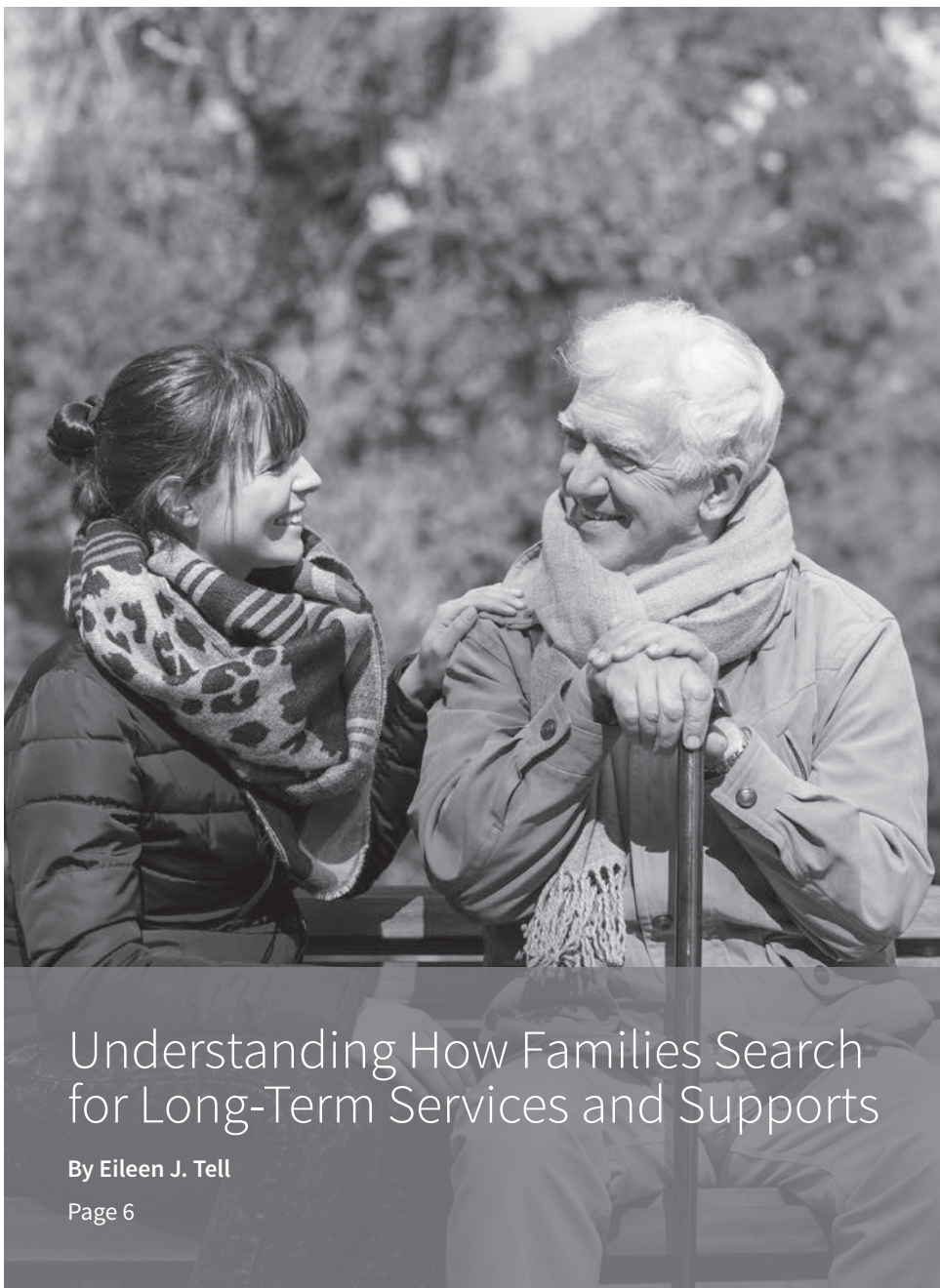


# Long-Term Care News



**SOCIETY OF  
ACTUARIES**

**LONG TERM CARE  
INSURANCE  
SECTION**



## Understanding How Families Search for Long-Term Services and Supports

By Eileen J. Tell

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# Long-Term Care News

Issue 50 • April 2019

Long Term Care Insurance Section of  
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# Chairperson's Corner

By Chris Giese

It seems like only a moment ago that I attended my first ILTCI conference in 2002 at the Beverly Hills Hilton. Beyond seeing a few celebrities in town for the Golden Globe Awards, I fondly recall how passionate and dedicated everyone seemed. Although the industry has seen its share of highs and lows since, I still see much of that same passion and dedication from volunteers in the LTC Section.

Drawing from those volunteer efforts, I am excited and looking forward to what we can accomplish in 2019. Our 2019 goals include:

- Publish three newsletters,
- produce four webcasts,
- liaise non-SOA volunteers,
- ensure LTC regulatory information on SOA website stays current,
- increase awareness of the LTC Section to recruit new members through the website and social media,
- provide educational content for regulators and policy makers in proactive ways,
- develop a game plan for the future and next evolution of the think tank,
- update the biannual membership survey to ensure the Council focuses on the “right” activities, and
- produce sessions at four SOA conferences.

We are close to wrapping up our survey on fraud, waste and abuse.

I am happy to report on one success already, with special thanks to Shawna Meyer and Robert Eaton for their efforts. The LTC Section sponsored the Long-Term Care Medical Symposium, “a one-day conference intended to extract the thinking of leading experts on historical and future trends that will influence future long-term care insurance (LTCI) claims experience.”



Seasoned LTC veterans know the challenges that come with setting assumptions for the future. I would encourage those looking for perspectives beyond the normal actuarial view to read the full report (<https://www.soa.org/sections/long-term-care/ltc-medical-symposium.pdf>). We are also hoping to leverage the knowledge from these “outside-our-industry” experts through other venues as well, such as webcasts and LTC industry conferences.

Also, we are close to wrapping up our survey on fraud, waste and abuse. Toward the end of 2018, the LTC Section sponsored a survey of companies to help the industry better understand concerns and support efforts related to addressing fraud, waste and abuse in LTC insurance. A report on the survey will be ready soon, so stay tuned!

With the year already flying by as we turn our attention from the cold and snow to looking forward to the spring and summer (at least for those of us in places like Wisconsin!), I cannot say thank you enough to the volunteers who continue to make this all possible. They are the true celebrities of our industry. ■



Chris Giese, FSA, MAAA, is a principal and consulting actuary at Milliman. He can be reached at [chris.giese@milliman.com](mailto:chris.giese@milliman.com).

# Editor's Corner

By Linda Chow

It's been my pleasure to serve the SOA Long Term Care (LTC) section as its newsletter editor. Over the past five to six years, I have watched a wave of retirement from our first-generation LTC experts. Many of my industry friends and I have grown into the second-generation LTC insurance practitioners serving this industry and the society. To me, LTC is not only a job but also a family matter and my career aspiration.

This year in the newsletter, I want to continue exploring a wide array of topics that provide readers a holistic view regarding LTC. In this edition, we included articles ranging from managing in-force blocks and their legal issues to new product, LTC reform and LTC from a family perspective.

Eileen Tell writes about how families search for long-term care services and support. I nodded while reading the article as I can totally associate my own experience as a family caregiver to what Eileen wrote.

Pedro Alcocer, Robert Eaton and Pamela Laboy write about Long-Term Services and Support (LTSS) in Medicare Advantage plans. I was fortunate enough to be one of the first few actuaries who supported the state of Minnesota in exploring the idea of adding an LTC component to MA plans back in 2014. I therefore am excited to see this idea materialize within such a short timeframe.

Marc Glickman writes about rate increases from a client's perspective, translating a complex topic to layperson's terms.

Nolan B. Tully, Sandra K. Jones and Jessica E. Loesing from Drinker Biddle write about Tax-Qualified Language: Litigation Risks Stemming from Common Policy Language. Claim management is one of the most important topics when it comes to in-force block management.

