SOCIETY OF ACTUARIES Long Term Care Insurance Section

Long-Term Care News

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Distributors Are Key to Manage Message about Gender-Based Pricing and In-Force Rate Increases

By Tom Riekse Jr.

Data doesn't lie. As Long-term care (LTC) Insurance actuaries have analyzed information on claim and underwriting data, carriers have made several adjustments to both in-force and new product pricing and underwriting.

Using data and making smart changes to products is the responsible thing to maintain the long-term growth of LTC Insurance and make sure that this valuable protection product is available to as many consumers as possible. The challenge for LTC Insurance marketers and distributors is to explain the reasons behind these changes while also furthering the cause of LTC Insurance sales. It's a difficult job, but one that needs to be done in order to increase awareness and refute myths about private LTCI.

One of the obstacles distributors of LTC Insurance confront is similar to what faces doctors when they are dealing with a newly diagnosed patient. Twenty years ago, the doctor had all the information on the disease and potential treatment options while the patient didn't have access to that information.

CONTINUED ON **PAGE 6**

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Long-Term Care News

Spring Is in the Air ...

By Denise Liston

... and suddenly we are surrounded by the bright sunshine and the promising colors of great things to come. Each year, spring arrives like a breath of fresh air. You can almost smell it in the air—or at least that is what everyone says. Myself, I am not so sure but I always look forward to the great things that the changing season will bring.

We are experiencing another spring in long-term care (LTC). Changes continue, and we must all try to find ways to embrace them in order to grow and thrive. There is much to be learned as we balance the consumer's need for LTC now and in the future along with the insurer's need for sustainability.

Change is coming from all directions, and we must keep abreast of the literature and legislature to assure our success. Companies are investigating new underwriting tools to improve risk selection. Claim teams are looking at ways to improve contact with the policyholder to promote wellness and to assure care and safety needs are met. Companies are looking at ways to proactively work with policyholders to keep the flower of health blooming brightly. Product changes continue to evolve and there are more to come—it is time to embrace the growth and change as a bright bloom for the future of the LTC industry.

Other insurance lines have begun to incorporate some of the lessons learned from LTC into their product offerings, and LTC is doing the same. With the average age of new applicants declining, companies have turned to tools typically utilized by life insurance to gather medical data on younger applicants who rarely see the need to visit physicians. The industry is collaborating more frequently with other business lines to learn how to better manage younger claimants toward recovery whenever appropriate.

As we gaze toward the bright sun we can only wonder what is next on the horizon. LTC is still a very much needed product that is evident by re-entrants into the traditional marketplace and combination products continuing to grow—as the flowers bloom and the grass becomes green, we all need to work toward assuring the LTC industry is able to balance risk and reward toward future sustainability.

I invite you all to join me in celebrating the spring of LTC and its continual summer bloom for many years to come!

Denise Liston

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Exciting Times

By Jeremy Williams

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Like many of you, I just returned from the 13th Annual Intercompany LTCI Conference held in Dallas. I would like to send out my personal thanks to the ILTCI and all the people who helped make for a wonderful conference. I was very pleased with the quality of session content and the lively conversations. The sessions focused on many aspects of the industry, but one underlying current seemed to dominate—change. More specifically, how will the industry have to change to meet the current and future long-term care (LTC) needs of insureds and the public?

For many, change can be scary as there is the fear of the unknown. This group tends to fight change at all costs. For others, change can be appealing as it creates new opportunities and provides the possibility to influence the future state. As it pertains to the LTC industry, I tend to be in this latter group as I feel that the industry must and will change to remain viable. However, I fear that we only have one shot to do it right. There will be no reset button, so all efforts need to be made to get it right the first time. With focus and determination from all stakeholders involved, I think things can develop favorably for all sides. These are indeed exciting times, and I hope you will be a part of it.

As I said, change creates opportunities. Many projects are currently in the works related to this potential transformation. Here is a quick update on some of those activities and how the LTC Section hopes to participate.

As I discussed in the last newsletter, the LTC Think Tank has embarked on an innovative project called "Land This Plane." For those of you who are not familiar with it, this undertaking will utilize a Delphi study to reach "consensus" on solutions to LTC funding issues. The study questions are far-reaching and cover several topics, ranging from insurance needs and family responsibilities to regulations and funding mechanisms. The goal of this project is to complete a white paper that can be utilized as a framework for education and discussion. The LTC Think Tank held a two-hour session at the ILTCI conference to discuss the results of the first round of the study. The results to date are very promising, and the discussion was certainly thought-provoking and energetic. Additional rounds of the study will be performed over the next several months with project culmination sometime in the fall. The LTC Section is co-sponsoring this effort, so expect to hear more on this project very soon.

On the national front, the CLASS Act was officially repealed within the fiscal cliff legislation. As part of this legislation, a new national commission will be established to develop a plan for better financing and delivery of LTC services. The commission will consist of a 15-member panel with members appointed by the White House and Congressional leaders. The commission will be tasked with developing a comprehensive plan that addresses the establishment, implementation and financing of a viable LTC system.

On the insurance regulatory front, the National Association of Insurance Commissioners (NAIC) is embarking on a project to update and overhaul the LTC model regulation. To date, the LTC Section has been asked to perform research on a number of topics for the NAIC, and we expect this assistance to increase over the next several months. My hope is that we as a section can provide new perspectives and generate valuable research that the NAIC can utilize to formulate a strong framework. Expect more to follow over the coming months.

Finally, I would like to put in a quick comment on the National Conversation on Long-Term Care Financing. This group continues to discuss proposals for a sustainable financing system framework. Steve

Schoonveld has been crucial to this endeavor and continues to help move the conversations forward in a constructive and equitable manner.

As you can see, there are many activities underway that will shape our industry for the foreseeable future. As always, if you have project or research ideas or you are interested in helping out, please feel free to reach out to me or to one of the other council members. The more hands we have on deck, the easier it will be to steer the ship through these exciting times.

As a final note, for those who attended the ILTCI Conference: If you see Frank Abagnale, ask him if he could return my wallet.

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Now, anyone with a mobile phone can use Google and uncover information—both good and misguided.

The same thing happens with LTC Insurance. The days of an insurance agent having all the information on the product is gone—there is an extremely high chance that the person interested in LTC has researched LTC Insurance online prior to discussing options with an advisor.

The following examples show how changes to LTC Insurance have affected that conversation with a consumer. Distributors, especially those that represent several carriers, have credibility and play a role that can't be duplicated by insurers. Here is how they need to communicate these important issues.

ISSUE: GENDER BASED PRICING CHANGES

What a consumer sees on the internet: Although the new health care bill largely prohibits charging woman larger premiums for health insurance, LTC Insurance is not subject to such rules so carriers are increasing new business premiums on females, those most likely to buy the coverage.

The carriers say: Our experience shows that woman receive two of three claims dollars and changing to gender based pricing reflects that experience and helps stabilize pricing.

What distributors need to communicate: Gender based pricing has been used on Life and Annuity business for years—similar products that require a long-term commitment by the insurer. Carriers who sell policies through the employer market will continue to maintain unisex pricing to comply with those regulations. The claims experience shows that woman are benefitting from coverage and will continue to do so in the future.

ISSUE: GENETIC INFORMATION USED IN UNDERWRITING RISK

What a consumer sees on the internet: It's legal for LTC Insurers to discriminate based on their genes—a loophole in GINA, the federal law that prevents insurers discriminating based on genetic information. This means that children of Alzheimer's patients who get genetic testing for the ApoE4 gene may have trouble obtaining LTC coverage if they are asked about it.

The carriers say: GINA does not apply to Life insurance or disability insurance and LTC Insurance and similar policies that are subject to anti-selection—i.e., those who may need the coverage someday will be more likely to buy it. Genetic testing allows us to minimize anti-selection.

What distributors need to communicate: If easily obtained genetic testing kits are used by applicants prior to apply for coverage that threatens the stability of the policyholder pool. Unless LTC Insurance becomes a mandated purchase similar to health insurance where everyone is insured, genetic history questions will be a necessary part of underwriting. Consumers should understand the types of information that carriers are using to underwrite.

ISSUE: IN-FORCE PREMIUM INCREASES

What a consumer sees on the internet: News stories that several carriers have in-force premiums increases from 40 percent to 80 percent, a "bait and switch" that forces seniors to drop coverage after paying thousands of dollars in premiums.

The carriers say: Based on adverse experience with lapse, interest rate, mortality and morbidity we need to adjust premiums on in-force blocks to mitigate losses to the company and adversely affect shareholders.

What distributors need to communicate: Those who had the foresight to purchase LTC Insurance probably made a smart choice. When compared to the cost of current similar coverage, even at issue age, annual premiums are higher today. In addition, most carriers are giving several options to adjust plan benefits and reduce the impact of premium increases. Finally, realize that premium increases are ultimately subject to the oversight of the state departments of insurance who need legitimate proof of the need to adjust premiums.

CONCLUSION

In addition to distributors, government agencies and nonprofit organizations such as the LIFE Foundation can play a valuable role in discussing some of the issues related to changes in the LTC Insurance business.

