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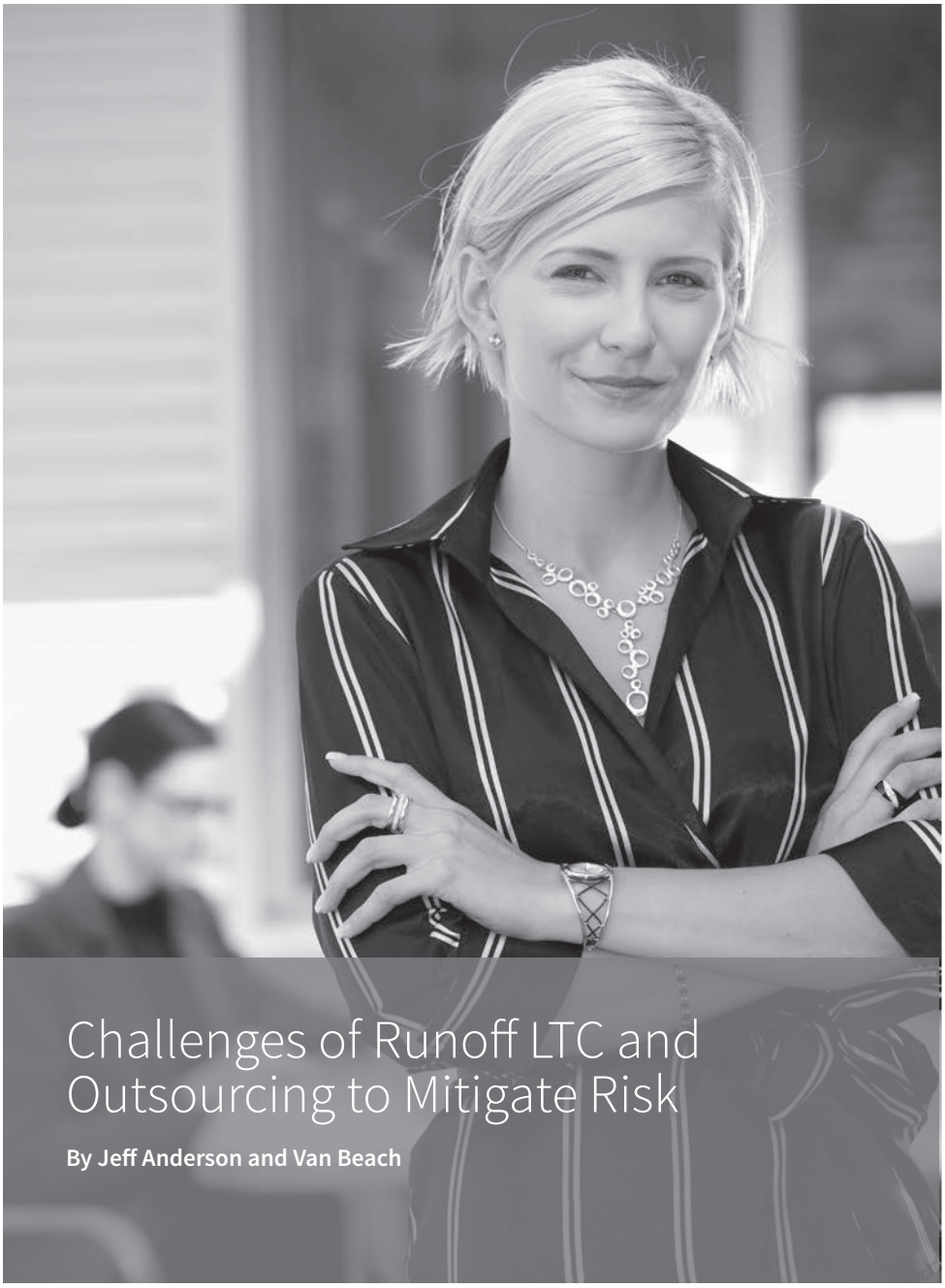
Long-Term Care News

SOCIETY OF ACTUARIES

LONG TERM CARE INSURANCE SECTION



Challenges of Runoff LTC and Outsourcing to Mitigate Risk

By Jeff Anderson and Van Beach

Long-Term Care News

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Long Term Care Insurance Section of the Society of Actuaries.

This newsletter is free to section members. Current issues are available on the SOA website (www.soa.org).

To join the section, SOA members and non-members can locate a membership form on the Long Term Care Insurance Section webpage at http://soa.org/ltc/

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Chairperson's Corner

By Robert Eaton and Chris Giese

FROM OUTGOING CHAIRPERSON, ROBERT EATON:

The Long Term Care Insurance (LTC) Section of the SOA is full of energy some might not expect from a struggling industry. In the past three years the members of the section council have maintained its core mission, facilitating professional development through thought leadership and education. From the outside, this activity may seem almost routine: putting on webinars, producing conference sessions, serving as a regulatory resource, maintaining the webpage, and of course printing this newsletter. On the inside you see that this work takes the effort, thoughtfulness, and sacrifice of the many members and friends of the section council. Our monthly calls are full of vibrant discussion and some laughter as well. Our in-person meetings at the ILTCI (over the last three years, I've met with the council in San Antonio, Jacksonville, and Las Vegas) are well-attended by Friends of the Council.

If you are passionate about long-term care I encourage you to reach out to any of the members of the section council or the SOA staff to find out how to get more involved. There are enough projects and subgroups helping turn the gears of the section that an hour or two a month of your time can make a real difference. You will find the camaraderie of like-minded actuaries and other LTC professionals such as producers, marketers, claims and operations managers. You will develop working relationships and friendships that will connect you for years to your peers. And you'll help the lot of us as we advance the education and thought leadership of LTC actuarial practice.

Thank you for letting me serve on the council for these past three years! I leave you in the capable hands of Chris and Jamala.

FROM INCOMING CHAIRPERSON, CHRIS GIESE:

I am grateful and humbled to serve as the next chair of the LTC Section. I will do my best to build upon the foundation and successes led by Robert Eaton and his predecessors. It is truly an honor to be part of a section comprised of so many devoted, hard-working volunteers.

For those that have lived and breathed in the LTC industry during their careers, we know the challenges that come along with financing LTC needs. Discussions on how to finance LTC will continue to emerge and evolve next year, and over the coming years. Many of these conversations are already well underway, ranging from addressing challenges within existing products to designing new private or public "solutions" for the future. Possibly now more than ever, the thought leadership and education of the LTC section is needed to help inform and shape how we move forward with LTC. I am looking forward to an exciting year, and hope you will consider volunteering in these efforts along the way!

As we embark on this next year, I would like to welcome in newly elected council members Vince Bodnar, Steve Schoonveld and Matt Winegar. I look forward to their eagerness and dedication to support the LTC Section's mission. We are fortunate to have three individuals with their level of experience and résumés joining the council.

Finally, a special thank you to outgoing council members Robert Eaton, Marc Glickman, and Shawna Meyer. Their contributions will be missed. I am confident they will continue to be great leaders in our industry outside the LTC Section (and hopefully still as Friends of the Council!). ■

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Editor's Corner

By Paul Colasanto

For years, the *Long-Term Care News* has been a part of my life as an LTC actuary, but even more so during the last two years. I'm proud to have been the co-editor, and now editor of this publication. Throughout this experience, I've enjoyed seeing the passion that exists for the product, as well as the willingness of people—from all backgrounds—to share their experiences. Even though it is a publication of the Society of Actuaries (SOA) Long Term Care Insurance Section, this newsletter includes much more than actuarial topics.

During my editorial tenure, we've tackled the topics of consumer behavior, home renovations (to encourage aging in place), Alzheimer's Disease research, the impact of immigration on care providers, and many other non-actuarial topics.