We continued our "New to LTC" series with Alex Vichinsky, John Mulheren and Andrew Sloan.

Lastly, I decided to share the results of a survey that was cosponsored by LIMRA and EY regarding the combination products market and industry landscape.



Again, I want to thank all the writers who have contributed to this edition of the newsletter. Your effort and ideas will help shape the future of the U.S. LTC insurance industry.

Our next submission deadline is May 24 for the August 2019 issue. Please continue to share your great LTC-related experience and ideas (work or personal). I look forward to seeing your articles in the next publication. ■



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# Understanding How Families Search for Long-Term Services and Supports

By Eileen J. Tell

**W**hile many articles in this publication address how to manage the costs of long-term care (LTC) or efforts to design better products to pay for care, what many people find equally, if not more challenging, is finding and maintaining appropriate care when they or a loved one need it. Indeed, I will gladly help friends and family make decisions about whether and which LTC insurance product to purchase and how to craft coverage choices that best fit their needs. But when they call with an urgent need for help choosing a nursing home, or understanding what type of care would be best for their long-distance loved one, my industry expertise quickly becomes almost useless. I know the service landscape, but not how to navigate it. And I certainly do not know how to do so during a care crisis. So imagine how the typical consumer feels!

This is what motivated the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) to study how families manage their way through this process. The research included a series of focus groups with consumers who had recently gone through the process of finding LTC services to explore the challenges they encountered and identify any helpful resources they may have encountered. This article summarizes findings from the consumer focus groups.

## DYNAMICS OF THE CONSUMER EXPERIENCE

The focus group discussions revealed that, whether there was a sudden or gradual decline in the health of a family member, for most, an acute incident such as a fall, a stroke, or the sudden illness or loss of the primary caregiver such as a spouse precipitated the need for broader family involvement in the process of finding LTC service and formal care options. A common theme heard in all the groups was the lack of awareness of the decline in either physical or cognitive health of their loved one until this acute episode occurred. Aging parents typically shielded their adult children from the realities of

their limitations. Even families where some individuals tried to engage loved ones in conversations about planning ahead, should LTC needs emerge, these conversations were generally shut down, especially if these inquiries involved talking about finances. Some of the illustrative statements from the groups include the following:

*“You don’t need to know. ... We’re fine. ... We’re handling everything.”*

*“My mom fell and there was a lot going on that we weren’t aware of. She was living by herself and we just did not know ... or recognize the signs of Alzheimer’s.”*

*“... whenever we called, mom said dad was out or busy. So we never talked to him on the phone. ... otherwise we would have realized how bad off he’d gotten.”*

## WHERE TO START

For many families, trying to find LTC options was completely new terrain. Even those who had been through the experience before in some capacity with another family member felt unprepared since each situation was unique. Most felt that they had no road map and that it is not a “once and done” process since changing care needs over time also means continually finding new solutions.

While consumers in the focus groups used the internet for research as an entry point to defining care needs and looking for long-term services and supports (LTSS), few found useful information in either the public or private sector online resources.

*“I googled ‘long term care’ and her sickness, like what to expect ... but I didn’t really know what I was looking for.”*

*“I’m on the internet and I think ... what do I do? Where do I go? How do I start?”*

*“I looked up nursing home, I looked up assisted care ... but I didn’t know what to look for.”*

Despite the large and growing presence of web-based information resources and their prominence in search results when consumers are looking for information about long-term care, very few of the focus group participants mentioned using or even being aware of these online resources. One or two of the heavily advertised services were mentioned, but many were skeptical that they would have the expertise or reliability to be worth trying. Those that did try one or two of the online services either could not understand why the recommended service options were not more convenient or understood that the service only included providers willing to “pay to play.”



*“They’re getting the recommendation of the ones that are gonna pay for the referral. It wasn’t a good fit for us.”*

*“I did sign up ... I went through all the steps. And they did call me and took a lot of my dad’s information. But they recommended places that were not really close by.”*

Many consumers looked largely to their family physician, hospital discharge planner or to the recommendations of family and friends as the most valued source of information on finding LTSS. In particular, for in-home care, word of mouth from others who had used that type of care was especially valued as a way to find a care provider. Families relied upon recommendations from friends, a religious organization with which they were affiliated or their healthcare provider.

*“I searched out from word of mouth, and you know, people that I knew who had elderly parents that went through this ... that’s how I found out.”*

*“I really relied on doctors and my friends.”*

Interestingly, familiarity with a facility simply in terms of having driven past it, seen advertising, or knowing it as part of one’s community was also important to peoples’ comfort in choosing a facility. Of course, that also corresponded to the desire to select a facility for a loved one nearby so that visits and other logistics are less complicated.

*“My family is born and raised here. It was just a place we’ve driven by and then that just came to mind. I don’t want to tell you it was recommended. It was just a place we knew.”*

None of the focus group participants was aware of the type of assistance that can be provided by a geriatric care manager. But when it was discussed, many found the idea of hiring a

professional familiar with local providers and able to match care needs with local resources to be a great service, and one they wished they had known about.

There was some familiarity with public-sector resources such as the Area Agencies on Aging (AAA) and Eldercare Locator. But those that had reached out found them to be of limited value. Respondents felt these options are not well positioned to serve the private pay population and are also not typically in a position to make provider recommendations. Indeed, many public agencies have long waiting lists and a mandate to serve a defined population. They also are often not permitted to offer provider recommendations but can provide lists, which these consumers did not find particularly helpful.

*“When you call the AAA, they can’t give you a straight answer. ... They tell you ... ‘well this is here and this is here.’ ... If you ask, ‘what’s the best?’ ... they say ‘well they’re all good.’ ... Well, no, they’re not all good.”*

*“They gave me lists ... I wanted recommendations.”*

The experience with Eldercare Locator was especially disappointing for those who reached out—expecting that it would help them “locate eldercare.” The toll-free number provides information about the Area Agency on Aging near where one lives which, as shown above, does not currently adequately address the needs of the typical private pay population, although the public sector is interested in doing so but can’t, both because of current mandates and limited resources.

## EVALUATING OPTIONS

Once a care facility was identified, some participants talked about using the internet to learn how that facility compared with others with regard to staffing, complaints, services,

features and other indicators that might shed light on the facility's quality or suitability for their loved one. While many said that they did online research including looking up quality ratings or state certification information, for most the critical next step was to actually visit the facility.

*"The internet will give you direction. But I'm hands-on. You have to go to the facility, look at the people and eyeball them when you're there. You have to check on the meals."*

*"It's a good starting point. But it's not an end-all. You still have to see it for yourself or know someone who had a good experience there."*

None of the participants in these focus groups were aware of the CMS websites [www.NursingHomeCompare.gov](http://www.NursingHomeCompare.gov) or [www.HomeCareCompare.gov](http://www.HomeCareCompare.gov), both of which provide quality ratings data on those services. When shown samples of the information available there, consumers were interested, although there was still some skepticism about how current the data are, how reliably it is collected and whether providers are able to game the system.

*"You never know if the nursing home knows when the inspectors are coming and if they 'spruce up' for it."*

#### MAKING A CHOICE

Many of the participants expressed frustration at the process of finding LTSS because—in the end—all that matters is cost and availability. Despite doing extensive research, the ultimate factors driving provider selection were availability, convenience and cost.

*"Even if you find a great place, you have to think about money, availability and the convenience of the place."*

*"We asked for recommendations in the area, and they did give us five. But only two had beds available. So we chose the one that was closest."*

#### IMPROVING THE PROCESS

The participants in these focus groups liked the concept of a public-sector, nonprofit entity that could help curate information on how to find and evaluate long-term care services. Some, however, were skeptical that even nonprofits might have an agenda and not truly represent individuals' needs. People wished they could rely more on their family physician, health plan or local hospital to get this type of time-sensitive support. While the concept of a geriatric care manager was appealing, few were familiar with this resource or how to use it. Interestingly, only one individual from across the three focus groups had a long-term care insurance policy; she spoke about the assistance she received from the care coordination feature of that coverage when it came to finding care for her husband.