Unfortunately (but not surprisingly!), many potential LTC Insurance buyers are not educated in the basic concepts of insurance. They may read information online and need guidance that the insurers by themselves cannot provide. Distributors need to play a key role in this education. ■

Three Questions

1. BRIEFLY, WHAT ONE THING WOULD YOU DO TO "HIT THE RESET BUTTON" ON LONG-TERM CARE (LTC) INSURANCE?

Glickman: Require mandatory cash value nonforfeiture for all standalone products. This would restore confidence in the rate stability regulation, increase consumer confidence in the value of the product beyond the catastrophe coverage, and restore confidence among the agents that the industry finally has it correct now. In addition, since lapse rates are so low, this approach would have very little cost.

Kupferman: Require an inverse relationship between years of LTC experience and percent of pricing margin; i.e., require not less than 30 percent margin for an insurer with three or fewer years of LTC experience graded to not less than 5 percent margin only after an insurer has 15 years or more of LTC experience. Pricing actuaries need regulations that help to explain to management and sales that an adequate rate is better than a larger market share in the long run.

Schoonveld: It is clear that an integrated public and private solution is necessary to enable the Middle Mass to finance their long-term care needs. The LTC Partnership Program should be reinvigorated so that smaller and incentivized private insurance products can coordinate with a reformed Medicaid program. This will greatly enhance the demand by the Middle Mass. A reformed Medicaid program will need to utilize efficient care settings and ensure that access to Medicaid is not inappropriately given.

Yee: This would be considered as a "hard" reset. I would aggregate all in-force policies issued prior to a given year (e.g., 2009) and manage them as one single block. There will be one initial rate increase to set the block on stable ground and then it will be managed diligently in the future. Because of the greater spread of risk, the level of rate increase may be lower. There should be economy of scale for operation and investment as well. Companies participate by reversing all prior gains and will be relieved of their future obligations.

2. WHAT ARE THE FEATURES OF PRODUCT DESIGNS THAT WOULD BEST SUIT THE MIDDLE MASS POPULATION?

Glickman: Selling lower daily benefit amounts ($50 to $100 per day) with modest inflation protection as an important first step to covering part of the risk, as well as enabling better access to care (due to the existence of insurance coverage).

Kupferman: Avoid first-dollar coverage and lifetime coverage to keep rates down.

Schoonveld: Since the middle mass has limited resources in dealing with their retirement risks, a single focused product with a use-it-or-lose-it aspect is neither affordable nor appealing. A product with sufficient benefits to cover a high percentage of risks and that encourages the use of efficient care settings will appeal to the middle mass. Such a product would require a death benefit for the surviving spouse or family members when long-term care benefits are not paid.

Yee: For workers, insurance premium pattern closer to the yearly expected claim costs and longer elimination periods. This should lower the initial price point. For retirees, a reverse mortgage program that is pre-approved before services are needed.

3. IF YOU WERE IN A ROOM WITH THE NEWLY APPOINTED COMMISSION ON LONG-TERM CARE, WHAT WOULD YOU ADVISE THEM TO FOCUS ON?

Glickman: I would advise the Commission to design a program where the private market provides the coverage and the government mandates the minimum benefits (this is essentially the PPACA approach for medical care). However, it is critical to advise the Committee that any proposed program (to be viable) must either remain voluntary

CONTINUED ON **PAGE 8**

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purchase with underwriting, or mandatory purchase without underwriting.

Kupferman: Consider the advantages of properly priced non-cancellable policies for middle mass policyholders who will ultimately be on fixed income. Raising rates on elderly policyholders is a disservice to the insuring public and creates a poor image for LTC. LTC is more like life insurance and less like health insurance. LTC should also be priced with a level lifetime rate or with pre-scheduled rate increases after a set number of years.

Schoonveld: Fully understand and appreciate the household consumer segments and their financial needs and means. The variations are significant and should be reflected, if not supported, in any comprehensive financing system proposals. In this way a public and private collaborative solution can be developed which is properly financed and incentivizes households to address their long-term care risks. A one-size-fits-all approach does not reflect the diverse needs and means of households and does not embrace efficient approaches to fund their anticipated long-term care needs.

Yee: LTC is more than an issue for older Americans. It is a time bomb for future generations because there will be fewer of them to support more seniors under Medicare and Medicaid. If we don't act now, they will suffer. How would the commission get this message across to the American people? ■

Facing Reality: LTCi Is Broken—Let's Fix It

By Roger Loomis

A few decades ago, we thought the ultimate lapse rate for long-term care insurance (LTCi) might be, say, 5 percent. That estimate proved to be high and contributed to severely underpriced products. We now price products with an ultimate lapse rate of 1 percent and sometimes lower. While low lapse rates cause consternation in the form of higher premiums, they do indicate how much consumers value LTCi.

The same cannot be said of insurers. From 2002 to 2013, the number of carriers offering LTCi has decreased from about 102 to 12[1]; over that 11-year time period, 17.7 percent of carriers left the market each year. While consumers see the value in purchasing LTCi, a shrinking few insurance companies see value in selling it.

This is surprising; there is an enormous need for LTCi coverage. So why aren't companies stepping up to the plate? Insurers who have exited the market have indicated they did so because the product is too risky, too capital-intensive, and too unprofitable.[2] In this article, I'm going to make a frank analysis as to why LTCi is so risky, capital-intensive and unprofitable. I will then make the case that if we rethink the fundamental way a stand-alone LTCi should work, it can be transformed into a vibrant product that is not only viable for insurance companies to sell, but also a better deal for consumers.

WHY LESS THAN 0.5 PERCENT OF AMERICAN INSURANCE COMPANIES SELL STAND-ALONE LTCI[3]

Insurance companies want predictable earnings. However, the income statements of LTCi blocks are inherently volatile. This is partly due to the way the products are designed, and is partly due to the way accounting rules operate. With LTC, every lapse, claim, death or recovery entails establishing or releasing a reserve (usually a large one), with profit serving as the balancing item. In all but the biggest companies, the statistical variance of lapses, claims, deaths and recoveries causes earnings to jolt from period to period like a bad rollercoaster ride. No wonder this product tends to make CFOs nauseous.

The more fundamental reason LTCi is risky, capital-intensive and unprofitable is because, as currently packaged, *LTCi risk isn't insurable*. There are six criteria a risk must meet in order to be insurable[4]:

1. **It should be economically feasible.** LTCi appeared to be economically feasible back when assumptions about low morbidity, high interest rates and high lapse rates led us to believe it would be affordable for the middle class. Knowing what we now know about these things, its economic feasibility is less clear.

2. **The economic value of the insurance should be calculable.** LTC dramatically fails to meet this criterion. As Ed Mohoric tersely explained, "Premiums are set based on assumptions for 60 or more years into the future, assumptions about utilization, longevity, cultural attitudes toward benefit use, expenses, lapses and investments. The insurance company sets a price that is expected to be locked in for the policy lifetime. No actuary can predict these assumptions with any accuracy."[5]

3. **The loss must be definite.** There can be a wide, fuzzy line between being able to perform an ADL and not being able to perform it. The likelihood that you can't perform a set of ADLs seems to increase substantially if you have insurance and your friends have become residents in a nice assisted living facility (ALF).

4. **The loss must be random in nature.** This is the single criterion for insurability that I believe LTC meets—whether you need extensive LTC before you die might not be definite, but it is random.

5. **The exposures in any rate class must be homogeneous.** LTCi is subject to at least some anti-selection, so the exposure isn't homogeneous.

CONTINUED ON **PAGE 10**

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6. **Exposure units should be spatially and temporally independent.** LTC fails this criterion in a spectacular fashion. Exposure to LTC risk isn't independent because it's a function of the elements that make it non-calculable (see 2 above). These unknowns about the future are statistically dependent and can't be diversified away by selling more policies.[6]

This brief analysis suggests LTCi is basically uninsurable. This is supported by the empirical evidence that so few companies are willing to sell it. When companies say LTCi is too risky, unprofitable and capital-intensive, what they are really saying is that it is uninsurable.

Insurance companies can't effectively manage uninsurable risks; such risks must be borne by either individuals or the government. However, I'm not going to suggest a government solution or a self-insurance solution. Rather, I'm going to suggest we change the basic framework of insurance policies so that the risk not only becomes insurable, but also becomes a better deal for consumers.

MUTUAL LONG-TERM CARE INSURANCE

The Ideal LTCi Policy

An ideal LTCi benefit design would have the following characteristics:

1. The premium would be fixed.
2. The benefits would be high in relationship to the premium.
3. Insurance companies would face low risk (and hence low capital requirements).
4. The insurance company's earnings would be smooth and predictable.

A product design with these features represents a win-win for policyholders and insurance companies.[7]

Here is a proposed policy design that seems to have all of these characteristics. I'm calling it "mutual LTCi."

Mutual Long-Term Care Insurance Defined

Purchasing a mutual LTCi policy entails entering into an insurance contract where you pay a fixed regular premium for life. As long as you continue to pay the premium, the policy remains in force (i.e., non-cancellable). The premium rate depends upon standard underwriting criteria.