This issue is no different. We have articles that provide meaningful insights—from both actuarial and non-actuarial perspectives—which can be leveraged by the entire industry in addressing some of the current challenges. This issue includes the following articles:

- **Sally Leimbach's** article on an LTC education Task Force in Maryland discusses the life cycle of creating and convening such a group and provides a first look at the output. We will make sure to follow this journey to completion and cover developments in a future issue.
- **Louis Brownstone** provides a follow up on the state of the California Partnership program and shares his optimism for the future.
- **Jeff Anderson** and **Van Beach** discuss options for dealing with closed LTC blocks, highlighting some common challenges to successfully managing the block internally.
- **Bruce Stahl** reflects on the possibility of an unintended consequence of a particular Actuarial Standard of Practice, and how to better balance optimism and pessimism in future assumption setting via sensitivity testing.
- **Rhonda Ahrens** and **Fred Andersen** discuss how the initial Actuarial Guideline 51 activity related to 12/31/2017 asset adequacy testing has impacted regulators' views of the most material key risks associated with LTC insurance blocks across the industry.
- In addition, we continue our "Experienced Insurance Professionals who are New to LTC" series with **Matt Capell**, who joined LTCG in September 2017 after running a homecare billing company, and a prior career in financial technology, venture capital and M&A advisory.

Serving as the editor for the *Long-Term Care News* has reinforced my view that this is the most interesting insurance product in the market. I am proud of the LTC community for its eagerness to share experiences, openly discuss challenges, and listen to a vast range of ideas from people of varied backgrounds. Only a small portion of those conversations end up as formal articles in a newsletter such as this, so I encourage you to continue to write and submit articles for future issues. Continuing to have these important conversations will help drive thought and innovation, and develop solutions to meet the LTC needs of the U.S. population as a whole. ■

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Up Front with the SOA Staff Fellow

By Joe Wurzburger

"Good, bad, or indifferent, if you are not investing in new technology, you are going to be left behind."
-Philip Green

Technology startups are disrupting the insurance industry, particularly in the property and casualty practice area. Sometimes referred to as InsureTech, innovations in the insurance industry to this point have focused largely on business functions such as distribution and marketing. But given the limitless potential of technology and the human innovative spirit, its reach is likely to expand rapidly.

For those of us who have lived within the traditional insurance model, technological disruption can be viewed as a threat or as an opportunity. Your perspective on this may be related to your personal tendency to be a glass half full or half empty person. Regardless of your perspective, I'd argue that you should consider InsureTech disruption as an inevitability. And its potential applications within long-term care are fascinating.

"I just invent, then wait until man comes around to needing what I've invented."
-R. Buckminster Fuller

Innovation is taking place whether we are aware of it or not. Many new innovative concepts and inventions would be useful in the long-term care industry, both by the insurance industry as well as by the provider community. For example, creative new ways to help people stay in their homes longer and age in dignity provide that elusive "win-win" proposition: Insurers love the lower costs of in-home care versus facilities, while consumers get the freedom and dignity of staying at home where they feel most comfortable.

Innovators have already created these technologies that would be so useful to our industry. In some ways, it's like the quote above from Mr. Fuller in that they have already invented and are just waiting for us to come around to need—or, perhaps more accurately, figure out how to best use—their inventions. How can we connect these innovators to professionals in the long-term care industry who can truly utilize these inventions?

"While technology is important, it's what we do with it that truly matters."
-Muhammad Yunus

The Society of Actuaries, thanks to the inspiration and leadership of the Long-Term Care Think Tank and in partnership with Maddock Douglas, will host an event, InsureTech LTC, in mid-2019 to do exactly that: Connect innovators to professionals in the long-term care industry. It will be centered on cutting edge developments in the delivery of long-term services and supports and formatted along the lines of InsureTech. This event will seek to introduce innovative, non-financial solutions and products developed by entrepreneurs and start-ups to insurance company executives, health care executives, government agency leaders and public policy makers. The hope is to accelerate movement in this important space so that we can all work together to make long-term services and supports more accessible, appropriate and affordable.

Rather than to simply encourage innovation, InsureTech LTC acknowledges that innovation is already taking place and is evolving very rapidly. However, much of the long-term care industry is unaware of this innovative technology and therefore is not utilizing it as effectively as possible—or at all. As suggested by the quote above, it's not enough to just have new technology. We need to do something meaningful with it for it to truly matter.

"Technology is cool, but you've got to use it as opposed to letting it use you."
-Prince

Technology is cool, and it has vast potential to disrupt the long-term care insurance world in potentially exciting and beneficial ways. Consumers, insurers, providers, and others stand to gain from the innovative spirit of these InsureTech startups.

Innovation is happening. Disruption is coming. And it promises to be very exciting. Be a part of it. Plan to come to InsureTech LTC in mid-2019 and prepare to consider ways to incorporate innovative ideas into your part of the LTC world. More details will emerge in the coming weeks, so please stay tuned. A great place to stay informed will be at the LTC Section webpage (www.soa.org/ltc). And once registration opens, note that space will be limited. So, act quickly. After all, much like innovation, the limited seats are sure to go fast. Don't miss out. ■

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Challenges of Runoff LTC and Outsourcing to Mitigate Risk

By Jeff Anderson and Van Beach

There has been tremendous change in the long-term care (LTC) insurance market over the last 20 years. The torrent of new carriers entering the market in the late 1990s and early 2000s transformed into a rush for the exit. While at one point there were more than 100 companies issuing new business, we are now left with fewer than a dozen that offer stand-alone LTC policies. Given the long duration of LTC contracts, this mass exodus from the new business market has resulted in many runoff blocks of LTC policies. There has been some market consolidation, but there are also many orphaned blocks as companies have pivoted away from LTC but retained the risk on their existing policies. These blocks present a wide range of business risks beyond the inherent LTC insurance risk. If not addressed, the potential impact to the company can be severe and, as time passes, the range of options to mitigate these risks becomes more limited. Instead of waiting for a crisis moment, companies would be well served to assess the situation and make a conscious decision on how to proceed with the runoff of these blocks.

> Third-party involvement can help reduce several risks involved in managing a closed block.

THE RISK OF ORPHANED LTC BUSINESS

Over time, many companies experience two phenomena with respect to blocks of runoff business. The first phenomenon is that product-specific knowledge becomes concentrated within a few individuals at the company. This occurs when a specific person or team is primarily focused on the runoff block. This can also occur when the company retains the subject matter experts (SMEs) involved in original product development or management of the block when it was still open, if their knowledge is not shared and/or documented. This results in key person risk as the knowledge base consolidates due to either retirement or turnover. The second phenomenon is that product-specific knowledge is eventually lost. This occurs either as a result of knowledge concentration and turnover or as a consequence of orphaned blocks being bought and sold. This can lead to estimation risk if the business is not well understood and properly modeled.

Exacerbating the phenomena noted previously, many companies find it hard to retain and/or attract new actuaries to manage runoff blocks of business. Because of the long-tail nature of LTC products, it is likely that many of the current closed blocks will persist beyond the careers of most current actuaries. As existing SMEs retire, knowledge is often lost instead of transferred, or is transferred only temporarily and then lost due to further turnover. If companies are unable to retain or replace SMEs, this knowledge loss occurs more quickly.

Many of the assumptions used in the original pricing of LTC policies during the industry's sales peak were aggressive in hindsight. This has led to widespread rate increases and many companies have looked outward to consultants, reinsurers, and third-party administrators for assistance with these filings. This decision to seek assistance has often been driven by the realization that current staff lacks either the capacity or knowledge base, or sometimes both, to prepare and submit the rate filings. Fewer companies have sought outside assistance with financial reporting tasks, potentially because many valuation and reporting processes are well established. Those that do are often driven by a desire to remediate audit deficiencies, improve modeling due to business or industry changes, or supplement dwindling staff.