While others in the group had some awareness of long-term care insurance, they did not realize it provided help finding care, along with paying for services.

*"There needs to be a liaison, somebody to help people make informed decisions right when it happens."*

*"Maybe the health care companies need to take some responsibility ... develop something that could help us ... that we would know who to contact."*

#### LIMITATIONS OF THE STUDY

It is important to note some of the limitations of the study upon which these findings are based. First and foremost is the qualitative and nonrepresentative nature of the focus group research design from which these findings are drawn. Additionally, while the groups included a diverse mix of individuals in urban, suburban and rural locations, the study was conducted within a single state. Also, the emotional and logistical impact of finding facility-based care dominated the caregiver conversation during these focus groups; therefore, the study did not provide sufficient insights into the process of defining and meeting in-home care needs.

#### CONCLUDING THOUGHTS

Consumers struggle as much with how to find and maintain in place good quality LTSS for their loved ones as they do with how to pay for care. The crisis nature of the need for care and the ever-changing nature of those care needs add to an already emotionally charged and challenging process. For the long-distance and/or working caregiver, there are additional emotional and logistical burdens. The emotions and guilt that loved ones experience also complicate the process. Families are trying to satisfy numerous constraints while they search for care options that are affordable, suitable, available, local and of good quality—all without having the knowledge and information they need to evaluate or identify care providers against these attributes. Trusted, easy-to-use and transparent resources that can help families identify and evaluate care resources are greatly needed. While long-term care insurance policies typically address these needs, expanding this type of care-finding support to the vast majority of the population without insurance would be a well-received and much-needed resource. ■



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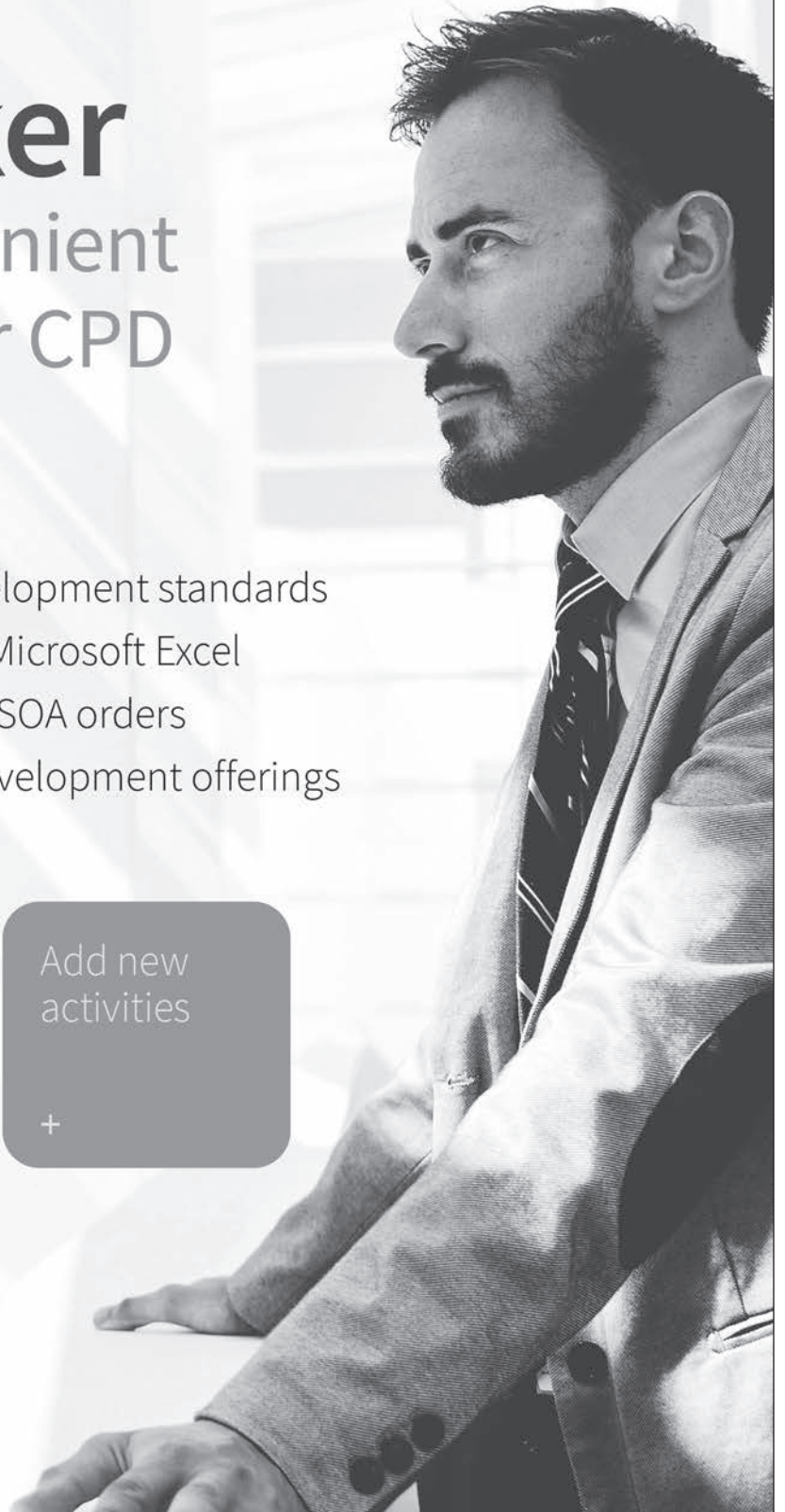
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# LTSS Services in Medicare Advantage Plans: The 2019 Market Landscape and the Challenge Ahead

By Pedro Alcocer, Robert Eaton and Pamela Laboy

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In April 2018 the Centers for Medicare and Medicaid Services (CMS) published a revised definition of “primarily health related” (PHR) benefits as applicable to Medicare Advantage (MA) organizations. CMS expanded the definition of a primarily health-related service starting in calendar year (CY) 2019 as one that is “... used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization.” These services are often used by individuals with chronic conditions in need of long-term services and support (LTSS). Many of these services are the same that private long-term care (LTC) insurance covers and reimburses.

This article will address how the MA marketplace responded in 2019 to CMS’s expanded definition of primarily health-related benefits, including which supplemental benefits plans are offering and where these benefits are offered. Finally, we will discuss the demand and costs for LTSS-type services among the elderly and the challenges that MA plans may face in developing these benefits.



## 2019 SUPPLEMENTAL BENEFITS UNDER THE EXPANDED PHR DEFINITION

CMS’s April 27, 2018, guidance letter presented nine possible supplemental benefits that could be offered starting in CY 2019 under the expanded “primarily health related” definition. We surveyed the approved MA benefit information for all organizations that submitted a CY 2019 bid, as published in CMS.gov<sup>1</sup>, and found that many plans are offering some of these supplemental benefits in 2019. The table in Figure 1

Figure 1  
2019 MA Plans Offering CMS’s Suggested Benefits Under Expanded PHR Definition

2019 SUPPLEMENTAL BENEFIT	COUNT OF PLANS
Adult day care services	2
Home-based palliative care	8
In-home support services	60
Support for caregivers (aka respite care)	421
Medically approved nonopioid pain management	None found*
Stand-alone memory fitness	None found*

\* These benefits may potentially be offered as part of a larger package.

Figure 2  
2019 MA Plans Offering New PHR Benefits in Addition to Those Outlined by CMS

NEW 2019 BENEFIT	COUNT OF PLANS
Activity tracker/fitness tracker	7
Alzheimer/dementia bracelet: Wandering support service	3
Backup support for medical equipment	2
Housekeeping	1
Nonskilled home health	8
Personal care/personal care services/personal home care	47
Restorative care benefit	4
Social worker line	91
Supportive care	5
Therapeutic massage	1
Vial of Life Program	10

shows six of the nine supplemental benefits described in CMS’s memorandum along with the number of plans covering them.