In exchange for the premium, you receive a fixed number of shares in a fund. The net premiums are deposited directly into the fund, which is jointly owned by the policyholders. If you die or lapse, the money you have paid remains in the fund for the benefit of the remaining policyholders. According to how much money is in the fund and how many shares you purchase, you would be able to draw from the fund to help pay for LTC events. Like traditional LTCi, drawing benefits from the fund would be subject to activities of daily living (ADLs), elimination periods (EPs), benefit periods (BPs), maximum daily benefits, coinsurance, and so-forth.

The benefit available at the time of claim is simply the number of shares the policyholder owns multiplied by the per-share benefit level in effect at the time of payment. An actuary serving in a fiduciary capacity to the fund will recalculate the per-share benefit level annually. If the fund is doing exceptionally well, he may declare dividends. In all cases, the fund's performance accrues to its owners. The actuary's primary responsibility is to ensure the fund's solvency and the equitable treatment of the policyholders regardless of when they incur claims.

The reason this structure succeeds where traditional LTCi fails is because all gains and losses from lapses, death, morbidity and interest rates will accrue directly to the fund. The fund absorbs the gains and losses by adjusting future per-share benefit levels.

Some might argue that this places too much uncertainty on policyholders and defeats the point of insurance. I argue just the opposite: More than traditional LTCi, mutual LTCi has the hallmark of true insurance and is more faithful to the theoretical definition of insurance: "the insurance mechanism is used to transfer risk from the individual policyholder to the pooled group of policyholders represented by the insurance corporation. The insurance company administers the plan, invests all funds, pays all benefits, and so on. However, the insurance company can only pay out money that comes from the pooled funds."[8]

Why This Design Is Good for Insurance Companies

In mutual LTCi, the insurance company would be in the business of administering the plan, which entails underwriting prospective members of the

plan, collecting premium, investing the assets, and adjudicating benefits. It would cover expenses and make a reasonable profit through the following fees:

- An administration fee deducted from every premium payment
- A fee for managing the assets in the fund
- A fee for adjudicating claims.

The insurance company enjoys predictable profits, low risk, and low capital requirements. This would attract competition into the market, which would keep profit margins low. The reserve is always equal to the assets, so management doesn't have to worry about wild swings in earnings every time there is a blip in claims or lapses.

Why This Design Is Good for Policyholders

The design is a winner for policyholders, too. Compared to traditional LTCi, the policies will be much less expensive for the same expected benefit level, and there is no risk of a rate increase. While policyholders won't know at issue precisely what the benefit level will be at claim, they will know that the benefit level will be more than reasonable in relation to the premium provided.

The public is naturally suspicious of traditional LTC policies because they recognize that the more an insurance company denies claims, the more money it makes. In mutual LTCi, this conflict of interest does not exist—the benefits associated with good morbidity are directly accrued to the policyholders.[9]

Major Action Is Needed

Changing the way we think about LTCi will be difficult for many. But if we don't face reality and make major changes to address a product design that is inherently uninsurable, then we should brace ourselves for the day when we wake up to find that nobody still sells stand-alone LTCi. Ninety percent of the insurance companies that have ever offered LTCi have left the market. The remaining 10 percent can't be far behind.

Long-Term Care Think Tank

The idea for mutual LTCi was inspired by the "Land This Plane" project, which is co-sponsored by the Long Term Care Section and the Forecasting & Futurism Section. In this project, a panel of 50 experts on long-term care (LTC) and aging is discussing the challenges of funding LTC in America, and is attempting to come to a consensus around a comprehensive solution. Our report will likely consist of specific recommendations for fixing Medicaid, designing a social insurance plan, and overhauling the private insurance market.

The electronic surveys used to solicit opinions from the panel are being opened up to a wider group so that we can get more ideas, more feedback, and greater consensus. If you have any feedback on whether mutual LTCi is the direction the industry should take, or if you want to weigh in on any other problem or proposed solution to the nation's LTC challenges, we cordially invite you to join the Think Tank. Please email either me *(Roger.Loomis@arcval.com)* or Ron Hagelman *(ron@rmgltci.com)* to join.

ENDNOTES

1 See Cohen, Marc A., "Factors Behind Carrier's Decision to Leave the Market" (session #37), 2013 ILTCI.

2 Ibid.

3 Based on an estimate, there are over 2,500 life and health insurance companies in the United States.

4 This list is taken from Dr. Robert Brown's *Introduction to Ratemaking and Loss Reserving for Property and Casualty Insurance, Second Edition,* pages 11–12.

5 Mohoric, Ed, "Long-Term Care Product Design: Two Common-Sense Recommendations," *Long-Term Care News,* January 2013, page 15.

6 The effect of future interest rates on independence merits extra attention. Future claims aren't financed by the net premiums alone, but also by the interest earned on the reserves. Interest returns are not statistically independent from policy to policy—all policies are subject to the same interest rate environment. The long duration of LTC liabilities exacerbates this lack of statistical independence.

7 Since one of the purposes of LTC regulation is "to promote the availability of long-term care coverage"(Long-Term Care Insurance Model Regulation, Section 1), a product design that creates a robust market is in the interest of regulators as well

8 Brown, page 13.

9 Technically, in mutual LTCi the carrier has the incentive to deny claims in order to grow the size of assets it is managing. However, this incentive is mitigated by the fee it earns by paying claims.

"… if we don't face reality … then we should brace ourselves for the day when we wake up to find that nobody still sells standalone LTCi."

Will the Mega Rule Have a Mega Impact on Long-Term Care Insurers' Use of Genetic Information?

By Michael D. Rafalko and Nolan B. Tully

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On Jan. 25, the Department of Health and Human Services (HHS) published its long-awaited "Mega Rule," which interprets, clarifies and, in some instances, extends the provisions of both the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act of 2008 (GINA). In the lead-up to the publication of the Mega Rule, there was much speculation over how HHS would protect genetic information and, in particular, whether the provisions of GINA prohibiting the use of genetic information in underwriting certain types of insurance would be extended to all HIPAA-covered entities—including issuers of long-term care insurance.

Due in large part to successful lobbying efforts and persuasive public comments submitted to HHS on behalf of the long-term care industry, the final Mega Rule exempted long-term care insurers from the blanket ban on the use of genetic information in underwriting that many in the industry expected. The Mega Rule did, however, extend this ban to every HIPAA-covered entity other than long-term care insurers. HHS appeared particularly persuaded by the argument that prohibiting the use of genetic information in long-term care underwriting would result in large-scale rate increase requests and/or threaten the viability of long-term care insurance generally.

If long-term care insurers are inclined to breathe a sigh of relief and continue business as usual, however, a close reading of the Mega Rule should disabuse them of that notion. While the present changes are less drastic than they might have been, HHS unequivocally conveyed its position that individuals have the utmost privacy interest in their genetic information. This is significant because it may be a harbinger of HHS' inclination to extend the underwriting prohibition to long-term care insurers in the future. Further, HHS reiterated that genetic information was protected health information and is covered by HIPAA's privacy rule. The Mega Rule did not stop there, however. It extended the HIPAA privacy rule beyond just HIPAA-covered entities to all business associates who receive protected health information from HIPAA-covered entities—including long-term care insurers. The practical effect of this is to extend the enforcement of HIPAA downstream from covered entities to those business associates, increasing the federal privacy protection afforded to protected health information. Perhaps most importantly, the Mega Rule made clear that HHS will revisit the question of whether the blanket ban on the use of genetic information should be extended to long-term care underwriting. The net effect of the Mega Rule on long-term care underwriting therefore remains to be seen.

FEDERAL REGULATION OF THE USE OF GENETIC INFORMATION: GINA AND THE MEGA RULE

GINA was signed into law by President George W. Bush on May 21, 2008. With the passage of GINA, the collection, use and disclosure of genetic information was regulated at the federal level for the first time. Generally speaking, in the insurance

context, GINA prohibits discrimination based on an individual's genetic information with respect to health insurance coverage. Additionally, GINA extends HIPAA's "privacy rule" to cover genetic information.[1] GINA specifically prohibits the following groups from using genetic information for underwriting purposes: (i) group health plans; (ii) health insurers issuing health insurance coverage; and (iii) issuers of Medicare supplemental policies.

In 2009, HHS released a proposed Mega Rule for public comment. In the proposed rule, HHS planned to extend the prohibition on using or disclosing genetic information for underwriting purposes beyond the present three affected groups to all health plans that are HIPAA-covered entities—including long-term care insurers. This led to significant push-back from the industry. The Society of Actuaries (SOA) and American Council of Life Insurers (ACLI) lobbied against a blanket ban on the use of genetic information in underwriting, concluding that such a ban could threaten the long-term viability of the private long-term care insurance market. These public comments and lobbying efforts proved effective.

The "final" Mega Rule was published on Jan. 25, 2013. It becomes effective on March 26, 2013. Covered entities and their business associates must comply with its requirements by Sept. 23, 2013. Notably, the Mega Rule prohibits the disclosure or use of "genetic information for underwriting purposes to all health plans that are covered entities under the HIPAA Privacy Rule, including those to which GINA does not expressly apply, *except with regard to issuers of long-term care policies"* (emphasis added). Even with the exemption for long-term care insurance, this was a significant extension of the prohibitions in GINA. Although there was public comment that HHS did not have the authority to extend the prohibitions, HHS disagreed. HHS concluded that there was no problem with HHS granting the same privacy protections outlined in GINA to those health plans that are not explicitly covered by GINA. HHS' conclusion could lead to an interesting legal debate about the extent of power vested in bureaucratic agencies. For the time being, however, HHS' guidance is the law of the land and all covered entities—except long-term care insurers—will be prohibited from using genetic information for underwriting purposes.