In many valuation and reporting processes, a large portion of the actuary's time is spent processing and moving data and results. This leaves less time for developing assumptions and analyzing results. Additionally, many valuation and assumption development processes have been in use for years. If not questioned, at least occasionally, this situation can result in actuaries and other staff following a certain process or using a certain method "because it's always been done that way." In light of recent industry news of large reserve increases and continued large rate increases, assumptions and processes should be reviewed with a fresh perspective and revisited regularly.

ASSESSING AND MITIGATING THE RISK

Third-party involvement can help reduce several risks involved in managing a closed block. Depending on the structure of the involvement, it is possible to reduce estimation risk, key person risk, and process risk. The level of third-party involvement can vary greatly and is usually driven by the types of risks a company

is trying to mitigate as well as the knowledge base and capacity of current staff. Involvement can vary from a high-level review of processes or assumptions to detailed experience analysis and assumption development to full outsourcing of actuarial tasks.

Estimation and process risk can each be mitigated through multiple types of arrangements. Often, when companies are comfortable with the status quo, the solution takes the form of high-level review by a third party. In situations when there are questions regarding the reasonableness of assumptions or the modeling approach, risk mitigation takes the form of a more detailed review or independent assumption and model development. In extreme scenarios with audit deficiencies or where material errors have been discovered, a more comprehensive assessment and remediation is required, often involving augmenting or replacing existing staff to reshape processes and controls. In some cases, the remediation required is so extensive that companies look to full outsourcing.

Key person risk can be effectively mitigated in multiple ways. Ideally, this is accomplished via thorough documentation of products, assumptions, and processes along with retention of existing staff. However, this is often not an option, given limited time and existing obligations of current staff. In these cases, companies may look to third parties to develop documentation or supplement existing staff to allow time for staff to assemble the documentation.

Unfortunately, some companies are unaware of their key person risk until it is too late and a key staff member has provided notice that they will be leaving. When this occurs, there is often a rush to do something as quickly as possible in order to take advantage of the key staff member's remaining time at the company. This is necessary to allow for as much knowledge transfer as possible. However, it may not be possible to sufficiently transfer enough knowledge to ensure a smooth transition. In this case, a third party may be needed to fill the

knowledge gap. In some cases the best answer is full outsourcing to address the impact of losing key individuals.

OUTSOURCING FOR CLOSED LTC BLOCKS

As noted previously, outsourcing—transferring the management responsibilities for an LTC block to a third party—is potentially a necessary move in order to address the adverse impact of various LTC business risks. However, for many companies, outsourcing certain processes is advisable even in the absence of an adverse situation. It is difficult with a small, orphaned block of LTC business to retain the talent, develop the process efficiencies, and achieve the scale needed for efficient and effective LTC actuarial operations.

Buoyed by the rise of cloud computing, there have been exciting developments in the capabilities of third-party outsourcing providers that reduce the previously noted risks and deliver scale and process efficiency. By aggregating the operations of these small blocks into a common platform, these third-party providers can bring greater levels of LTC expertise as well as advanced technology to address the requirements of the LTC business.

The typical infrastructure starts with a secure data exchange between the company and the outsourcing provider to move data that supports actuarial processes and also to return output, results, and analyses back to the company. Once in the cloud, highly-scalable data repositories capture and store the incoming data, often with automated validations and data cleansing algorithms. Valuation and modeling processes are built into controlled cloud environments that allow for end-to-end auditability while automating as much of the process as possible. Responsibility for assumption input and review can remain with the company or be transferred to the third party, and can be managed seamlessly through web-based portals where assumption governance protocols are enforced in a secure environment.

In conjunction with the scaling capabilities of cloud computing, the automation results in a dramatic reduction in time spent performing each valuation. Results are delivered through secure online portals where cutting-edge reporting tools are used to visualize and analyze the results. With nearly limitless capacity to capture and store data, the breadth and depth of reporting is similarly boundless, but effective reporting will put the most critical information at the fingertips of management. For LTC business, important business management metrics such as actual-to-expected results, variance attribution, and historical trend comparisons can all be automatically produced, along with other metrics requested by the company.

Checks and controls on both data and results are performed throughout the automated process. The top outsourcing providers are staffed with an in-house compliance officer and will also provide a System and Organization Controls Type II Report (SOC 1 Type II Report) demonstrating successful execution of controls and security necessary for SOX compliance. This allows the company to rely on the results without needing to conduct its own audit of the provider.

In addition to the noted technological capabilities, top outsourcing providers can also contribute their expertise in order to support the company in many ways, ranging from developing assumptions to interpreting results. In situations where the company retains internal actuaries, the net result is that the company actuaries are freed from manual and inefficient operations and can focus on making business decisions to derive more value from the business. In situations where the company fully outsources all actuarial functions, the net result is a reduction in key person risk, an increase in available expertise and capacity, and a move toward a more variable expense structure. In both situations, the company is able to greatly reduce operational risk.

LTC IS RISKY BUSINESS BUT DOES NOT NEED TO INTRODUCE BUSINESS RISK

Today's LTC insurance landscape has many remnants from a rapidly expanding and then rapidly contracting market. Orphaned blocks of LTC business are scattered throughout the industry and pose business risk to the companies that retain the actuarial operations. There are many options for reducing key person risk, process risk, and estimation risk, among others—often facilitated by a third party for additional expertise or bandwidth. Third-party outsourcing providers have historically been a source of expertise for many companies. The recent technological advances of cloud computing have provided the scale, efficiency, and accessibility to enable these providers to also become an attractive option to address the business risks associated with runoff LTC blocks. The last 20 years have proven that LTC business is risky, but with options for outsourcing LTC actuarial operations and expertise, there is no reason that LTC needs to continue to be a business risk. ■

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Actuarial Guideline 51 Impacts to Regulatory View of Current Predominating LTC Industry Risks

By Rhonda Ahrens and Fred Andersen

As regulators, we have a significant responsibility to monitor the care an organization is taking to understand and manage its risks and to allow management to distribute capital under the assumption of profitability or excess surplus. For long-term insurance products, profitability and return are, to some extent, unknown for decades and early distribution of expected profit can create significant risk for the guaranty association system if adverse experience develops. A priority in protecting insureds and the insurance industry from insolvencies is to understand whether companies are considering an appropriate level of moderately adverse conditions in their analysis of reserve adequacy. This process is important even for companies appearing to be the most financially stable. In addition, understanding the role of capital to cover more severe conditions and address the other risks competing for capital within an organization is also important.

AG51 was made effective for yearend 2017 reserve adequacy testing and specifically addressed areas regulators were most unsure about.

In 2017, the NAIC's Long-Term Care Valuation Subgroup, a subgroup of the Health Actuarial Task Force, determined that regulators needed a mechanism to better appreciate the reserve adequacy analysis being utilized by insurance carriers with significant blocks of long-term care insurance. The group determined that standalone testing of blocks with more than 10,000 lives would capture most of the industry-wide risk and it would be beneficial to financial solvency regulators in better understanding the state of the market. Solvency regulators are not only concerned with capital adequacy for an entity retaining long-term care insurance risks, but also to ensure the proper capital considerations are made if and when these risks are transferred to other entities. In addition, there is a general regulatory interest in the assumptions used for premium rate modifications to be consistent with assumptions for asset adequacy analysis.