Although the CMS guidance also included “Home & Bathroom Safety Devices & Modifications” (PBP 14c), “Transportation” (PBP B10b) and “Over-the-Counter (OTC) Benefits” (PBP B13b), we did not include these benefits in our analysis as they are not new to CY 2019. While we were unable to definitively identify plans offering these benefits in CY 2019 under the revised definition, our research showed a significant increase in the number of plans that offered bathroom and safety devices and transportation services in CY 2019.

In addition to CMS’s list of nine potential new benefits under the revised PHR definition, we identified additional “other supplemental benefits” for 2019 that appear to qualify under the expanded PHR definition. We identified these potential benefits based on the descriptions outlined by CMS in its April

2018 guidance. The table in Figure 2 shows the count of MA plans offering these additional benefits in 2019.

#### LTSS SERVICES IN 2019 MA PLANS

Many of the services in Figures 1 and 2 (such as “respite care” and “personal home care”) are LTSS-type services that qualify under the “primarily health related” benefit expansion.

We found 577 MA plans that offer LTSS-type benefits in 2019 by searching in the other supplemental benefit descriptions for key words representing LTSS benefits, such as “adult day care,” “in-home support” and “nonskilled home health.”<sup>2</sup> The table in Figure 3 lists the number of MA plans offering LTSS-type benefits in 2019 by plan type.

Finally, we show where these plans are concentrated nationwide, illustrating a heat map of the United States. Figure 4 highlights which counties have the most MA plans with LTSS

Figure 3  
2019 MA Plans Offering LTSS-Type Benefits, Count by Plan Type

NETWORK / PLAN TYPE	NONSPECIAL NEEDS PLANS	DUAL ELIGIBLE SNP	CHRONIC OR DISABLING CONDITION SNP	INSTITUTIONAL SNP	TOTAL
HMO	340	62	25	6	433
LPPO	91	7	2	0	100
HMO-POS	18	3	0	0	21
PFFS	2	0	0	0	2
RPPO	11	4	6	0	21
Total	462	76	33	6	577

Note: HMO = health maintenance organization, LPPO = local preferred provider organization, HMO-POS = HMO with place of service benefit, PFFS = private fee-for-service, RPPO = regional preferred provider organization.

Figure 4  
MA Plans Offering LTSS-Type Benefits, Count by County

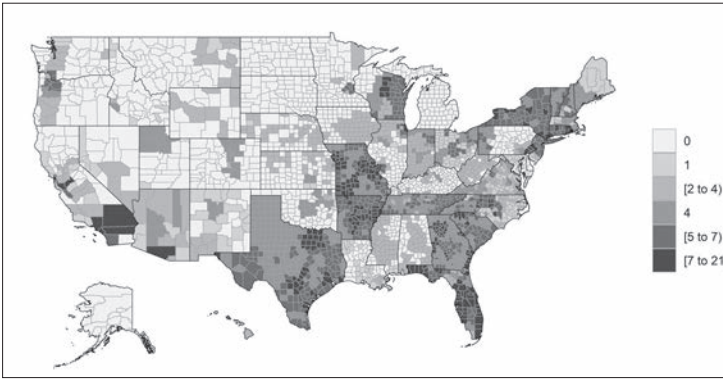
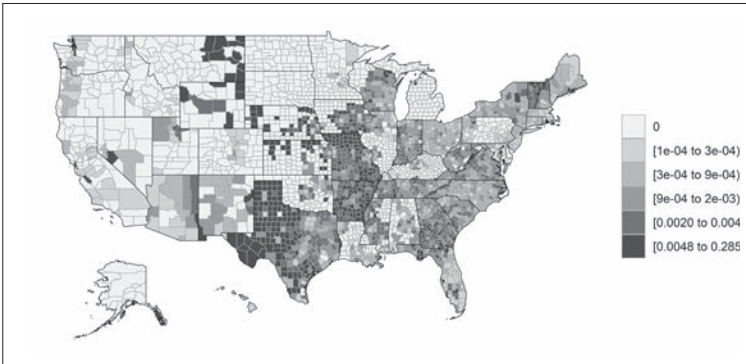


Figure 5  
Density of MA Plans With LTSS-Type Benefits: Plans Offering LTSS-Type Benefits per MA Member, Within Each County



benefits. Figure 5 shows the counties with the highest density of plans offering LTSS-type benefits for each MA-enrolled member as of January 2019.

### LTSS DEMANDS AND COSTS

The benefits approved by CMS for 2019 MA plans cover some of an individual’s long-term support needs. From the MA plan data we surveyed, the benefits offered cover only a small subset of the potential needs of someone requiring long-term custodial care.

More broadly, LTSS encompasses the services and support that individuals may require for their health over a long period of time. These services are most important for individuals who are chronically ill—unable to perform some of their activities of daily living (ADLs<sup>3</sup>) or suffer severe cognitive impairment.

How many people are chronically ill in the United States, and what may LTSS services mean to them financially? To understand this we review some nationwide data.

The number of people in the United States expected to need LTSS is growing. In part, this stems from general improvements in population mortality: more people now survive to older ages where they have more LTSS needs. The U.S. Department of Health and Human Services (HHS) estimates that about half (52 percent) of Americans turning 65 will require long-term care services at some point over the remainder of their lives<sup>4</sup> due to limitations with multiple ADLs or severe cognitive impairment. A January 2019 issue brief from the Commonwealth Fund<sup>5</sup> found that, for Medicare beneficiaries aged 65 and older, 28 percent had a “high LTSS need” and 33 percent more had a “limited LTSS need,” while only 39 percent had no LTSS need. Medicare beneficiaries who had income under 200 percent of the federal poverty line (FPL), or who were eligible for Medicaid, had even higher rates of LTSS need.

Research by the Society of Actuaries (SOA) published in 2016<sup>6</sup> based on the National Long Term Care Survey (NLTCS) through 2004, shows that seniors face disability rates that increase by age. The table in Figure 6 shows a selection of disability rates for seniors needing assistance with instrumental activities of daily living (IADLs) such as doing laundry, managing finances or doing light housework,<sup>7</sup> as well as disability rates for seniors needing assistance with one or more ADLs. Note that the tables below show information as of 2004 and for disability triggers specified by the NLTCS.

Figure 6  
Disability Group Estimates (%) by Age: NLTCS  
Age-Standardized to 2004 U.S. Population

Age range	SEVERITY OF DISABILITY	
	IADL only	1 or more ADLs
65–74	1.79%	6.22%
75–84	2.54%	15.20%
85+	4.23%	29.92%

But what costs do the disabled or chronically ill face? For those needing round-the-clock assistance, a semiprivate room in a nursing home may cost between \$90,000 and \$100,000 annually.<sup>8</sup> The table in Figure 7 shows the 2018 median annual costs for various levels of LTSS care and the recent annual trend in costs.

HHS indicates that most of these LTSS services will be funded by out-of-pocket expenditures (55.3 percent) or through Medicaid (34.2 percent). Because private LTC insurance premiums are expensive and less healthy individuals will not pass underwriting, only a few insurance-type options are available.

### A CHALLENGE FOR MA PLANS

The LTSS-type benefits that we see MA plans offering in 2019 appear to be more in line with lower-cost benefits such

Figure 7  
Median Annual Costs and Trends of Certain LTSS<sup>9</sup>

DESCRIPTION	ANNUAL COST	ANNUAL COST TREND
Semiprivate room in a nursing home	\$89,297	3%
Home health aide	\$50,336	3%
Care in an adult day health-care center	\$18,720	2%
Assisted living facility	\$48,000	3%

as providing in-home support services or adult day care. Nevertheless, MA organizations need to be aware of the large potential demand for LTSS services. In particular, CMS does not require<sup>10</sup> that LTSS-type PHR benefits in MA plans be triggered by the inability to perform ADLs or severe cognitive impairment. While a plan will decide for itself any restrictions on PHR benefits within the rules established by CMS, looser eligibility requirements may imply higher benefit utilization than traditional LTC insurers see.