THE MEGA RULE'S IMPACT ON "BUSINESS ASSOCIATES"

Though it exempted long-term care insurers, HHS emphasized that "long-term care plans, while not subject to the underwriting prohibition [on genetic information], continue to be bound by the Privacy Rule, as are all other covered health plans, to protect genetic information from improper uses and disclosures, and to only use or disclose genetic information as required or expressly permitted by the Rule, or as otherwise authorized by the individual who is the subject of the genetic information." Because long-term care insurers continue to be bound by the privacy rule, there is a second aspect of the Mega Rule that will impact the long-term care industry immediately—the extension of the HIPAA privacy rule to business associates. The Mega Rule requires business associates of HIPAA-covered entities to safeguard individuals' protected health information (PHI)—including genetic information. Because business associates receive PHI from HIPAA-covered entities, this extension of the privacy rule will require long-term care carriers to review and likely revise their contracts with business associates to ensure that they require the business associates to safeguard the privacy of PHI in compliance with HIPAA's privacy rule.

DOES THE MEGA RULE OFFER A GLIMPSE OF THE FUTURE?

The Mega Rule does not appear to be the end of federal regulation of genetic information. Though HHS exempted long-term care plans from the blanket underwriting ban, the Mega Rule tracks HHS' observation that an individual has a strong privacy interest in his own genetic information. However, HHS could not, as of the Jan. 25, 2013 release of the Mega Rule, determine the "proper balance between the individual's privacy interests and the [long-term care] industry's concerns about the cost effects of excluding genetic information." For that significant reason, the fate of the industry vis-à-vis the use of genetic information in underwriting remains uncertain.

> In terms of the future of the use of genetic information, HHS stated:
>
> [W]e are looking into ways to obtain further information on this issue, such as through a study by the National Association of Insurance Commissioners (NAIC) on the tension between the use of genetic information for underwriting and the associated privacy concerns in the context of their model long-term care rules. Based on the information the Department may obtain, the

CONTINUED ON **PAGE 14**

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> Department will reassess how best to move forward in this area in the future."

This portends a future reevaluation of the exemption granted to long-term care insurers, which could result in a restructuring or elimination of their exemption.

The Mega Rule also failed to set a uniform, federal standard on how genetic information can be used in underwriting long-term care insurance. In addition to the limited federal regulations on the use of genetic information set by GINA and the Mega Rule, most states have enacted statutes that require compliance from all insurers. Many of these statutes qualify, restrict, ban or otherwise regulate the use of genetic information in underwriting. Although each state statute is different, the states that have enacted laws generally fall into one of three categories: (1) permissive use of genetic information is allowed; (2) use of genetic information is permitted but with restrictions; or (3) use of genetic information is prohibited. The result is a patchwork of regulations that range widely from complete prohibition to liberal use of genetic information. Long-term care insurers must therefore ensure that if they are using genetic information in underwriting, their guidelines are responsive to each state's regulations and their underwriters and producers, among others, are trained accordingly.

IMPORTANT CONSIDERATIONS IN THE WAKE OF THE MEGA RULE

So what does this mean for long-term care insurers moving forward? In the short term, insurers can continue to use genetic information as they have in the past, provided they pay close attention to individual state laws which govern the use of genetic information in underwriting. Beyond the underwriting component, however, long-term care insurers, as covered entities under HIPAA, must ensure that their business associates are affording PHI the privacy protections required by HIPAA.

The long-term takeaways are less clear. What would happen, for instance, if the prohibition on the use of genetic information in underwriting were extended to long-term care insurers in the future? HHS has made it abundantly clear that individuals have a strong privacy interest in their own genetic information. Moreover, HHS did not extend a permanent or unequivocal exemption to long-term care carriers—instead, HHS exempted long-term care carriers based on the current information available to HHS. Indeed, the Mega Rule contemplates a study by the NAIC to examine the effect of the underwriting prohibition on long-term care insurance. The current reprieve is hardly a long-term guarantee.

It also seems fair to speculate that prohibiting long-term care insurers from using genetic information altogether in underwriting could influence the need for rate increases due to anti-selection. Though far too early to draw fatalistic conclusions, it is not entirely out of the realm of possibility that an outright ban on the use of genetic information could discourage some wary insurers from remaining in the long-term care space. At a minimum, such a ban could complicate the underwriting and pricing processes.

Another interesting legal question is whether HHS actually has the authority to extend the underwriting prohibition to all HIPAA-covered entities. The original underwriting prohibition, found in GINA, applies strictly and specifically to group health plans, health insurance issuers and issuers of Medicare supplemental policies. Several commenters have suggested that HHS lacked the power to extend the underwriting prohibition beyond those three groups, as doing so would result in an executive-branch agency improperly abrogating powers reserved for the legislature. HHS dismissed these concerns on the grounds that GINA and HIPAA authorized HHS to devise the Mega Rule, and that nothing in the Mega Rule is contrary to the statutory text of GINA. Nevertheless, the extension of the Mega Rule certainly goes beyond the plain language of GINA, and one could foresee a legal challenge seeking to strike down portions of the Mega Rule. ■

ENDNOTES

[1] The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. See The Privacy Rule, Department of Health and Human Services, available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html (last accessed Feb. 28, 2013).

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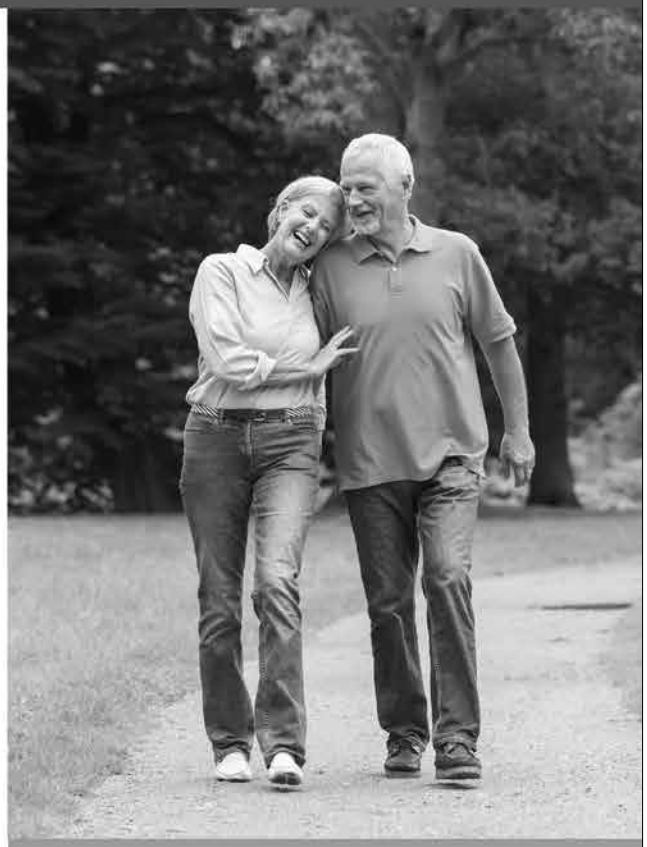

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Credibility Theory and Long-Term Care Insurance

By Jim Berger

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A classic problem in group insurance begins with the benefit manager's question: "Why is my group's premium so high when our experience is so good?" Ms. Jones is the benefits manager for a group of 50 employees. Mr. Black, the insurance broker, quoted a rate from the rating manual that was twice what the inflation-adjusted experience over the last five years showed. The rating manual looked at age, family composition and occupational class. Yet there were unique aspects to Ms. Jones' group that fundamentally made them a better risk.

Mr. Black considers the group and realizes that this is not just a run of good luck, so he goes to the actuary to see if something can be done.

This trip into one of the lesser-understood realms of actuarial science was given a theoretical structure in the early part of the 1900s when a workers' compensation actuary wrestled with this problem and developed a way of dealing with these tensions. **Limited fluctuation credibility theory was born.** This theory found a way to blend the experience of the group with the overall experience of the general insured population.

In our case, the experience of Ms. Jones' group was assigned an amount of credibility, Z, and a blended rate was determined. The blended rate is [group experience x Z] + [manual rate x (1-Z)], a simple proportional weighting. With this formula in hand, and knowing the manual rate and the group experience, what we need to know is the value of Z, a value between 0 and 1, inclusive.

Limited fluctuation credibility uses an elegant and appealing approach. Assuming the actual claim count is n and asking how many claims would make the group "fully credible," call this N, it works its magic: Z = sqrt(n/N). So far, so good. But where does N come from?

N is defined by a confidence interval calculation that needs two parameters. The first would be the width of the interval, say ± 3 percent, and then the confidence that the result is within this interval, say, 98 percent.

At this point, I will refer the reader to a good source for the details of finding N. *An Introduction to Credibility Theory,* fourth edition, by Thomas Herzog is a solid starting place.