Actuarial Guideline 51 (AG51) was made effective for yearend 2017 reserve adequacy testing and specifically addressed areas regulators were most unsure about. The guideline does not disallow the use of Gross Premium Valuation (GPV) traditionally used to demonstrate adequacy of health insurance reserves, however, it encourages the use of cash flow testing in many cases. Because long-term care insurance requires a very long projection period and has prefunding of claims via premium higher than the cost of insurance in early years, regulators feel that even though GPV analysis can somewhat address investment income sensitivities, cash flow testing may do a better job of testing specific asset risks in a portfolio backing the product. In order to address the importance of asset management, the guideline requires that assets modeled or investment income assumed reflects the actual management of the block of business, especially if the company has a carved out portfolio specific to their long-term care insurance management strategy.

The guideline also requires a deeper conversation within the analysis and the actuarial memorandum documenting the organization's approach to applying not-yet-approved future rate increases related to past adverse development of experience. For rate increases, the guideline requires future activity to be, at the very least, supported by a level of management approval that presents a strong likelihood that the rate increases will be filed with regulators and documentation of what the company assumes the approval level and implementation timing will be.

Finally, in developing the requirements for AG51, regulators are most interested in whether companies with significant blocks of long-term care insurance are complying with the requirements of the Accounting Practices and Procedures Manual, Appendix A-010, Paragraph 48.e. which states, "The total contract reserve established shall incorporate provisions for moderately adverse deviations." Approaches to meeting the moderately adverse condition requirement could include use of baseline assumptions that contain a margin for conservatism or analysis that demonstrates sufficiency of reserves over a set of sensitivities for each key assumption.

During 2018, a team of regulatory actuaries from several states convened several regulator-only calls and in-person meetings to review and discuss all 50 AG51 reports submitted for year-end 2017. This review process provided regulators with a wide view of practices used by companies in contemplating their long-term care insurance risks for their in-force blocks of business. The review has given those of us in the regulatory community the ability to refocus our attention on key risks that we believe need a greater level of attention from regulators and companies as we all contemplate the current sufficiency of funding for long-term care insurance liabilities across the industry.

Most long-term care insurance actuaries would say that the key risks related to standalone long-term care insurance product are morbidity (claim incidence, utilization, and continuance), persistency (driven by voluntary lapse and survival), and long-term investment earnings potential on assets backing the reserve buildup. As noted within the design of AG51, regulators felt a need to see more analysis around the investment earnings risk and also recognized a risk that has emerged for companies in the ability to implement future planned rate increases related to the development of adverse experience that has emerged over time. In the review of the AG51 submissions for year-end 2017, we developed additional curiosity around risks or risk subsets that we would like to understand more in future year-end analyses. Any findings of concern to a specific company are being addressed through the domestic insurance regulator and details of those findings cannot be shared publicly. However, each company subject to AG51 has or will receive additional guidance around expectations for year-end 2018 analysis and reporting. Following is a list of questions about the predominant risks that regulators are currently most interested in learning more about.

With respect to morbidity:

1. What is the basis for a morbidity improvement assumption? Is actuarial judgment used to support the assumption or is there a study referenced? If a study is referenced, was the data used to complete the study population data or insured data? To the extent a study demonstrated improvement, was there an indication of what medical advances or changes in way of life have driven the improvement and is that level of change likely to continue?

2. To the extent the ability to opine that a block of business has sufficient reserves, would removing morbidity improvement cause the block to be unsustainable on its own?

3. For any morbidity basis used in projections, what is the credibility at older ages? To the extent credibility is lower at older ages, has sensitivity analysis been used to assess the impact of worsened morbidity at older ages for contemplation of moderately adverse condition requirements?

4. What is the basis for future morbidity projections? Is it an internally developed study, is it external or is it a combination? When was the last update to the basis? If longer than three years, what is the justification for not updating the study?

5. Whether a company uses internal or external claim cost guidelines, when is the last time the historical claims were studied or the last time the company performed an actual-to-expected of recent claims data against the basis?

With respect to persistency:

1. Most companies use fairly low voluntary termination rates. In cases where voluntary termination rates appear to be outliers, is this difference addressed in the way total terminations, including deaths are analyzed by the company?

2. To the extent long-term persistency expectations are driven currently by older age mortality rates that are significantly higher than the voluntary termination rate, is sensitivity to the mortality basis contemplated in the analysis?

3. Are newer or more conservative mortality tables being used? If not, does the company adjust for experience by using adjustments to the table that is being used?

With respect to investment earnings rates:

1. Most companies assume reasonable net investment and reinvestment return and spread assumptions. For companies assuming aggressive investment or reinvestment spreads, are they appropriately modeled?

2. Are aggressive or less well-known asset classes being utilized by the company?

3. How does the level of sufficiency in the current reserve change if the analysis is run using a limitation of 150 basis points above Treasury yields on all current assets as well as for the reinvestment assumption?

With respect to dependence on future rate increases:

1. What is the level of the increase, including the amount planned for the future as well as the level of past increases already implemented?

2. Is the timeline for continuing a planned rate increase campaign/effort realistic?

3. How material is the present value of the projected increase to the sufficiency of the reserve?

4. Has regulatory risk of disapprovals been considered through sensitivity testing? Is consideration given for policy change that may be implemented across states, either to enhance or reduce uniformity?

With respect to reinsurance:

1. Have all risks related to any reinsurance transaction been contemplated? Does the actuary performing the analysis have access to the treaty or do they get their information from another area of the company? Are there recapture provisions that are being overlooked?

2. It is not enough to state in an AG51 report that "reinsurance has been modeled." What is expected is that a current assessment of the risks transferred has been made.

3. What mechanisms does the cedant use to assess counterparty risk or model the reinsurance collectability risk?

4. If risk is only partially transferred, are both companies performing asset adequacy testing for their portion of the risk? To the extent they may have similar views of the risk, whether or not they are required under the treaty to communicate with one another about the risk, are they leveraging their analysis by working together on observed experience and projections?

In addition to the above risk topics, we are working to educate multiple interested parties who depend on our guidance at the regulatory level that significant risks discussed in our proceedings may or may not be present in a block of business. When present, a risk factor can vary in predominance across entities. The additional factors that come into play include, but may not be limited to, the materiality of long-term care insurance to any insurer's total liability, the richness of benefits still available on the contracts in force at a company, and the ability for capital to be available to fund adverse developments, including capital currently at the insurance entity holding the risk, as well as the ability to raise capital or receive it from within a holding company environment.

We plan to continue to work to improve the comfort level of, or appropriately alarm financial regulators regarding, the sufficiency of reserves across the long-term care insurance industry. Our plans are to engage in public discussions and potentially develop better awareness and standards around the appropriateness of certain key assumptions related to reserve adequacy and mentioned above. The public discussions will take place at the NAIC's Long-Term Care Valuation Subgroup and possibly within other long-term care insurance focused groups within the NAIC Committee structure. We have already provided additional guidance for year-end 2018 AG51 submissions. In addition, we are likely to convene the same regulatory group to review year-end 2018 submissions. It is possible that the guidance provided to companies will be used to revise Actuarial Guideline 51 for year-end 2019. Discussions about any changes to AG51 would also be held publicly by the LTC Valuation Subgroup.