On Jan. 30, 2019, CMS’s Advanced Notice letter<sup>11</sup> laid out expanded MA benefits that plans may offer, labeled “Special Supplemental Benefits for the Chronically Ill” (SSBCI). SSBCI are non-PHR LTSS benefits available to enrollees if the services have a “reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease.” Chronically ill enrollees must meet strict criteria,<sup>12</sup> but “MA organizations have broad discretion in developing items and services they may propose as SSBCI.”

For people retiring today, financing an LTSS need is a major concern for maintaining adequate retirement funds. Seniors may be looking for new ways to obtain coverage for some of these LTSS benefits. The MA market is slowly expanding coverage to include more LTSS services, as seen in the expanded definition of PHR benefits for CY 2019 and the SSBCI starting in 2020. Given the high demand and potential high costs of LTSS-type benefits, MA plans must make careful considerations when offering LTSS coverage as they enter into the 2020 bid season. ■



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## ENDNOTES

- 1 We focused our survey in benefit 13d, e, and f, which are the benefit categories in the plan benefit package (PBP) for “other supplemental services.”
- 2 The complete list of LTSS-type benefits in these data: “adult day care,” “backup support for medical equipment,” “caregiver services,” “home-based palliative care,” “in-home support,” “in-home support services,” “nonskilled home health,” “outside service area benefit,” “palliative care,” “personal care,” “personal care services,” “personal home care,” “restorative care benefit,” “supportive care,” “supports for caregivers.”
- 3 The six ADLs that trigger most LTC insurance benefits are: bathing, continence, dressing, eating, toileting and transferring.
- 4 HHS (July 1, 2015). Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Retrieved Feb. 5, 2019, from <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.
- 5 Willink, A., Kasper, J., Skehan, M. E. et al. (Jan. 24, 2019). Are older Americans getting the long-term services and supports they need? Commonwealth Fund. Retrieved Feb. 5, 2019, from <https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/are-older-americans-getting-LTSS-they-need>.
- 6 Society of Actuaries (July 2016). Long-Term Care Morbidity Improvement Study: Estimates for Noninsured U.S. Elderly Population Based on the National Long-Term Care Survey 1984–2004. Retrieved Feb. 5, 2019, from <https://www.soa.org/Files/Research/Projects/research-2016-06-ltc-morbidity-improvement.pdf> (PDF download).
- 7 Society of Actuaries, *ibid*. A complete list of these IADLs can be found on page 16.
- 8 Genworth. Cost of Care Survey 2018. Retrieved Feb. 5, 2019, from <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>.
- 9 Genworth, *ibid*.
- 10 The April 2018 guidance specifies that the expanded supplemental benefits must “focus directly on an enrollee’s health care needs and be recommended by a licensed medical professional as part of a care plan ...”
- 11 CMS (Jan. 30, 2019). Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter. Retrieved Feb. 5, 2019, from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Advance2020Part2.pdf>.
- 12 A chronically ill enrollee according to the Bipartisan Budget Act of 2018 is one who:
  1. has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
  2. has a high risk of hospitalization or other adverse health outcomes; and
  3. requires intensive care coordination.

# Dear Actuary: Facing Rate Increase

By Marc Glickman

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**E**very situation is unique, so always have your clients consult their long-term care, legal or tax adviser. The views discussed in this article are opinions of the author and not those of National Guardian Life (NGL), LifeCare Assurance or CLTC.

*Dear Actuary,  
My most important client just received a long-term care insurance rate increase. What should he do with his existing policy and should I consider a new carrier for his LTCI coverage?  
Fearful in Florida*

*Dear Fearful,*  
First of all, let me empathize with your client. Nobody wants to receive a rate increase letter. Now that you have the details in front of you, you have a chance to be a hero for your client. The best solution is probably to do nothing more than reinforce the value of the original plan.

The best solution is probably to do nothing more than reinforce the value of the original plan.

Most LTCI rate increases were a result of the original coverage being underpriced. It is likely that more claims will be paid out than originally anticipated. It turns out few people lapsed their policies each year and more people will eventually claim benefits. At the same time, the insurance carrier investment portfolios are earning much less than originally expected because of today's low interest rates. This means that the carrier needs to request extra premiums to fund the extra cost of future claims. Analogously, it is even more difficult to self-insure an extended-care event as an alternative to dealing

with the rate increase when low-risk investments are earning low rates of return.

One positive of the current lapse and interest rate expectations is that new products being sold today are much more likely to be price stable. A recent Society of Actuaries study<sup>1</sup> estimates that even under adverse circumstances, today's products have less than a 10 percent chance of needing a future rate increase. So, despite higher prices, new LTCI products still provide significant protection against a catastrophic long-term care need and with more price stability. Traditional LTCI remains the least expensive way to fund an LTCI plan.

Carriers that are filing for rate increases on their legacy products are trying to improve the adequacy of premiums to be more in line with today's new products. However, the price after the rate increase is usually still lower than today's price for the same benefits! This is despite the fact that the lower original prices have been paid for many years. This demonstrates that the insured have typically received an extremely good value on their existing coverage as long as the increased premium is at a level they can still afford to pay.

## INSIDE THE NUMBERS

This leads us to the method of analyzing the value of your client's original plan by using new product pricing. It is very likely that the reasons for the client's original purpose for LTCI protection are even more relevant today now that the person is older. We are going to use the price of today's new policies to assess whether the client is best served maintaining the current plan. This will at the same time highlight the value of the original plan even after considering rate increases.

Let's go through the analysis with a sample client who purchased LTCI 10 years ago when she was 55 years old. Let's assume she paid a premium of \$2,000. Now at age 65, she has paid \$20,000 into the plan. The client received a 50 percent rate increase bringing her annual premium up to \$3,000. She is planning for her long-term care needs to begin in another 20 years at age 85.

Run two new quotes from a current LTCI carrier's product. Both quotes should match the original benefits. If you are recommending that a client reduce benefits, you can also compare new quotes at that reduced benefit level. Run the first quote using the client's original issue age and the second quote using the client's current age. You will use the first quote as the hypothetical cost of a plan reflecting current actuarial assumptions. You will use the second quote to represent the replacement cost of a plan should the client have any thoughts of forgoing their current coverage.



LTCI premiums are around 2.5 times more expensive for the *same benefits* compared to plans sold 10 years ago.<sup>2</sup> The increase will be less noticeable for males compared to females because of the industry shift to gender-specific rates. Yet, the average LTCI premium of about \$2,500 purchased today is almost the same average price as 10 years ago after adjusting for inflation<sup>3</sup>. The reason for this seeming anomaly is that lower benefit periods and/or lower inflation rates are purchased on plans today. Lifetime benefits and 5 percent compound inflation used to be the most commonly purchased plan. Three- or five-year benefit periods and 3 percent compound inflation are more commonly purchased today. Reducing benefits instead of paying a rate increase results in the client having benefit structures that are more in line with today's policies.

The cost for our sample client's coverage today at her original age and rate class would be closer to \$5,000 instead of the \$2,000 she originally paid. At this point, it should be clear that the \$3,000 it will cost her to continue her current plan is still a great value compared to the \$5,000 that she would spend buying a new policy today with the same benefits.

Use the first quote you ran to evaluate your client's actual situation. Each situation will be unique based on gender, product, state and carrier.

Now let's assess the client's current alternatives.

#### **Scenario A—Client decides to lapse her current coverage:**

The \$20,000 already paid into the plan is a sunk cost. She is likely to be eligible to receive a very limited benefit (contingent nonforfeiture) should she lapse the policy.

If a new policy is 2.5 times more expensive at the client's original age, it will almost certainly be even more expensive now that the client is 10 years older. If the client originally purchased 5 percent compound inflation protection, also keep in mind that she has already accrued significantly higher benefits during the first 10 years of owning the policy. Also, it is possible that the client may no longer qualify at the same preferred health class or may not qualify at all because of a change in health during the 10 year period.

