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

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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.

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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 year-end 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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