In order to participate in public discussions held by any NAIC Committee, Task Force, Working Group, or Subgroup, visit www.naic.org, find the group within the "Committees" tab and contact the NAIC staff person listed as the contact for the group. ■

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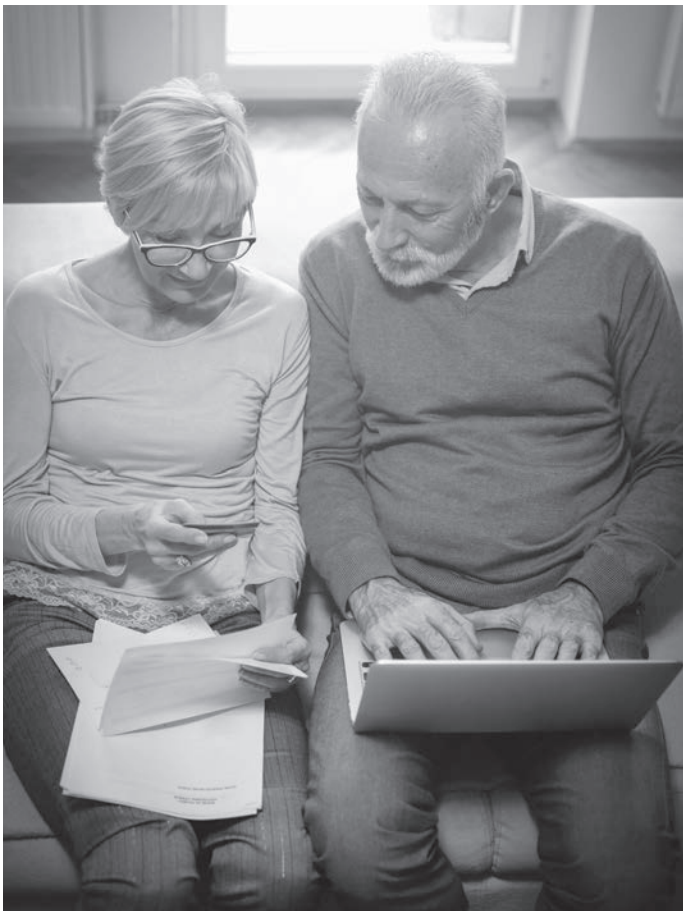
State of Maryland Adds New Initiative to Raise Awareness of LTC Crisis

Success at the State Level: One State's Awakening to Crisis of Aging Baby Boomers

By Sally H. Leimbach



PREFACE

This article is the first in a series. It will be a cliff hanger, with either a happy or tragic or something in-between ending. The conclusion remains to be seen as this story continues to unfold. While I am unable to predict the outcome, I have been and am now living every moment. The "moments" began the last Friday of 2016 when an opportunity was presented to create long-term care (LTC) legislation to be introduced during the 2017 Maryland legislative session. That opportunity became Maryland Law 953.

This preface is in no way meant to make light of a very serious subject that is now often referred to in the media as the "aging crisis unfolding in America" and "the silver tsunami washing over America." The impact of swelling Medicaid budgets in every state, impacted not only by demographics but also driven by rapidly rising long-term care costs, is increasingly smothering other necessary state responsibilities. Sufficient relief has not come from the federal level. Therefore, states must be resourceful and share successes so that mitigation of the crisis will surge up from the states, without waiting for additional federal assistance that may never come.

The Governor's Report, although written, has not yet been presented to Governor Hogan. This task force has been an entirely volunteer effort, including the administrative aspects. It is extremely rare that a Governor's Task Force in Maryland does not have a state agency overseeing all things administrative. This normally includes writing the final report after gathering input from task force members. The United Seniors of Maryland, a coalition dedicated to assisting Maryland seniors by influencing legislation and public policy, agreed to be added to the legislation as administrator. Without their "19th" hour lifeline to be added as administrator, the legislation would have experienced a quick death. The task force members wrote the report. Now United Seniors of Maryland is formatting it to be ready to present to the governor. With Law 953 sitting in a now past due state, this information is not provided as an excuse but rather as an explanation.

The state agency appearing in the original legislation declined to be included due to being short staffed. Ironically, one of the reasons that Maryland departments have had to tighten budgets across the board is the swelling Medicaid budget.

So now on to the first of the four chapters. Chapter 1: In the Beginning, will include the purpose of the law, the makeup of the Public/Private Task Force, the process the task force used to come up with the 10 Recommendations, how to implement them and pay for the implementation, and, finally, how to make the Maryland Medicaid program (known in Maryland as the Maryland Medical Assistance Program) understandable to residents.

Chapter 2: Reception of the Report by Maryland Governor Hogan will include the 10 Recommendations as well as what was covered in the other 16 sections of the report.

Chapter 3: Implementation of the 10 Recommendations will cover which recommendations were embraced, which ones were delayed

and which were ignored (if any). Also the timing to implement recommendations will be addressed.

Hopefully, chapters 2 and 3 can be covered all or in part together. The timing is unknown for the governor to actually address the information in the report. The report will first be read by the governor's deputy legislative officer. It will be marked up, commented on, and then given to the governor.

Finally, we hope to provide a follow up article after a year or so to report what actually happens in Maryland after the recommendations of the report are implemented. This could include an evaluation of what went right, what did not, and how the effort could have been more successful. Or how the effort can at that point achieve an even higher level of success then it has.

Did I mention that this is a gubernatorial election year in Maryland? This may well influence the timeline for the Task Force Report to receive attention.

CHAPTER 1: IN THE BEGINNING

Introduction

Maryland Bill 953, signed into law April 2017 by Maryland Governor Hogan, is titled "Task Force on Long-Term Education and Planning." The purpose of the task force has been to consider options to educate and make recommendations regarding education methods that will "ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long-term care and the private options available to pay for long-term care; and include information about the Maryland Medical Assistance Program, how the Program is funded, and whom the Program is intended to serve." The task force is also charged with finding ways to fund recommendations to achieve these goals.

The makeup of the task force deliberately included representation from both the public and private sectors. The intent is to have, as a result, a clear message coming with one voice from both the public and private sectors. Too often in the past, there have been confusing, conflicting, changing messages that have made the information misinterpreted and often ignored altogether. The easy alternative is to ignore the need to have a LTC plan. However, as quoted from Benjamin Franklin, "A failure to plan is a plan to fail."

The LTC crisis at the federal and states level can no longer be responsibly ignored. The impact of the ever-swelling Medicaid budget is increasingly smothering other necessary state responsibilities such as education, safety, transportation and infrastructure. Employers are adversely affected by loss of productivity and higher medical expenses for caregiving employees. State residents suffer from lack of knowledge as to how to avoid the need for crisis planning when confronted with a need for themselves or a family member or someone else for whom they feel responsibile. Far too often, residents think they are covered by the state and/or federal governments or their employer health plan. It comes a great shock to them when they discover they are not.

Maryland, with bipartisan support, has created the opportunity for a conduit, not for a complete answer, but for a necessary step to assist in finding answers, by education through clear messaging with one voice of the public and private sectors in unison. If successful, Maryland can provide a model for other states to follow. Maryland has become the eighth state recently or currently offering efforts to raise awareness among residents and provide residents with tools to use to plan for LTC. The other states are Hawaii, Maine, Michigan, Minnesota, Nebraska, Rhode Island, and Washington State. Of these, Minnesota has been the most successful to date in supporting state residents in the area of LTC education, access to valuable information to use in LTC planning and access to state provided LTSS services. The 10 Recommendations of the Maryland Task Force have been influenced by better understanding efforts of all of these states

Assistance from the federal level could be most helpful. It is hoped that success at the state level will spill over to leverage federal assistance, allowing even higher levels of success. This would accelerate the opportunity for a crisis to evolve to a more manageable situation.

Task Force Members

As already mentioned, the task force composition includes members from both the public and private sectors. The original legislation included a member of the Senate of Maryland and a member of the House of Delegates of Maryland. The final draft that became Law 953 struck out both of these participants. The reason remains unknown.

The three public sectors that have been represented on the task force appointed by their respective Secretaries and the Insurance Commissioner are the Maryland Department of Aging, the Maryland Department of Health, and the Maryland Insurance Administration (MIA).

All of the private sector representatives had to go through an application process and be appointed by the governor. Those chosen received endorsements from their respective organizations.

