLICY & PROVIDER/ COMPLIANCE AND CLAIMS TRACKS

Chair: Eileen Tell
Co-Chair: John Cutler

The Policy & Provider Track collaborated with the Compliance and Claims Track to convene a double session addressing "Independent Third Party Review of Claims in LTC." Panelists offered perspectives on both the federal and state level, provided research data on the nature of claimant satisfaction and discussed the challenges of establishing independent third-party review for LTC. "State Initiatives on LTC" discussed the large and growing impact on state Medicaid budgets and suggested ways in which states can promote consumers take private responsibility for planning ahead for their LTC needs. A lively discussion focused on what new directions and issues may emerge with "New President & Congress." The panelists feel that for long-term care reform to occur, it must be included within the broader context of health care reform. "Providers' Views on LTC Financing Reform" presented proposals by two of the largest provider groups in that industry for including LTC in health care reform, with panel reactors from both the consumer and insurance perspectives. "Foreign Concepts" focused on lessons from abroad—discussing the public/private solutions that exist in Canada, Germany, the United Kingdom and France.

UNDERWRITING TRACK

Chair: Denise Liston
Co-Chair: Beth Kolanski

"Is There Such a Thing as a Successful Rescission?" equipped the audience with a clear understanding of the processes and how to minimize the risks. In "Medical Director's Forum" it was clear that the impact of cognitive claims was on the forefront of everyone's minds. Many questions were related to traumatic brain injury, depression and psychiatric illnesses and the medications used to treat these conditions, highlighting both the risks and rewards. "Playing the Game of Change: Can We Improve the Odds?" revolved around the topic of family history and genetics, and how these factors may impact the industry in the future as the average issue age decreases. "RENOvation of Diabetes and the Diabetic Lifestyle" focused on the importance of healthy lifestyle and how this is an important factor when assessing a client for insurability. "Deal or No Deal: Blood Disorders" created a better understanding of underwriting blood disorders for LTCI. Using live polling, the topics covered were: disorders that challenge the LTC underwriter; when are findings important; and how do they impact the outcome. This session included initial survey questions which focused on when, how and why LTC underwriters use blood profiles.

CEO FORUM

The conference concluded with the "CEO Forum" where an audience-panel discussion covered: CEOs' commitment to the market; the impact of the recent economic downturn; sales and distribution; vision of the future for LTCI; how to address the risk of the underinsured public; the impact of potential health care reform; and collaborative efforts within the industry to direct positive change.

A ROUND OF APPLAUSE

I want to thank all of this year's volunteers. The dedication, so generously giving of your time, energy and knowledge to the conference made it a huge success. This review gave you a small glimpse of the many talented sessions produced at the 9th ILTCI Conference. As in the past, you can expect a DVD with all of the presentations synced with audio to be distributed to each attendee. Next year we will celebrate the 10th Annual ILTCI Conference and a decade of dedication in New Orleans, March 14-17. Please contact conference chair, Carroll Golden, at *cgolden@aegonusa.com* if you'd like to volunteer in any way. We are always looking to involve talent from within the industry, seasoned and new. See you in New Orleans! ■

SPECIAL NOTE: For more information about the specific sessions described touched on in this article, visit the ILTCI 2009 Web site at *http://www.iltciconf.org/*. Click on Powerpoints on the left-hand side of the page.

SOCIETY OF ACTUARIES Long-Term Care Insurance Section

Long-Term Care News

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