While easy to apply, limited fluctuation credibility is not without its theoretical challenges. In a letter to *Contingencies,* March/April 2004, Herzog notes several concerns. How are the parameters chosen? How comfortable are we with the accuracy for the "manual rate" with which we are blending actual experience? Should we ever give data 100 percent credibility or just let full credibility be approached asymptotically?

It's not clear as to how one should obtain the two parameters of the limited fluctuation model. They appear to be subjectively determined and, in fact, in practice that is what this author has personally observed. In fact, in some cases the full credibility amount was simply stated without appeal to the parameters. Moreover, unlike the Bayesian credibility approach, the limited fluctuation approach allows the analyst to hide all of the model's assumptions. But for all these issues, limited fluctuation credibility gives a better answer than if we did not use any credibility approach.

CREDIBILITY AND THE LONG-TERM CARE ACTUARY

Before reviewing some alternatives to limited fluctuation credibility, it would be useful to ask in what way a long-term care (LTC) actuary might be interested in using credibility theory. The most common usage of which this author is aware would be in rate filings with various states. State regulators typically ask for experience in their state as well as nationwide.

Suppose there are 10,000 policies with 700 claims in state X, giving a loss ratio (LR) of 82.3 percent. The nationwide LR is 89.9 percent. If due to the natural volatility of the data it is decided that "being within 5 percent of the actual loss ratio 90 percent of the time" is a good measure, then full credibil-

ity is found with 1,082 claims (see Herzog book or multiple other sources). Thus Z = sqrt(700/1,082) = .804, and state X would blend its state-specific loss ratio with the national loss ratio using LR(blended) = .804 * 82.3% + .196 * 89.9% = 83.8%.

A concern with the approach just demonstrated involves the theoretical underpinnings. Standard credibility theory is developed for claim count or amount during a specific period. When loss ratios are considered, the time period is expanded and a new variable is introduced—policy decrements. This complicates a less-than-perfect method. The actuary should use caution in applying credibility theory to lifetime loss ratios and verify that theoretically what is being done is appropriate.

A few states have their own full credibility definitions, but the one-size-fits-all nature of their formula may make the state actuaries interested in a different approach to the problem if the filing actuary would offer it. Of course, it never is that easy.

The state not being fully credible poses a concern glossed over above. With what will the filing actuary blend the experience? Above, the choice was nationwide data. An alternative is to blend with other LTC forms within that state. Using nationwide data might seem the most appropriate choice since there is a similar basis for the experience. The use of other forms within a state may cause blending of experience that is different in some fundamental way. This inter-form variation is likely not a big issue for most LTC forms, but it could be. As well, it could be that the total pool of experience among all forms in a state is still "less credible" than nationwide experience on the one form.

Another potential application would be for group LTC pricing, much as discussed above. This application would be uncommon as the LTC experience development is glacial compared with most other group coverages.

Credibility adjustments to pricing parameters could be considered. This becomes a bit more complex. Count-oriented parameters might work here, such things as mortality, voluntary lapse and claim incidence, but it would seem that severity is a tough item to go after. One of the first questions to pursue with pricing parameters is the standard table with which to blend experience. Is this the pricing assumptions? Or the industry experience, such as an actuary can determine? Should we even be doing this if we see trends moving in one direction while the process of credibility blending pulls us away from where experience is trending toward? An alternative approach might be to determine a confidence interval for decrements based on pricing assumptions. If the experience develops outside the confidence interval, make a change; otherwise, not.

If one can get by these issues, the Financial Reporting and Product Development sections, along with the Committee on Life Insurance Research, commissioned a research project in 2009. The resulting paper, titled Credibility Theory Practices, can be found on the SOA website at *http://www.soa.org/research/research-projects/life-insurance/research-credibility-theory-pract.aspx*. In this paper and accompanying spreadsheets the authors provide a reasonably detailed theoretical workup of both the limited fluctuation method and the greatest accuracy method along with a discussion and significant example of how to apply these methods to actual-to-expected ratios for mortality experience. For a step-by-step treatment, this is a highly recommended source.

GREATEST ACCURACY CREDIBILITY

To get the idea of greatest accuracy credibility, a standard example supposes a marksman is shooting at one of four targets, the targets being positioned at the four corners of a square. If the square is "large" rather than "small," it will be easier to tell at which target the marksman is aiming. This concept is at the heart of greatest accuracy credibility.

In this case, Z = n/(n+k) where n is the exposure and k is determined in some manner. Note that Z never reaches 100 percent. Greatest accuracy credibility is certainly more difficult than limited fluctuation but it avoids many of the theoretical challenges. There are no parameters to pick. It simply looks at means and variances within the population based on expectations.

BAYESIAN CREDIBILITY

The Bayesian world starts with Bayes' formula that all statistics students learn. It philosophically addresses the concept of how much we know outside the data presented specifically in a case. So a prior understanding of how the data works is brought into the problem, e.g., a rating manual. A non-Bayesian (a "frequentist") feels this pollutes the data. The Bayesian feels she knows something relevant but frequentist techniques don't allow her to use it. The

Perhaps one of the good disciplines coming from Bayesian thinking is that the world asks to be specified probabilistically. That's a good habit for any actuary to cultivate.

CONTINUED ON **PAGE 18**

Bayesian knows that not all her knowledge is being tapped. And if the data is thin, any knowledge may be useful.

From a credibility perspective, the general knowledge of the rating manual is updated with the actual experience.

This may take the classic Bayesian form of the prior distribution being updated by the observed data to give a posterior distribution. Loss Models, by Panjer, et al., describes this process and gives some examples. A standard Bayesian example starts with a prior distribution which is a beta, B(a,b). The prior mean is a/(a+b). If we observe r claims in n trials, then the posterior distribution is B(a+r,b+n-r) with the posterior mean of (a+r)/(a+b+n). This is an appealing outcome. The beta distribution is nice for Bayesians, and while it isn't the only distribution with this "conjugate" property, there aren't many.

Bayesian strengths include its nice mathematical theory with all the assumptions clear. It gives reasonable results in extreme examples. But the guidance in how to make the assumptions is weaker. There is much subjectivity. But a Bayesian would say that is appropriate if you don't have much else to go on. For example, what is the probability that a nuclear war breaks out this year? There are (thankfully) few data points for this question, so bringing some subjective reasoning to bear on the problem may be the only hope of developing any answer. And that answer is constantly updatable as new information and understanding is obtained.

One of the challenges of the Bayesian approach is finding the prior. It is helpful if it fits the form of one of the conjugate distributions, but it well may not. What is to be done? A table of prior beliefs is needed, and an application of Bayes' formula gives an answer. These prior beliefs can come from the actuarial muse (aka actuarial judgment) or they can come from techniques such as the Markov Chain Monte Carlo (MCMC) simulation. MCMC uses a tree with probabilities as to which branch is taken and then does many random simulations. The result is a prior distribution derived from some set of assumptions which are to be updated by observations. Note that there are potentially many subjective assumptions used in developing this prior.

Perhaps one of the good disciplines coming from Bayesian thinking is that the world asks to be specified probabilistically. That's a good habit for any actuary to cultivate. Instead of giving point estimates, a range of possible outcomes is given with probabilities assigned. There may be some appeal to the actuarial muse once again.

CONCLUDING THOUGHTS

Credibility should not be applied blindly. Start with a good understanding of the theoretical structure. This isn't easy to do but should be pursued to avoid unfortunate applications.

It is worth emphasizing that one must ask what makes a table the standard table. Why is one confident that it is the appropriate item with which to blend a particular set of experience? Related to this, just because data is judged to be credible doesn't make it relevant. For example, data may be fundamentally different from the standard table being used. The world is changing and past relevant data may no longer be so. Is data predictive of the future?

Credibility may be a bit like graduation of data. Actuaries learn now to smooth data in various ways. The mathematical methods from the exams give reasonable results. A professor explained one of his graduation techniques. On a piece of paper he would graph the data points, sit on the sill in one of the big windows at the company, stare at the data for a few moments, and draw a line through it. After all, whatever the results of a more mathematic presentation may be, it still has to line up with intuition. ■

On the Research Front

SOA COMMITTEES, SECTION RELEASE LIVING TO 100 MORTALITY OVERVIEW REPORT

Get a good overview and analysis of the mortality models, theories and trends contained in the papers presented at the past four international Living to 100 symposia by reviewing a new report sponsored by the Society of Actuaries' Committee on Life Insurance Research, the Committee on Knowledge Extension Research and the Product Development Section. Authored by Jennifer Haid, Michael Chan and Christopher Raham of Ernst & Young, this paper offers an overview of the technical materials related to data sources, validation techniques and methodologies used by practitioners to develop mortality estimates for present and future periods. A summary of discussions regarding business, policy and social implications of increased longevity is also included. Find out more at *http://www.soa.org/Research/Research-Projects/Life-Insurance/soa-living-100.aspx*.

LTC Bullet: States Decry Medicaid LTC Loopholes

By Stephen Moses

Stephen Moses is president of the Center for Long-Term Care Reform in Seattle, Wash.