The six private sectors that have been represented on the task force include the Maryland Association of CPAs (MACPA), the Maryland State Bar Association (MSBA), the Financial Planning Association of Maryland (FPA-MD), the Maryland Association of Health Underwriters (MAHU), the National Association of Insurance and Financial Advisors of Maryland (NAIFA-MD), the Health Facilities Association of Maryland (HFAM), and the American's Association of Health Plans (AHIP).

A seventh organization that appeared in Bill 953 was Maryland Association of Private Colleges and Career Schools. This organization, not to be confused with a similarly sounding association of Universities in Maryland, did not respond to repeated requests and so did not have a representative on the task force.

The facilitator/administrator is the president of the United Seniors of Maryland.

This task force worked well together right from the first meeting in October 2017.

Task Force Activities to Meet the Charge of Maryland Law 953

Starting in October 2017 and concluding in June 2018, the task force held nine meetings. Most of the beginning meetings included time for outside speakers to help this talented and diverse group of professionals learn as a unit about the numerous areas of information that would need to be molded to address the charge as appears in the law. For example, like all states, Maryland has differing regions that would receive messaging best if tailored to the unique aspects of that region. So, the regions needed to be identified, defined and best messaging tools identified.

Another important area of research for the task force was to identify and understand what states were doing that had similarities to what Maryland was trying to achieve. Had anyone already "invented the wheel" we needed? Perhaps "spokes of the wheel" if not the wheel in its entirety. Indeed they had, and this proved helpful in the work of the task force. What other states have recently done or currently are doing is a section of the Governor's Report.

Likewise, had Maryland state agencies already made efforts with established results that could be used in the efforts of the task force? Yes they had! The task force was able to build on what already existed, although perhaps not in the most desirable formats for effective results for Maryland residents to access. This has been molded into one of the 10 Recommendations and will be a great cost savings to the state not to have to start sophisticated access information from "scratch."

There was time spent on brainstorming for possible funding and other assistance sources other than from the state. Potential private partners and foundations were identified, then also molded into a recommendation of the task force. Task force members reached out to some sources that had been identified. One was the Alzheimer's Association of Maryland. This association had just unveiled a new communication effort for Maryland and other states. As a guest speaker, a representative for this association described their program which is already in several languages (a need for the task force to address) tailored to the four distinct regions in Maryland for effective outreach and has offered to assist in the task force effort by perhaps adding a component that will address the educational charge to the task force in the law.

Another organization that has been already generous with encouragement and time is the Society of Actuaries' (SOA) Long Term Care Insurance Section. References to the SOA appear in the appendix of the Governor's Report as well as other sections of the report with links to pieces that may well be used to assist Maryland during implementation of recommendations.

The May and June meetings had no outside speakers, just hard work for the task force members. Consensus was reached on the best actions for Maryland to take so the law charge could be achieved to meet the goal of the task force. Writing assignments were assigned and the drafting process began.

Conclusion

Since Maryland Governor Hogan has not yet received it, specifics of the report cannot be included. Please look forward to chapters 2 and 3 for more detail.

However, in the interim, a few aspects of the report can be revealed. The initial educational effort is geared to Maryland residents between the ages of 14 to 50. In investigating the Maryland educational system an already established mandated vehicle was discovered that could be expanded to include more LTC education. In the future, within that framework, it could be possible to begin the education at the kindergarten level.

State of Maryland employees approaching retirement age, with many still below the age of 50, are invited to attend comprehensive preretirement planning seminars. This vehicle could also have a section expanded to easily provide more LTC planning education.

Both the state and private employers provide an accessible vehicle for messaging with little additional expense to the state. One of the 10 Recommendations outlines how.

The "can" that is the LTC crisis in America can no longer be "kicked on down the alley" by responsible people. As said before, education that comes from the public and private sector with cooperation and one voice does not make the problem go away. But it will serve as a solid foundation on which other programs can build and experience success. It can save states money by reducing Medicaid reliance by those that, with LTC pre-planning, could provide a happier outcome for themselves and for their families, and at worst, delay the need for state assistance. ■

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Participating Organizations

The following organizations have agreed to participate in this research endeavor with the Society of Actuaries as of Aug. 2018. To view the current list, visit *Livingto100.SOA.org*.

- Actuarial Society of South Africa
- Actuaries Institute Australia
- American Academy of Actuaries
- Canadian Institute of Actuaries
- Conference of Consulting Actuaries
- Employee Benefit Research Institute
- International Longevity Centre - UK
- Office of the Chief Actuary, Canada (within the Office of the Superintendent of Financial Institutions)
- Pension Research Council and Boettner Center for Pensions and Retirement Research of the Wharton School
- The Actuarial Society of Hong Kong
- Investments and Wealth Institute
- American Geriatric Society
- International Actuarial Association
- LOMA
- LIMRA
- Government Actuary's Department (UK)
- The Institute of Actuaries of Japan
- Women's Institute for a Secure Retirement (WISER)
- Institute and Faculty of Actuaries

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Q&A with an Experienced Insurance Professional New to Long-Term Care: An Interview with Matt Capell

What's your background? How did you end up in the LTC industry?

I have come full circle to insurance. When I graduated college, the internet boom was in full swing. So naturally I took a job in … investment banking, focused on insurance companies and community banks. My job was to comb through financial statements, sift through data, build complex models in Excel (or Lotus 1-2-3!), and create presentations to support M&A and capital raising transactions. I then moved on to do the same for telecom and technology companies before entering venture capital. Once I realized that entrepreneurs have more fun, I jumped to the "operating side," focusing on health care software, claims processing and payment processing. After a stint working in strategy for a large assisted living operator, I was offered the opportunity to be CEO of a business that provided billing and collection services to homecare agencies. A large portion of our business was managing LTC claims for policyholders and providers, in addition to over 300 other third-party payers like Medicaid, the VA and even private pay. About one year ago, I was recruited to join LTCG to head up their new Provider Solutions unit.

Compared to your past industry, what kind of efficiencies can the LTC industry obtain?

My early career taught me pattern recognition. I had the privilege of evaluating and analyzing thousands of companies to understand their operations, revenue models, profitability, and how they apply technology to their business. I then spent a chunk of my career in software, payment processing, and health care claims, where I saw how trillions of transactions were validated and executed using technology. The great part is that you can borrow concepts from one industry and bring them to the next. What jumps out at me the most is that LTC carriers paid out $9.2 billion last year, paying full retail prices via paper check for invoices—often handwritten—received via fax. There is so much opportunity in this industry! Aside from the obvious efficiency gains, the industry could benefit from richer, real-time data, predictive analytics, fraud detection, and a better experience for both claimant and carrier. LTC is the last corner of "health care" to embrace concepts like provider networks and electronic claims. That is understandable from the perspective that many LTC blocks are closed and the influx of claims is a recent phenomenon. But given the scrutiny from Wall Street and growing claims volume, the time is now to change.

What do you think care providers misinterpret about the LTC insurance industry?

Payers and providers have always been at odds in all areas of the health care continuum. Now that I have been on both sides of the LTC fence, I know that homecare agencies and other providers believe that insurance companies intentionally overcomplicate the process, drag their feet and deny claims. On the flipside, those in the insurance world—LTC included—suspect that all providers are gaming the system at best, and committing fraud at worst. In reality, we share a common mission to help elderly care recipients and their families. I believe there is genuine interest by the LTC industry in doing the right thing for claimants. Both sides would benefit from greater transparency and efforts to understand one another. There are ways we can help each other, and my job at LTCG is to develop and launch products around that mission.

What do you see as a blind spot in our industry?