You might think it makes sense to replace her coverage with another type of plan like a combo policy that combines a life or annuity product with an LTC rider. This might be attractive

if the client's needs or preferences have changed. However, it will be very difficult to replace the value paid into the original policy, especially considering that the life or annuity plan is typically much more expensive than the traditional LTCI plan for the same level of LTCI protection.

**Scenario B—Client decides to keep her current coverage:**

She has another estimated \$60,000 (\$3,000 x 20) remaining to fund the plan assuming no additional future rate increases. The value of the existing coverage will continue to increase as she pays premiums, even if she prepares for the possibility of needing to fund an additional future rate increase.

**Scenario C—Client decides to reduce policy benefits:**

Most LTCI rate increases provide for a “landing spot” approach that allows the policyholder to reduce benefits while keeping the premium close to the original level. This way, the client may be able to both lock in the value already paid, still retain significant benefits, and keep the premiums at an affordable level.

Out of the three scenarios, real-world data suggest that most clients keep their current coverage. Individual situations differ based primarily on the magnitude of the rate increase(s). This author estimates that roughly 70 percent of people pay the full increase premium, 25 percent reduce their benefits, and only 5 percent lapse their policies.<sup>4</sup> After paying the rate increase, those policyholders tend to be even less likely to lapse their policies in the future. This indicates that most clients are making rational decisions and most LTC advisors are giving solid advice.

The main ongoing question is will there be additional rate increases? There is now significant rate increase data to assess this risk. The California Department of Insurance<sup>5</sup> publishes data for rate increases across all states. The majority of rate increases have occurred on policies issued prior to the adoption of rate stability regulations in the early to mid 2000s. In the California report, you can review both the rate increase amount approved and also the amount that was *originally requested* by the company. It is more likely that another rate increase will be requested if the full amount of the original filing was not granted. Be aware that this is not an exact science because company experience continues to develop and actuaries can refine pricing assumptions and models.

Some advisers also question the viability of the existing carriers. However, there is a robust regulatory framework that reviews every carrier's ability to pay claims and takes action accordingly.

**IN CONCLUSION**

Insurance by its nature will always have those who are *fortunate* enough to receive little or no benefits, while others will receive

large amounts of benefits due to the misfortune of requiring care. Yet, this is the primary reason for buying LTCI coverage. The insurance funds help ease the financial and emotional burden that comes with a need for extended care. Those who have received rate increases and have not yet received benefits should not feel as if their money went to waste. Just like term life, health, auto, or homeowners, the insurance provides peace of mind. They are still better off being healthy and not having a need for long-term care. In fact, these policyholders had great foresight to lock in the once-in-a-lifetime value offered by low premiums and the wide availability of richer benefits. You see this phenomenon clearly when those who purchased 10-pay receive a rate increase on their last remaining premiums. Their phone call to the adviser is usually one of gratitude.

It is hard to take the emotion out of receiving an unanticipated rate increase. Luckily, they have their trusted adviser to count on to help them keep their best options on the table. Usually, this is the plan they already have in place. Add value by asking them if they own a profitable business. They may not have considered that the rate increase could be an additional business expense deduction. In fact, they may not yet be deducting the premium at all! See the April 2018 “Dear Actuary” *Broker World* article for more details. After your conversation, it may even be possible that they will look to add more LTCI coverage to supplement their existing plan. Taking that initial phone call from the client that may make you feel like the goat may prove instead in their eyes to be the G.O.A.T. (Greatest of All Time). You will be surprised how addressing their fears the right way will open many doors to getting clients coverage in the future.

Do you have any LTCI questions for the actuary? Please write to Marc Glickman, FSA, CLTC at [marc.glickman@lifecareassurance.com](mailto:marc.glickman@lifecareassurance.com). ■



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**ENDNOTES**

- 1 <https://www.soa.org/Files/Sections/ltc-pricing-project.pdf>
- 2 Based on *Broker World* Survey data
- 3 Based on LIMRA Survey data
- 4 Based on major carriers that have reported these statistics in public statements
- 5 For Inactive Companies: <https://www.insurance.ca.gov/01-consumers/105-type/95-guides/05-health/01-ltc/rate-history-inactive.cfm>  
For Actively writing carriers: <http://www.insurance.ca.gov/01-consumers/105-type/95-guides/05-health/01-ltc/rate-history-active.cfm>



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# Tax-Qualified Language: Litigation Risks Stemming from Common Policy Language

By Nolan B. Tully, Sandra K. Jones and Jessica E. Loesing

**M**any long-term-care (LTC) insurance policies in the market are “Tax-Qualified,” or “TQ,” meaning that they meet the federal standards for favorable tax treatment specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (or were grandfathered in to that definition). This is an attractive option for most insureds because under TQ policies, certain LTC insurance benefits qualify for favorable federal income tax treatment—if the policy pays only benefits that reimburse the insured for qualified LTC costs, the insured will not owe federal income tax on those benefits. Likewise, premiums are tax-deductible up to a maximum limit that increases with age. These benefits are not provided by policies that are “Non-Tax-Qualified,” or “NTQ.”

Congress included provisions concerning LTC insurance within HIPAA in an attempt to improve access to private LTC insurance. In doing so, however, Congress created some confusion for both insureds and insurers. For instance, in order to qualify as a TQ policy, the policy must contain a multitude of statutorily required provisions and language. Specifically, TQ policies must provide coverage for “qualified long-term care services,” which “are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.” 26 U.S.C. § 7702B(c)(1). The term “chronically ill” is defined as “any individual who has been certified by a licensed health care practitioner as—

- (i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity ... or

- (iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

26 U.S.C. § 7702B(c)(2)(A)(i)-(iii)” [emphasis added].

## THE TWO “S” WORDS—“SUBSTANTIAL” AND “SEVERE”

The terms “substantial” and “severe” are not defined in § 7702B, HIPAA or the accompanying regulations. As a result, there is significant gray area that creates uncertainty as to whether individual claimants’ conditions fall within the bounds of these terms. After all, an insurer’s duty is to pay claims that are valid and covered and deny those that are not. Yet with a consistent increase in claims across the LTC insurance industry, there will organically be more risk associated with “close call” or “gray area” claims decisions. Likewise, as claims continue to increase, and more “gray area” claims are denied, there is a greater chance for dissatisfied insureds and thus a stronger likelihood of litigation. This article discusses hypothetical claims scenarios and identifies potential blind spots as a thought exercise on how insurers may approach “gray area” claims decisions with TQ policy language.

### Scenario One—“Inconsistent Assistance” with Activities of Daily Living

The insured is a 70-year-old female, Jane Row, who lives alone in a two-story row home in an urban area. Ms. Row suffers from rheumatoid arthritis, which is progressively becoming worse. At her most recent rheumatology appointment, Ms. Row told her physician that she was struggling to care for herself more frequently, and the physician suggested that she begin receiving assistance at home.

At the first meeting, the home health-care provider chosen by Ms. Row discovers that Ms. Row’s capabilities vary widely depending on whether she is having a “good” or “bad” day—all of which can change based on weather, amount of physical activity and sleep. On good days, Ms. Row primarily travels by taxi but walks to the grocery store, convenience store and pharmacy to run her errands, all of which are located within three blocks of her home. However, on “bad” days she struggles to climb the stairs to the second floor master bedroom and sometimes has to sleep on the first-floor couch instead. She no longer cooks because of the pain in her fingers, but she can microwave food that her family prepares for her. At times, however, she cannot hold her silverware, and on those days, she eats only hand-held fruits and vegetables. Ms. Row indicated that she only bathes on her “good” days, when she is able to grab the bar in the shower, lift her arms above her head to wash her hair and bend down to wash and dry her lower extremities. The clothing she wears depends on the type of day she is having, too. Sometimes, she can wear button-down

blouses and pants with zippers, but on most occasions, she needs pull-on types of clothing and will even stay in her pajamas all day. She is independent in toileting and continence. An on-site assessment likely occurred on a “good” day, because the nurse-assessor noted that Ms. Row shows some stiffness but is otherwise able to perform all of her activities of daily living with only minimal assistance.