Legislation introduced by Congressman Charles W. Boustany, Jr., M.D., R-La., and others has called for the study and reform of Medicaid long-term care (LTC) eligibility and estate recovery rules. The bill's sponsors sent letters to state governors asking their opinion of the proposed legislation and requesting their replies to four key questions about the appropriate role of Medicaid long-term care financing. Despite prodding from the members of Congress, only 15 states replied to their letter. But in those 15 replies, there is strong evidence that Medicaid eligibility and estate recovery rules are subject to frequent and egregious abuses.

The following are selected replies to each of the four questions:

1. SHOULD THE FEDERAL GOVERNMENT GIVE STATES GREATER FLEXIBILITY TO CONSIDER ASSETS, INCLUDING SUBSTANTIAL HOME EQUITY, WHEN DETERMINING ELIGIBILITY FOR LONG-TERM CARE COVERAGE THROUGH THE MEDICAID PROGRAM? WHY OR WHY NOT?

New Mexico Governor Susana Martinez: "I agree that alternate policy options should be pursued to prevent state Medicaid programs from becoming the default financier of long-term care services for middle-income individuals, and to protect the program as a safety net for those who need it most."

Wisconsin Department of Health Services Secretary Dennis G. Smith [Smith was director of Medicaid at the federal Centers for Medicare and Medicaid Services (CMS) for eight years during the George W. Bush administration]: "Greater flexibility should be provided to states regarding Medicaid eligibility policies, including which assets should be considered for purposes of determining Medicaid eligibility. Increased flexibility will allow states to adopt changes to their Medicaid programs in order to help ensure the long-term sustainability of such programs for their residents most in need of government assistance."

Maine Governor Paul R. LePage: "Regulations should be simplified so that states can deny Medicaid to all people who have transferred resources to become eligible for Medicaid, not just for institutional level of care."

Tennessee Deputy Director of Policy and Research Beth Tipps—Office of Governor: "Taking substantial home equity and other assets currently exempt under the law into account in determining eligibility for Medicaid reimbursement of LTC would result in fewer people with substantial means qualifying for Medicaid-reimbursed LTC until such time that those assets have been exhausted, and target Medicaid reimbursement to those with the greatest financial need. The effectiveness of any such policy would also likely require adjustments to the look-back period for asset transfer.

"Persons who want to protect assets would still be able to purchase an LTC Partnership policy and protect assets up to the value of private insurance benefits provided. This would encourage those who can afford LTC insurance to purchase it in order to protect assets, and decrease dependency solely on Medicaid for payment of LTC."

Virginia Secretary of Health and Human Resources William A. Hazel, Jr., M.D.: "Giving states flexibility to change eligibility rules and expanding LTC insurance coverage options for middle-income individuals will help to protect Medicaid LTC as a safety net for the low-income Americans who need it most."

Georgia Governor Nathan Deal: "Federal restrictions fail to recognize significant variation across states. Home values, household incomes, cost of living, demographics, and cost of health care are factors that determine eligibility but are widely different from place to place. States are better suited to establish criteria which ensure their safety net programs better serve those for which it is intended."

2. PLEASE PROVIDE EXAMPLES OF BARRIERS TO EFFECTIVE MEDICAID ESTATE RECOVERY PROGRAMS AND TOOLS THAT MIGHT HELP STATES IN THIS AREA.

North Dakota Human Services Department Interim Executive Director: "State Medicaid programs have, by default, become the major form of insurance for long-term care. Medicaid estate planning has increasingly become a way for middle-income Americans to impoverish themselves to the point that they can become eligible for Medicaid. The current system is consuming both state and federal budgets and is unsustainable. It is imperative that states have the flexibility to pursue creative and innovative options for state-appropriate solutions."

Wisconsin Department of Health Services Secretary Dennis G. Smith: "There has been an increase in the number of beneficiaries age 65 and older seeking disability determinations solely to place excess assets into … pooled trusts. The trusts are preventing the state from recovering Medicaid costs in certain cases, and the extra requests for disability determinations from persons over age 65 are straining the state's resources.

"The prohibition against filing a TEFRA lien prior to the outcome of a fair hearing has been increasingly problematic because beneficiaries or their responsible parties postpone hearing dates while attempting to sell the home. When the home eventually sells prior to the hearing, no lien can be placed because the beneficiary is no longer the owner. Many beneficiaries then seek a determination of disability and, if granted, the sale proceeds are placed into a … pooled trust and not available to pay for the cost of care which then continues to be borne by Medicaid."

Pennsylvania Department of Public Welfare Secretary Gary D. Alexander: "The underlying policy debate on estate recovery involves the very character and purpose of Medicaid. Should the Medicaid long-term care program be a strictly needs-based program for individuals who have no ability to pay for their own care? Or should middle class individuals and couples be permitted to qualify for benefits without losing the ability to transfer wealth to their children? When the economy falters, allowing the latter to occur places an increasing amount of stress on limited human services budgets and requires policymakers to consider service reductions."

Hawaii Governor Neil Abercrombie: "When a Medicaid recipient dies while having only a life estate interest in the property, the lien that was on the property must be released, which results in the loss of revenue. The federal statute should be amended to allow recovery of up to the value of the life estate at the time of the recipient's admission to the facility."

Rhode Island Governor Lincoln D. Chaffee: "Medicaid estate recovery programs are problematic because of legal options allowable under current state and federal laws. People are currently able to find refuge for assets in the form of life estates or promissory notes."

Virginia Secretary of Health and Human Resources William A. Hazel, Jr., M.D.: "In addition to Virginia's current broad estate recovery authority, we are considering several other measures to increase recovery efforts, but these are currently stalled due to the Affordable Care Act (ACA) maintenance of eligibility (MOE) provision which precludes more restrictive eligibility policy for adults enrolled in Medicaid until at least 2014."

3. SHOULD STATE AND FEDERAL GOVERNMENTS ENCOURAGE MIDDLE-INCOME AMERICANS TO ANTICIPATE AND PLAN FOR THEIR FUTURE LONG-TERM CARE NEEDS, INSTEAD OF RELYING ON

CONTINUED ON **PAGE 22**

MEDICAID, A SAFETY NET FOR THE POOR? WHY OR WHY NOT?

North Dakota Human Services Department Interim Executive Director: "The current lack of limitations on estate planning virtually eliminates incentives for individuals to plan for their own future needs. While the long-term care partnership act was enacted to encourage couples to plan for their long-term care needs, the interpretation of the Medicaid act to allow people to shelter an increasing number of assets makes the allowances found in the long-term care partnership act a less desirable option to assist a couple in retaining their assets."

Maine Governor Paul R. LePage: "People would be more inclined to purchase LTC plans if there were tighter rules around transfers and greater incentives to purchase such policies."

Rhode Island Governor Lincoln D. Chaffee: "Yes; using Medicaid as the primary source of funding for long-term care is not sustainable."

Georgia Governor Nathan Deal: "Encouraging all Americans to plan for their future needs is critical to ensuring our Medicaid program is able to serve the most vulnerable citizens for which it is designed. Personal responsibility is fundamental. … The Medicaid program is a 'welfare' or 'poverty' program which was established as a safety net program for the poor."

4. DO YOU CONSIDER MEDICAID ESTATE PLANNING TO BE A SIGNIFICANT PROBLEM THAT TAKES RESOURCES FROM THE TRULY NEEDY IN YOUR STATE? PLEASE EXPLAIN AND PROVIDE EXAMPLES.

North Dakota Human Services Department Interim Executive Director: "Shortly before going into the nursing home, the couple had liquid assets worth about $700,000, not including the home or car. They were ***over the Medicaid limit by more than half a million dollars.*** The community spouse, on advice of an attorney, sold the home the couple had lived in for years and bought one worth twice as much and sold the car they had and bought a brand new one worth three times as much. The car is completely exempt under Medicaid rules. The house also is completely exempt under Medicaid rules, as long as the community spouse lives in the house. After successfully sheltering those assets, the community spouse took $400,000 cash, money that was available to be spent on the institutionalized spouse's care and, instead, bought an annuity from their attorney (an 'investment' which essentially returns the premium with a very small return) in an effort to tie up the money to make the couple appear to have fewer resources. The annuity is irrevocable, non-assignable, and non-transferable. …

The North Dakota Department of Human Services was sued in federal court under a civil rights action for denying Medicaid to this wealthy institutionalized spouse. … The community spouse has successfully retained nearly all of the wealth the couple had before the institutionalized spouse went into the nursing home and the nursing home has not received one penny. The bill is nearly $100,000 and the couple wants Medicaid to cover it. The couple receives nearly $8,000 a month from pensions, social security, the annuity payments, and oil lease money. This couple is not needy and they are simply not who the Medicaid program was or is intended to cover.

"In another case, the day the institutionalized spouse entered the nursing home, the couple had more than $528,000. At that time, the couple represented to the nursing home that they intended of be 'self-paying,' and in fact, paid for two months of care. After learning of ways to exploit Medicaid laws, the community spouse purchased not one, but two annuities from their attorney after realizing the first one did not maximize the assets that could be sheltered. The community spouse bought a new home, a new car, and an annuity for $220,000 and the next day, a subsequent one for $20,000, and then applied for Medicaid to pay the institutionalized spouse's nursing home costs.