Wage pressure pushing up the cost of care. Not only is there a tremendous caregiver shortage and the ongoing "fight for $15" movement driving up caregiver wages, but over the last five years there have been concerted efforts by labor unions and departments of labor at the state and federal level to increase compensation in the homecare industry. For example, a longstanding overtime exemption in homecare, which kept high-hour cases affordable for seniors was eliminated, plus the Department of Labor has discouraged paying per diem rates. As a result, a live-in caregiver should now be paid hourly and would flip into overtime by Tuesday of each week. Claimants and carriers will pay more for homecare, or many claimants will just move into an assisted living facility which may now be less expensive. But unfortunately, this same labor pool works in assisted living facilities too.

What was the most surprising aspect of the LTCI industry once you understood the nuances?

Since moving from the provider side to the carrier side, there have been a few surprises. First of all, the complexity of the products. There are so many different policy levers in infinite combinations that complicate all aspects of our business. Secondly, the "information gap" we have between underwriting and the point of claim. While we are good at collecting premiums, we generally do not gather other information about a policyholder's lifestyle or health condition that could help us reduce incidence or intensity of claims. Finally, everyone knows each other in the LTC industry! Meetings and conferences are like high school reunions. That said, people have been very welcoming to a newcomer like me.

What are you most excited about?

The opportunity to bend the cost curve in the LTC industry by bridging the gaps between carriers, policyholders and care providers. I believe we can make a material dent in the rate of spend, which ultimately benefits both claimants and carriers. ■

Matt Capell is senior vice president of provider solutions at LTCG. He can be reached at *matthew.capell@ltcg.com.*

The LTCI Pricing Actuarial Mindset Needs to be Reset

By Bruce Stahl

Actuarial Standards of Practice are the foundation for an actuary to perform work that helps others trust the work. They set the actuary's mind on producing work that is trustworthy.

For many years, LTCI products have faced materially large premium rate increases, shockingly high reserve charges, and even some insolvencies. Consumers, regulators, and investors have come to question the credibility of the actuarial work on these products. In hindsight, the Long-Term Care Actuarial Standard of Practice (ASOP 18) may have unwittingly contributed to this loss of trust.

The writers of the original guideline and those who have reviewed/revised it over the years appear to have intended to place weight on sensitivity testing. However, from a pricing perspective, the standard's "Premium Rate Recommendations" section may have actually restricted the ability of sensitivity testing to effectively contribute real value.

As with many Actuarial Standards of Practice, ASOP 18 intentionally grants a large latitude for performing sensitivity tests. It also states that the range of sensitivity tests should be expanded in cases when the applicability of the underlying assumptions may be less credible. This was often applicable to LTCI pricing in the past, due to the historically necessary reliance on general population noninsured data for pricing.[1] For similar reasons, it still may be applicable for such assumptions as morbidity and mortality improvement or morbidity and mortality at extremely old ages because they are not always measurable from industry data. Improvements or trends are often distorted by changes in distribution of claims over time when evaluating industry data. For just one example, some insurer specific data may be more heavily present in one time period than in another.

ASOP 18 recognizes that, due to the long-expected duration of LTCI policies, changes in actual experience may occur throughout the life of a contract. For example, it states that an actuary should use investment return assumptions "consistent with initial and reinvestment returns on assets," as many of the assets supporting a policy's promises will likely mature before actually needed.

The standard also recognizes the need for a broad range of sensitivity tests because of the large number of assumptions needed when pricing LTC benefits. It identifies mortality, voluntary lapses, expenses, taxes, investment returns, and mix-of-business as material and therefore worthy of consideration for sensitivity analysis in pricing. It also identifies and requires morbidity assumptions, including incidence, continuance, and utilization assumptions as well as numerous influencing factors such as differences arising from the variety of providers of care, nursing home, assisted living facilities, and homecare.

In addition, the standard mentions "change-over-time assumptions" as an LTCI plan "is expected to remain in force for **a very lengthy period of time.**" [boldface added] Sometimes credible supporting data is available for identifying projection assumptions from an earlier issued product for an insured population with similar characteristics. Still, the potentially lengthy duration of the contract warrants sensitivity testing.

Presumably, some variables were considered independent of others while some were seen as dependent or correlated. For example, a pricing actuary might not recognize a correlation between morbidity improvement and active life mortality improvement, and therefore might treat them independently. It may be advisable for the actuary to do a sensitivity test to gauge the impact on pricing if the morbidity and mortality improvement assumptions were actually linked. On the other hand, a pricing actuary might recognize that the benefit utilization rate is correlated to the investment yield rate. In this case it may be advisable to decouple the utilization rate from the investment yield rate in case historical correlations of LTC services inflation changes such that relatively high inflation exists when investment yields are low.

The standard has helped with many projections. Stochastic sensitivity testing, for example, has proven helpful in identifying economic capital that may be required for liabilities or assets. If designed to address misestimation risk (sometimes called parameter risk), stochastic modeling can also help identify the amount of capital required at specified probability levels.

Scenario testing has proven useful as well in identifying and optimizing investment strategies or tactics. This is particularly true when correlation is assumed between liabilities and investment returns. For example, liabilities for expense reimbursement policies may be correlated with automatic increasing maximums because the actual reimbursed expenses will increase in relation to the investment yields.

All of these uses for sensitivity testing can affect how LTCI programs are managed, enabling insurers to plan and prepare for adverse scenarios. They can also help insurers communicate the potential financial impact of various scenarios to regulators and investors.

While ASOP 18 emphasizes the need for sensitivity testing, the "Premium Rate Recommendations" paragraph proposes a balancing act that may seem to minimize the use of the information derived from these tests for pricing.

The specific language reads as follows:

> **Premium Rate Recommendations**
> Any premium rates recommended by the actuary should conform with statutory requirements, including those for loss ratios. Such recommended rates should reflect any premium guarantees of the contract. **In developing such recommendations, the actuary should not use assumptions that are unreasonably optimistic.** If a premium rate schedule is described by the actuary as applicable for the lifetime of the insured, the actuary should use assumptions that are consistent with that description and that have a reasonable probability of being achieved. In particular, the actuary should not rely on anticipated future premium rate increases to justify the selection of unreasonably optimistic assumptions when recommending premium rates. **On the other hand, the actuary should not use assumptions that are unreasonably pessimistic. It may be appropriate, however, to include provision for adverse deviation in assumptions.**

In the paragraph's third sentence, the pricing actuary is told not to "use assumptions that are unreasonably optimistic." Then, in the same paragraph, the actuary is told, "On the other hand, the actuary should not use assumptions that are unreasonably pessimistic." In other words: sensitivity testing is needed, but the full breadth of assumptions used in the testing cannot be applied because the pricing actuary may view them as either "unreasonably optimistic" or "unreasonably pessimistic." Indeed, nothing in the Standard's language suggests that "unreasonably" may be measured differently when modifying optimism and pessimism until the end of the paragraph, which states that it may be "appropriate to include provision for adverse deviation in assumptions."

Apart from that provision, the standard's language seems to restrict the application of the sensitivity tests when choosing scenarios for pricing of long-duration products with rate stability in view. The pricing actuary needs to limit the scenarios to something that is not unreasonable either from an optimistic or a pessimistic perspective. The paragraph does not allow a pricing actuary to move at will from a central position between optimism and pessimism, and the final statement allowing provision for adverse deviation in assumptions did not take away the strong impression that the assumptions must be balanced between optimism and pessimism.

The commentary around the added final statement, found in the ASOP appendix, rendered any perceived freedom from that statement even less clear. Essentially, ASOP 18's authors believed that "the subjects of loss ratios and state regulations should not be addressed in this ASOP." Meanwhile, the Standard's essential requirement of a balance between optimism and pessimism remained. The pricing actuary still had to consider whether assumptions shifted for adverse experience were not unreasonably pessimistic. The size of the margin itself became the focus for setting premium rates.