Ms. Row would like to hire the home-health agency for one hour each morning to help her bathe and dress in regular clothing, and then for two hours each evening to cook and help her eat dinner, assist her to climb the stairs to her bedroom and to help her change into pajamas and prepare for bedtime. In her claim submission, however, Ms. Row acknowledges that on good days she would not require any of this assistance except for making her dinner. She does not deny leaving her home to walk to shops within her normal three-block radius. There are no other care or medical records available at this time.

Does Ms. Row require **substantial assistance** with two or more of her activities of daily living such that she would be eligible for benefits under her TQ LTC insurance policy? Her physician did not specifically find that she requires assistance—just that she would benefit from it. There is no documentation of what constitutes a “good” or a “bad” day for Ms. Row, but on “bad” days she arguably requires assistance with bathing, dressing and perhaps even eating. If she does not need any help on “good” days, then is the need for assistance substantial within the meaning of § 7702B and the applicable policy language?

When there is uncertainty like this in a claim file, claims professionals can gain information that might assist them in making the correct claims decision by conducting additional interviews with the insured’s physician(s) and the insureds themselves. While a physician could exaggerate the facts to try and obtain coverage for his or her client, in most scenarios the physician will likely be able to provide a clear and complete picture of the type of care that is required. And in any event, a statement from the insured’s own physician stating that the insured does or does not require substantial assistance with any activities of daily living is certainly one of the strongest pieces of evidence in determining the proper claim decision and having it withstand any external scrutiny. If more information is sought, however, the claims professional must be prepared to walk through the full scope of the insured’s condition and the facts surrounding the claim, so as to gather as much relevant information as possible from the insured, the insured’s physician or the insured’s caretaker. Simply asking, “is the assistance this insured requires “substantial?” will not yield helpful data, as the response will simply be a judgment call based on that individual’s definition of substantial. Obtaining this information will permit the insured to make a more informed decision



and, in the hopefully few but undoubtedly inevitable number of instances where the insured disagrees, it will help the insurer avoid extracontractual liability for bad faith, given that the insurer can show that they went above and beyond to obtain relevant data to make the proper claims determination. Finally, insurers should work within their existing guidelines to make sure that this additional information gathering takes place within the appropriate statutory and/or regulatory timelines.

### **Scenario Two—“Substantial Supervision” Required Due to “Severe” Cognitive Impairment**

The insured is an 80-year-old male, Tom Doe, who lives alone. His daughter, however, believes that he needs to be in an assisted living facility because his mental health is declining. For example, Mr. Doe’s daughter is focused on Mr. Doe’s new and bizarre behavior. Mr. Doe recently went to the grocery store in his pajamas, and sometimes cannot remember the names of his grandchildren. Recently, Mr. Doe was hospitalized for dehydration, which his daughter attributes to his

failure to drink enough fluids. After the hospitalization, Mr. Doe's daughter decides that it is best for him not to live alone anymore, and so Mr. Doe moves in to an assisted living facility. He does not live in the memory care unit of the facility (even though it has one), and he receives "Level Two Care," which means that he receives assistance with one activity of daily living—bathing—and also receives administration of his medications. Mr. Doe's daughter instructs the facility that Mr. Doe needs assistance with dressing because otherwise he will forget to put on street-appropriate attire. She also believes that if he does not take his blood pressure medication, he will become very ill, and so the medication is given to Mr. Doe by the facility each day.

A forward-thinking and risk-conscious claims operation is ... aware of the pitfalls and gray areas ... [in] TQ policy language.

Mr. Doe's daughter files a claim for benefits under Mr. Doe's TQ LTC insurance policy. In support of the claim, she submits a copy of the assisted living residency agreement, which is signed only by Mr. Doe and outlines that Mr. Doe will receive "Level Two Care," including reminders at mealtimes, cuing and prompting at bath time and assistance with dressing. Mr. Doe's daughter also submits a copy of the intake form, which was completed and signed by the head nurse at the assisted living facility, and states that Mr. Doe is "oriented x3, alert and appropriate, and exercises good judgment." The intake form states that one person is required to assist Plaintiff with dressing but provides no explanation of the exact care that will be provided or the need for the care. Recent care notes state that Mr. Doe is "doing well" but has been showing signs of "sundowning." Mr. Doe does not wander, but the facility is locked, and Mr. Doe could not leave the building without being noticed by security. An on-site assessment results in a Mini-Mental State Exam (MMSE) score of 26/30.

Finding a lack of support for a cognitive impairment claim, the carrier requests medical records from Mr. Doe's primary care provider. One month prior to Mr. Doe moving to the assisted-living facility, the primary care provider administered another MMSE, on which Mr. Doe obtained 28/30. During the appointment, Mr. Doe admitted he could not remember his grandchildren's names and could not remember the name of the street on which his new assisted-living facility was located.

The provider noted that Mr. Doe was exhibiting "minor short-term memory issues" but made no reference to activities of daily living or other physical health problems. After the insurer informed Mr. Doe's daughter that the medical records received from the primary care provider were insufficient to support a finding of benefit eligibility, Mr. Doe's daughter took Mr. Doe to a neurologist a few weeks later. The neurologist found that Mr. Doe had "dementia, mild; things are at an early stage right now, but of course dementia is progressive, and Mr. Doe is not living independently right now. Mr. Doe should not drive or cook for himself." An MMSE administered by the neurologist resulted in a 22/30 score. The neurologist also prescribed Aricept, which the assisted living facility provides to Mr. Doe. Mr. Doe's daughter is very upset about her father's decline, and she is adamant that the claim is approved quickly because neither she nor her father have much money to pay for his care otherwise.

Claims Decision: Does Mr. Doe require 1) substantial supervision to protect him from threats to his health and safety 2) due to a severe cognitive impairment?

First, the claims adjuster must decide whether supervision provided by the facility is "substantial" in Mr. Doe's case. Although the scenario suggests that Mr. Doe could receive a higher level of care in the memory unit of the facility, it does not provide any information about the level of supervision that Mr. Doe receives in his current unit. "Substantial" supervision cannot, realistically, mean that a human being is watching Mr. Doe all day and all night since so few, if any, claims would satisfy that standard. This is particularly true given modern technology, which can obviate the need for physical human supervision. There is also a gray area as to what the triggers for "requiring" substantial supervision might be. For instance, just because an insured does not wander or self-harm does not mean that he or she does not require substantial supervision to ensure that future injury or harm does not occur. Therefore, claims examiners should ask appropriate questions to gauge whether or not supervision rises to the level of "substantial." For instance, even if a staff member or nurse does not physically watch an insured, does the facility monitor residents through the use of cameras? Can Mr. Doe come and go as he pleases or are the doors locked at all times? All of this information, if accurately received, would inform the decision as to whether or not Mr. Doe requires substantial supervision.

Next, if substantial supervision is required to protect Mr. Doe from threats to his health and safety, the claims administrator must determine whether any cognitive impairment is "severe." This is hard to do. All insureds are different, and individuals will respond to testing (like the MMSE, for instance) differently. Here, the neurologist's note that Mr. Doe suffers from "mild dementia" in an "early stage" seemingly suggests that

Mr. Doe does not suffer from a **severe** cognitive impairment. On the other hand, the remainder of the note (namely, that Mr. Doe should not cook or drive), coupled with other aspects of Mr. Doe's file (i.e., sundowning and the decreased MMSE score), could support a finding of severe cognitive impairment. To mitigate the risks associated with conflicting elements of a file, an insurer again could speak with the insured's neurologist to ask for clarification about the discrepancies in the record and to gain additional information about Mr. Doe's condition. Also, it should not be discounted that "early" dementia could be a "severe" cognitive impairment. Claims professionals should be careful not to focus on individual words and their plain meanings but to look at each claim holistically.

Another common mistake that arises is "claim segregation," or deciding preliminarily that an insured has only a claim based on his or her cognitive deficits as opposed to being an "ADL" based claim. Here, for instance, the claim examiner should note that Mr. Doe is receiving assistance with dressing and needs cuing to bathe and at mealtime. Regardless of Mr. Doe's cognitive status, the claims examiner should take note of Mr. Doe's functional capacity and evaluate whether these facts establish that he needs substantial assistance with two or more ADLs.