"These scenarios are being duplicated around the state, with an increase in the sales of these types of annuities, and around the country in other states. Medicaid is not intended for people who artificially impoverish themselves by sheltering their wealth instead of using it to pay for nursing home care, but these are the people who are fighting for it and winning—at the expense of the taxpayers and those who legitimately need the assistance of the Medicaid program.

"The North Dakota Department of Human Services argues that annuities like these should be treated as an asset available to pay the long-term care costs incurred by either spouse.

"Changing the federal law to clarify that these annuities are assets or to allow states to determine how to treat these annuities as assets would be a significant first step in helping states determine appropriate limits of eligibility for the Medicaid program. This would help ensure that Medicaid funds would be used by states for those who are the intended recipients rather than being diverted to subsidize those who can and should pay for their own care."

Wisconsin Department of Health Services Secretary Dennis G. Smith: "One example is related to spousal impoverishment laws. More and more, institutionalized spouses are transferring assets to community spouses who refuse to sign the Medicaid application. … Interspousal transfers are not considered divestment so Fred was able to maintain eligibility while Bonnie was able to keep $600,000. This is over five times the maximum Community Spousal Resource Allowance of $113,640. If the department could deny eligibility if a spouse refuses to sign the application, Fred would have been able to cover at least six years of private pay nursing home care using his own resources."

New York Deputy Secretary for Health James E. Introne: "Promissory notes, even when made after an individual has been admitted to a nursing home, preserve the 'half-loaf' strategy. This strategy allows an individual to divest him/herself of assets (say $50,000 is transferred outright) and pay for nursing home care during a penalty period with monies returned through a promissory note (a second $50,000 loaned with repayments made at the private pay nursing home rate—which covers the transfer penalty). The same strategy is employed using an immediate annuity. Money is transferred, and an immediate annuity is purchased to pay for nursing home care for the number of months the person is subject to a transfer penalty. With spousal refusal, all assets are put into the name of the community spouse who then refuses to make the resources available for the nursing home spouse. Medicaid must be provided if the institutionalized spouse executes an assignment of support from the community spouse in favor of the Medicaid office or the denial of Medicaid would create an undue hardship. Medicaid does not have sufficient resources to pursue all these cases in court."

Rhode Island Governor Lincoln D. Chaffee: "Trusts allow the wealthy to shelter assets. The more affluent have access to better estate planning and thus, are more likely to have properly crafted legal documents (i.e., trusts, promissory notes, life estates with enhanced powers, caregiver contracts, etc.). In addition to the use of annuities for married couples, and promissory notes for those single individuals or married couples, the amount of monies paid for legal advice is sizable.

"Some examples:

"Mr. and Mrs. Smith have $400,000 in a bond account. Mr. Smith needs to go into a nursing home. After the spousal share has been determined, Mrs. Smith has excess resources transferred to her 'spouse to spouse' and purchases a large single premium immediate annuity paying her thousands per month. Mr. Smith has less than $4,000 and is found eligible for LTC in the next month.

"Mr. Jones is a single individual with $100,000 in the bank. He goes into a nursing home. He transfers the whole $100,000 to his son. Applies for LTC/MA, meets a level of care due to his poor health and is 'otherwise' eligible for LTC except for the prohibited transfer of $100,000. His son creates a promissory note for $50,000 and pays him back monthly. This allows for the father to pay privately for ½ of the time he would have paid privately, except for this 'Medicaid estate planning' tool. (Assume the promissory note is created with the correct DRA language.)."

Virginia Secretary of Health and Human Resources William A. Hazel, Jr., M.D.: "The following are examples of loopholes that the Virginia Medicaid program has wanted to close, but has been unable to due to the federal MOE requirement in the Affordable Care Act (ACA):

1. The ability to count the value of life estates as a resource.

2. The ability to shelter assets for one year by purchasing savings bonds.

3. The ability to exclude as a resource the unpaid balance of an annuity.

"Prior to applying for Medicaid LTC services, an individual placed approximately $900,000 into an annuity and named his wife as the beneficiary of the annuity. The annuity paid his wife $89,000 per month, but the Virginia Medicaid program could not count this income for purposes of determining the husband's Medicaid LTC eligibility." ■

2013 ILTCI Conference Recap

The 2013 Intercompany Long-Term Care Insurance (ILTCI) Conference was held March 3-6 in Dallas, Texas. The theme of the conference was "Utilizing Technology and Balancing Risks". Before the conference officially began, there were several opportunities for participants to expand their LTC knowledge such as the CLTC Master Class, the SOA LTC Section Council meeting, and the LTC Think Tank session. There were networking opportunities at the Exhibit Hall Reception and the SOA/ILTCI reception.

The conference officially began on Monday morning with the keynote speaker, Frank Abignale. In addition to the opening keynote, Mr. Abignale also led a session on fraud. There were 48 educational sessions from 10 tracks. Finally, the conference concluded with an Exhibit Hall Reception and Casino Night on Tuesday. On Wednesday, there was a post-conference Actuarial Professionalism Session.

CLAIMS TRACK

The 2013 Claims Track included a number of diverse sessions. The one that caused the most buzz was a session called 'Deal or No Deal? A Care Debate' in which care providers took input from the audience on how involved providers should be in the claims process. A session called 'What Can We Learn from DI?' helped us to explore processes in the DI world that might cross over to LTC. 'The Quest to Preserve Home Care Benefits' used a Family Feud format to help us learn more about what claimants want vs. what carriers want when it comes to independent caregivers. A session called 'Social Media, Surveillance, and Interviews' helped us understand the options available to us for investigating a suspect claim. The 'Claims Roundtable' session (back by popular demand) allowed the audience to voice their views on critical claims topics. And, last but not least, for the first time ever, we offered a session where Nurses in attendance could earn CEUs while learning about 'Managing Multiple Chronic Conditions Long Term'.

SALES TRACK

The Sales Track featured three sessions. The first covered a provocative subject, "Is the LTCI Specialist the Next Endangered Species?" Scott Williams, Vice President – Sales, John Hancock Financial Services, spoke from the carrier's viewpoint. Terry Truesdell, President/CEO of the National LTC Network and Sales Track Co-Chair, expounded from the point of view of the broker, and Mike Skiens, President of Master Care Solutions, Inc., represented the point of view of the individual agent. All three agreed that the LTCI Specialist is indeed an endangered species if the specialist fails to make major adaptations to the changing conditions of our industry. This session was well attended and produced spirited questions from the audience.

The second session was entitled, "Partnering for Sales" Steve Cain, National Sales Leader of LTCI Partners, chaired this session. Bill Dyess of Dyess Insurance Services, Inc. talked about partnering with associations. Nathan Sanow, Business Development Manager for Master Care Solutions, centered his presentation on employer groups. Both speakers emphasized the increasing role of partnering in order to provide expert advice to consumers.

The third session emphasized technology and discussed "How to Sell the Lead Remotely." Phyllis Shelton, President of LTC Consultants and a very experienced LTCI broker, chaired this session. Jonas Roeser, President of the 3in4Need More Association, a gifted marketer, brought his experience working with internet marketing to the session from paper click to the use of social media. Katie O'Rourke, Managing Partner of California Long Term Care Insurance Services, educated the audience on how to prepare for the remote sale. This session was lauded for its nuts and bolts approach to remote selling.

UNDERWRITING TRACK

The Underwriting track focused on the conference theme of "Utilizing Technology and Balancing Risks" by producing several sessions on how technology offers the potential in the future to change the landscape for underwriting practices across the industry. Specifically, "Genetic Testing: Underwriting Risk or Fear?" focused on new technology that was specific to genetic testing information and the latest developments related to potential impacts to the industry. The "Obesity: Understanding the

Risk" session discussed the near- and long-term risk of obesity and related health conditions in order to bring awareness about the potential future impacts on risk evaluation strategies. The ever-popular "Meeting with Medical Directors" session led to some healthy discussion around technology and industry trends associated with anemia, tremor and cerebrovascular disease. This most informative session also allowed the medical experts to highlight the importance of determining the etiology of certain diagnoses and symptoms and quantifying risk associated with possible underlying conditions that may negatively impact risk. Lastly, "Actuaries and Underwriters—You Do That?" along with "Opposite Opinions or on the Same Page?" too proved to be a hit with attendees. As to no surprise, this was another year where underwriting experts openly discussed long-term care insurance (LTCI) underwriting challenges (present and future) and lessons learned.

MANAGEMENT TRACK

The Management track developed five new sessions for the 2013 conference, beginning with a session pertaining to personnel development in the LTCI industry. This session explored the challenges and best practices in creating high-performance teams. The speakers in this session shared pros and cons of various recruiting methodologies, showcased an array of methods used to develop current talent as well as aid in retaining existing talent. The Management Track collaborated with the Actuarial Track to produce the session titled "Management View of Capital and Other Financial Matters." This session provided an open forum to examine financial concerns and considerations of management, and provided insights from a rating agency and investor community perspective.