For illustration, a pricing actuary may have judged that a product's ultimate lapse rate could reasonably be set at 1.25 percent per year without any margin for adverse experience. The actuary may have thought the 1.25 percent ultimate lapse assumption neither unreasonably optimistic nor pessimistic, but rather, was a good midpoint position between those two poles. If the actuary wanted to add some margin for moderately adverse experience, he/she may have initially considered cutting the 1.25 percent to 0.50 percent. However, after reading the ASOP 18 pricing paragraph again along with the commentary around it to make sure the interpretation was correct, he/she may have decided the 0.50 percent assumption was unreasonably pessimistic, and changed it to 1.00 percent, based on the size of the margin for moderately adverse experience the assumption produced. The focus on balancing optimism and pessimism, and thus on the size of the margin, shifted the pricing actuary away from the potential financial impact of adverse events.

This is important, as LTCI has faced many large financial shocks over the years. Balancing pessimism with optimism has been less than helpful to a product designed to have stable premium rates over many years. The standard might serve the industry better if it eliminated its insistence on balancing unreasonably optimistic and unreasonably pessimistic assumptions for pricing.

Historically, ASOP 18 has served asset-liability management and valuation actuaries well. Still, many stakeholders today may wish LTCI's earliest pricing actuaries had been able to place more weight on pessimistic scenarios by including more sensitivity testing information directly into the premium rate recommendations. Now may be the time to reset this mindset. ■

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ENDNOTES

1 Section 3.2.1 of ASOP 18 states "Specific data from the entity to which the actuary's calculations apply generally are preferable to data from other sources. Where such data are not adequately credible, industry data should be considered next in setting assumptions. As a last but sometimes necessary source, general population noninsured data may be utilized."

The California Partnership for Long-Term Care Revives

By Louis Brownstone

There has been significant progress in reviving the California Partnership for Long-Term Care. The Partnership is still in an intensive care mode, its sales are non-existent, and it's barely on life support. But the needed legislative changes have occurred which will bring the plan out of intensive care and into a period of widespread usage.

The California Partnership for Long-Term Care (Partnership), begun in 1994, was one of the original four Partnership states. Its purpose was to provide long-term care protection for Californians with moderate income and assets. Sales were robust initially but became almost non-existent because the cost of this insurance and the cost of care have risen drastically, while Partnership regulations have historically failed to make the adjustments needed to keep the product affordable.

That began to change with SB 1384, which became law in September 2016, and was the first material step in making Partnership plans more affordable. It allowed for inflation options besides 5 percent compound. This alone can reduce the annual premium by 50 percent in some cases. SB 1384 also created a task force of some twenty individuals inside and outside of State government to consider reforms that could encourage carriers to file new and far more saleable plans.

After almost two years of meetings, the task force recognized that future nursing home claims will probably be less than 10 percent of all long-term care claims. Therefore, it believed that basing future requirements on nursing home costs would be an outdated guideline, and that it would be far more pertinent to base future protection on far less expensive residential care facility and home care costs where the vast majority of care will be received. It also noted that new robot and sensor technology will change the caregiving dynamic, especially in the home.

Next, the question became what structure would be both affordable to the middle class and provide meaningful protection. There was serious debate on the answer to this question, but in the end, the task force agreed to recommend the following:

1. A minimum benefit of $100/day, or $3,000/month, in all settings;
2. A minimum lifetime benefit of $73,000;
3. Elimination period maximum of 90 calendar days.

It was decided that these would be the only requirements in a policy, giving the insurance carriers maximum flexibility in their product design. Carriers would be encouraged to file structures similar to those in their non-Partnership policies in order to ease their filing processes and obtain speedy approval. In addition, for a brief period only, the carriers would be guaranteed expedited approval of filings in three to four months.

Here are some examples of plans which would fit the guidelines. Carriers could file either a lifetime benefit of $75,000 over two plus years with a daily benefit of $100, a lifetime benefit of $73,000 over two years at $100/day, or a lifetime benefit of $100,000 over two years plus at $140/day.

Industry studies have concluded that the market for long-term care insurance would be substantially larger if premiums would be at or under $100/month. This was the premium goal

of the task force. Indeed, a two-year plan at $100/day with a lifetime benefit of $73,000 with 3 percent compound inflation and a 90-day elimination period could cost under $100/month for males and for each individual of a married couple in their mid-fifties. Premiums would be higher for unmarried females, but still under $150/month.

Of course, a $100/day benefit with a $73,000 lifetime benefit would only constitute partial coverage in many scenarios. But these benefits could be a big help to claimants and could be coupled with Social Security income and other income to fully cover costs in many cases. The assumption here is that the market for Partnership policies is not appropriate for the lower 50 percent to 60 percent of the population in income and assets, who would have to rely solely of their own resources and on Medi-Cal. But the top 40 percent to 50 percent of the population could likely afford these premiums and might have other income and assets they could utilize to cover the balance of the costs of care. Long-term care insurance in California is currently primarily being sold to the top 10 percent of the population in income and assets, and it would be a major step forward to increase the marketability of the product to the top 40 percent to 50 percent.

For citizens with moderate income and assets, such plans could be terrific, in effect offering lifetime protection. For example, if a person had $73,000 in non-exempt assets, he or she could purchase a Partnership plan with a benefit limit of $73,000. Once that person became sick, he or she could use up the benefits in the policy, apply for Medi-Cal, protect their $73,000 in assets, and be covered by Medi-Cal for the rest of his or her life. With Medi-Cal waivers, he or she may be able to stay at home for at least most of the period of care. That's what we all want in a long-term care insurance policy… lifetime protection, preservation of assets, and coverage for home care. Perfect!

The task force then considered whether to wait for revised regulations from the Department of Health Care Services or attempt to pass an urgency statute through the Legislature. The approval process of DHCS revised regulations was deemed to be too slow, and the legislative approach was endorsed. The bill would include emergency regulations, declaring that the passage of this bill was "deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety." Filings were consequently intended to be approved within 120 days.

These conclusions were codified and introduced to the Legislature as SB 1248. This bill was endorsed by both political parties, easily passed both the Senate and the Assembly on Aug.28 and was signed by Governor Brown on Sept. 19.

SB 1248 is a game changer for Californians, but its passage only begins the process of once again providing millions of Californians potentially lifetime, affordable long-term care insurance. The immediate goals will be difficult to achieve and involve insurance carriers, insurance agents, and the public. These goals are the following:

1. Convince the insurance carriers that new Partnership policies can be filed expeditiously and with minimum expense;
2. Convince the insurance carriers that Partnership policies can be saleable in volume and can be sufficiently flexible to ensure future profitability;
3. Convince the insurance carriers that modest rate increases will be approved if justified—current regulations allow up to a 40 percent increase over three years;
4. Convince the insurance agents that new Partnership policies can create a major new market of Californians with moderate income and assets that doesn't exist today;
5. Institute major educational campaigns aimed at getting agents excited enough to expend resources to enter this new market;
6. Create new marketing campaigns for these new Partnership policies;
7. Educate the public with a major campaign showing that they can protect themselves and their families from the financial and emotional stresses of unplanned for long-term care scenarios.

A private/public partnership continues to be the most viable solution to our growing long-term care crisis. Washington, D.C., won't provide a solution at this time. California is in the best position to lead the nation, and the revived California Partnership for Long-Term Care is the best vehicle to utilize.

Long-term care expenses are likely to sky-rocket in about ten years when the baby-boomers begin to reach their eighties. Billions of dollars of Medi-Cal expense can be saved if this new Partnership program works. It can also be duplicated in other states. Anyone want to join in this effort? ■

Louis H. Brownstone is chairman of California Long Term Care Insurance Services, Inc and ex-chairman of the National LTC Network. He can be reached at *louis@cltcinsurance.com.*

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