In consideration of recent trends and changing regulations pertaining to rate increases, a panel of industry experts presented a session on managing rate increases from the actuarial and legal perspectives. The panel discussed experiences with rate increase filings and shared their predictions on what to expect from regulators and the industry in 2013 and beyond. The panelists on the "Outsourcing" session shared their experiences on the types of services that can be outsourced. They led an interactive discussion on the key decisions to be made in determining if outsourcing is the best approach. The final Management Track session, "Executing Operational Change in LTC," drew a large crowd of conference attendees. The presenters provided three different perspectives of LTCI management. The speakers shared their experiences on managing the impact of evolving regulatory, product and technology changes, as well as customer expectations.

ACTUARIAL TRACK

For the 2013 ILTCI Conference, the Actuarial track produced five sessions. During the "Morbidity Improvement" session, two approaches to measuring improvement in company experience were discussed. This was certainly a session not to miss, as, due to confidentiality concerns, neither the presentation nor the recording is available post-conference. "Valuation Hot Topics" addressed the many-faceted question of whether active life reserves should be held on disabled insureds. The session also reviewed valuation considerations after rate increases and for combination products. In "LTC Claims Management," speakers discussed the latest claims management techniques while also laying out potential methods and pitfalls in measuring claims management effectiveness.

"LTCI in a Low-Interest Rate Environment" started with a review of the current investment environment and potential pathways from this point forward. Bruce Stahl discussed why there might actually be some good news with low interest rates (for background on this topic, see Bruce's "Aspirin, Not Morphine" article in the September 2012 edition of *Long-Term Care News*), while Heather Majewski discussed an innovative product designed to address the challenges of low investment returns. "Advanced Actuarial Topics" was a lively session discussing the challenges of applying credibility methods to LTCI work, why using a total lives approach in your work can lead to very non-intuitive results, and experience study best practices and pitfalls. After the conference, many actuaries took advantage of the interactive SOA Professionalism

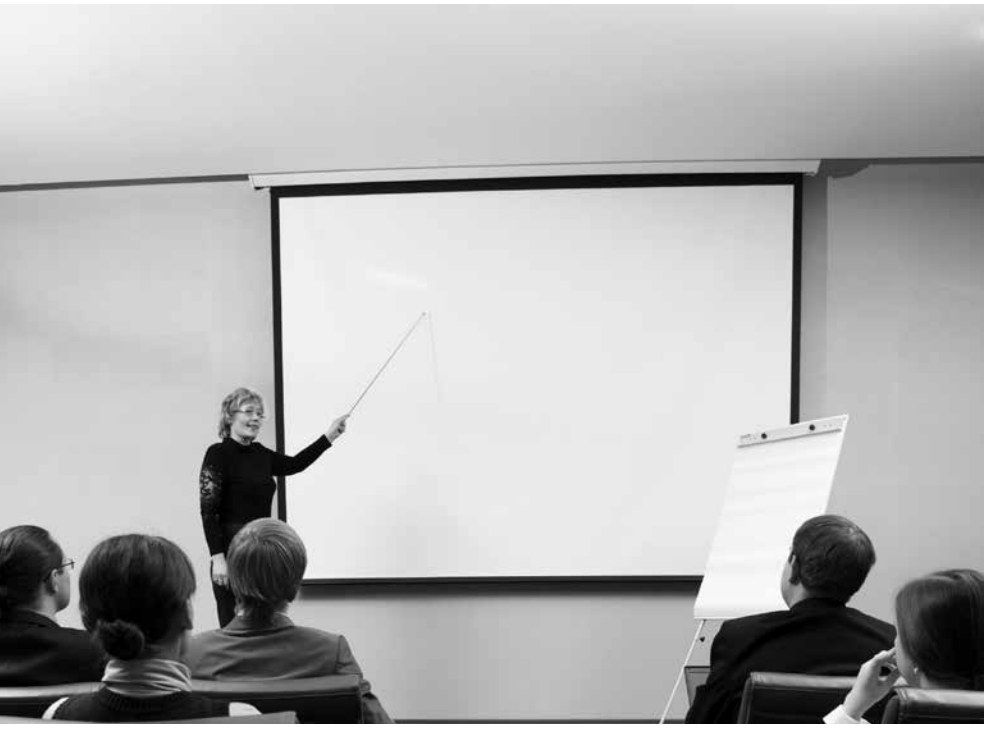
CONTINUED ON **PAGE 26**

Course to earn three CE professionalism credits. The track chairs want to thank the producers and speakers for creating a slate of thought-provoking and informative sessions.

OPERATIONS AND TECHNOLOGY TRACK

The Operations and Technology track produced four sessions this year: one that addressed a complex interdisciplinary process in insurance company operations, and three that focused on some of the technology advances being introduced in companies this year. Reinstatements have continued to challenge insurance companies as they receive an increasing number of requests to reinstate a policy after it lapses. This decision involves regulatory and legal analysis, underwriting assessment and the premium operational areas. After presenting legal updates, compliance procedure recommendations, and tips to manage the risks and challenges, the session used online polling to determine how session participants would respond to reinstatement requests. It was informative to see how additional information changed the decision for some disciplines, while others stayed firm on their initial decision based on key facts. The interaction of multiple disciplines on this topic made this an interesting and helpful session based on evaluation feedback.

"Power Tools" was a session that introduced straight-through processing and mobile applications that companies are developing. These power tools streamline communications from the field to the home office and expedite transactions between the agent and the applicant. The process for straight-through processing included quoting tools, integration of field underwriting, completing the ticket with a mobile device, fulfillment of application and requirements, the e-delivery of the policy/contract, and commissions paid. The benefits and regular status updates were well received by the audience, and feedback was positive for the value this provides and the time savings for producers to continue selling.



A second company discussed its field facing application, which leverages this tool for the home office use. It is a solution to the field teams who often do not have office resources available to them in homes and on the road. The Quick Estimate program is an application that provides first-year premium estimates, medical impairment risk class estimates, age and amount underwriting requirements, and product brochures. Quick data entry customizes the results and provides a valuable field and home office resource. Key to the success of the application are the business rules development system and the standardized risk assessment. This was very well received, and development is ongoing for multiple technology platforms.

TECHNOLOGY SESSIONS

There were two technology-specific sessions at the ILTCI Conference. "'E' Initiative" gave an overview of the work from the LTC Business Technology group. Started in 2011, this group has been focusing on e-application and e-contracting. E-application, headed by Andy Falvey, has industry enthusiasm around developing a quick ticket approach with the collaboration of the LTCI carriers in the industry. E-contracting has been working on breaking down the wall between electronic contracting packages to the carriers with true STP. The other technology session was "Security/Compliance in a Paperless World." Attendees heard from two top data management companies as to how they protect against hackers and identity thieves, as well as a deep dive into the laws that protect our businesses.

POLICY AND PROVIDER TRACK

The Policy and Provider track sponsored five sessions covering a diverse range of looking-forward topics. One session examined various studies and demonstrations of care management for chronically ill patients in the health care arena. The potential for similar positive impact on long-term care is

quite inviting. There were two sessions on product innovations. One session described an extension of home care services under the Continuing Care Retirement Communities model. This unique insurance program offers pre-claim risk assessment, care counseling and wellness guidance with the intention of keeping seniors at home. The other session, "How to Hit the Reset Button," introduced a number of new LTCI product ideas to bolster the value proposition to the consumers. The presenters also shared their views on enhancements to LTCI regulations.

The remaining two sessions focused on broad overviews. One session was a concise but informative survey of the long-term care service providers—nursing facilities, assisted living facilities and home care agencies. The last session, "Financing Framework for Social LTC Security System," was conducted by three distinguished policy experts from Washington, D.C.

MARKETING TRACK

2013 was a year where sessions featured marketing and sales innovation and out of the box thinking. The marketing track produced 5 sessions, including one joint session with the sales track. That session, titled "Short and Thin-The Marketing and Sales of Affordable Alternatives," was produced by Louis Brownstone, and featured excellent presentations on an innovative approach to making inflation protection more affordable for consumers and less risky for carriers. It also included an informative discussion on the market rationale for affordable "transition" products.

Continuing the innovation theme were two case study sessions that evaluated the effectiveness of new marketing methods to increase awareness of the need to plan for long-term care. The session "Old Problems, New methods" produced by Eileen Tell, provided an in-depth examination of the "Own your Future" campaign, including evaluations of new advertising approaches and traffic generating methods in the State of Minnesota. "One for all and All for One" produced by Jonas Roeser highlighted a similar program with the State of Texas that featured the non-profit 3in4 long-term care awareness campaign, and its ability to generate high levels of free publicity.

John O'Leary produced perhaps the most "out of the box" session, "Are we marketing the right product?" That session examined the feasibility of combining wellness programs and health activities with long- term care insurance as a way to both increase consumer interest and reduce carrier claims and risks. The final marketing session featured a stellar panel of distribution All-Stars discussing trends, issues and the future of long term care distribution. That included the distribution expert's thoughts on the impact of assisted and virtual selling on a going forward basis.

Note: The introduction for this article was provided by Laurel Kastrup. Track chairs provided the reports on the respective tracks: Jenny Goodyear, Management; David Benz, Actuarial; Jacqui Carreno, Claims; Sandra Latham and Sharon Reed, Operations and Technology; Bob Yee, Policy & Provider; Rob Brown, Underwriting; and John O'Leary, Marketing. ■

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