A forward-thinking and risk-conscious claims operation is one that is aware of the pitfalls and gray areas associated with TQ policy language and acts smartly and appropriately to avoid the consequences that can result from the lack of clear definitions for

"substantial" and "severe" as those qualifying words are applied to everyday claims scenarios. Spotting potential "gray areas" and missing information will oftentimes lead to receipt of information needed to close those gaps and make the appropriate claims decision. Similarly, a heightened awareness of the need to clarify discrepancies in medical and care records will reduce the risk of litigation and/or negative regulatory scrutiny. ■



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# New to LTC

By Alex Vichinsky, John Mulheren and Andrew Sloan

## **W**hat drew you to working in the LTC industry? And what makes you excited to continue working in LTC?

Like most actuaries, the three of us universally enjoy the opportunity to solve complex, meaningful problems. This was a key factor in our decision to enter the LTC industry. The industry does not have a shortage of problems, which can be concerning, but it can also make it an exciting place to work where you can make a difference. LTC is still a relatively new product and we are facing some of the most difficult challenges. This allows LTC actuaries the opportunity to be creative while designing solutions. While the product can be quite complex, we feel the complexity makes it interesting and rewarding.

Once we started working in the LTC industry we realized many of the reasons we entered the industry were validated. We get to work with complex products, are provided the opportunity to design solutions and are given the opportunity to take on new and exciting projects. We realized although it is difficult to truly become an expert in LTC, it also means there are always new things to learn and new opportunities to grow as actuaries. Further, the burden of paying for LTC expenses in America is unyielding and the need for LTC coverage remains indispensable. The work we do allows us to fulfill our promises to our current policyholders while also putting us in a position to provide coverage to those who still have LTC needs. We continue to work in the LTC industry because we see the value we are bringing and the overall impact we are making to our company, industry and broader population.

### **Compare Life and LTC in terms of:**

#### a. Product Design

Even though LTC is a relatively new product, the industry has come up with a wide variety of product designs and features. Many older LTC policies pay benefits on an indemnity basis, while newer policies pay benefits based on the actual cost of care. Typically, the insured must demonstrate that they are unable to meet at least two activities of daily living in order to start receiving benefits. Other key product features include inflation protection and elimination periods that act as a deductible that delays the initial payments. Due to the long duration of the product, experience often takes decades



to emerge. This, combined with the lack of industry and historical experience, presents challenges in product design and assumption setting.

#### b. Assumptions

LTC tends to be more reliant on assumptions than life insurance, which can make it more interesting to work with, but also gives a steeper learning curve. Similar to life insurance, LTC insurers keep track of mortality and lapses. Additionally, LTC actuaries analyze incidence rates (the probability of going on claim) and track policyholder behavior once on claim. Since LTC claims often occur 30+ years after the policy is purchased, estimating claim severity can be very challenging. Often severity is split out between benefit utilization and claim termination rates. Trends in the cost of LTC are also studied, as they can affect future benefit utilization.

#### c. Regulations

LTC policies are generally guaranteed renewable and noncancelable. As such, insurers can pursue rate increases if experience

deviates from expectations subject to state regulations. States often employ different regulatory approaches, leading to a very diverse regulatory environment. The LTC regulatory environment is constantly changing, which gives actuaries an opportunity to collaborate with regulators to help create the future of LTC. New potential regulations are being developed and proposed in an effort to create a landscape that solves current problems while encouraging a healthy market.

#### d. Challenges

An initial challenge for the industry was lack of applicable data for assumptions. Early LTC products were priced using disability insurance assumptions, which have proven to be very different. The low interest rate environment has proven challenging for LTC, as it has for many life products. Poor understanding of assumptions and early mispricing have led to the need for rate increases that have damaged the reputation of the industry. Poor understanding and communication of the product features and designs by companies and agents have added to this reputation deterioration.

Many players have exited the market and only focus on managing their in-force block. The overall market has declined in recent years emphasizing the importance of in-force management. Many carriers are focusing on pursuing actuarially justified rate increases for in-force policies. It is very challenging to balance innovating solutions for the market while addressing issues with existing business. While LTC insurers face many challenges, this provides opportunities to fix these problems and improve the industry.

#### **Describe an interesting LTC actuarial project you worked on.**

Each of us has had opportunities to work on projects that are unique to LTC. This includes building tools to aid assumption development, pricing alternative options that mitigate the impact of rate increases and working on rate-increase filings while directly interacting with regulators. These projects have challenged us and increased our LTC knowledge while allowing us to contribute to valuable efforts.

#### **Why is it important for LTC insurance to exist?**

There are 74 million baby boomers in America. As this generation ages into its 70s and 80s, a large number (some studies say 50 percent plus) will need some type of long-term care. While

health-care and long-term care costs continue to rise, people are living longer and not saving enough. Many are unprepared or surprised by the large costs of staying in an LTC facility or receiving home care. Medicare only covers short LTC stays and Medicaid requires one to spend down assets before eligibility. LTC insurance is a great way to prepay and pool risk for these costly events.

#### **What makes you hopeful for the future of LTC and why should a new FSA consider working in LTC?**

The need for LTC isn't going away. While we still face the problems of the past there remains a need for innovation. This is an opportune time to enter LTC as the industry learns from its past and works to provide solutions for a growing need for coverage. Working in LTC allows an actuary to have a real impact at a pivotal time for the product where the future is uncertain. LTC has plenty of opportunity that other industries can't offer due to the unique circumstances surrounding the product. In our experience, the biggest and most challenging problems are often the most satisfying to work on and result in the most growth. ■



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# Combination Products: A One-Stop Solution?

By Scott R. Kallenbach and Linda Chow

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**W**ith the aging population in the United States, is long-term care (LTC) a crisis in the making, or is it already at our doorstep? Clearly, LTC is a growing concern. Half of people turning 65 today will require some form of LTC support during their lives.<sup>1</sup> Yet, many people lack the financial resources, including insurance, to pay for this care. While consumers recognize the need for LTC coverage, few actually purchase it.

With limited ownership of private LTC insurance, financing will continue to come from personal assets and Medicaid. This problem will only worsen as Baby Boomers age. Both public and private stakeholders recognize the need for a viable LTC insurance marketplace. More companies are developing an alternative to stand-alone LTC insurance. One of the few primary insurance alternatives is a life combination product that offers the ability to cover some costs related to LTC by adding riders to a base life insurance product.<sup>2</sup>

This executive summary is drawn from our full report, *Combination Products: A One-Stop Solution?* and highlights the key findings.

To be successful in the combination product market, companies must address five key challenges, ranging from consumer perceptions to regulatory compliance to risk management. Some are concerns triggered by legacy issues inherited from the stand-alone LTC market.

## 1. CONSUMER PERCEPTION

In general, consumers have a negative impression of stand-alone LTC insurance, and this mindset influences their perception of combination products. They deem the coverage as expensive, and there is uncertainty surrounding the costs and benefits. Due to the challenges insurers have had with experience, combined with changing policyowner behaviors during the life of the policy, premiums may increase significantly. There is also the feeling of loss if LTC expenses are

not incurred. Significant premiums can be paid with no benefit payments in return. There is also a widely held assumption that government programs will pay for LTC.

Combination products address the “use it or lose it” attitude, thanks to the underlying life insurance death benefit. When permanent life insurance is the base of a combination product, the insured, in essence, is funding a benefit that may or may not be paid with a benefit that will be paid. The coverage flexibility can meet the evolving needs of the policyowner. In addition, compared to a stand-alone LTC policy, there is less risk that the premiums, or more specifically the nonguaranteed policy charges, will rise with a combination product.

Education is key. The need to fund potential LTC expenses will not go away, and consumers should be aware of the alternatives to stand-alone LTC solutions.

## 2. PRODUCT VIABILITY

The concept of product viability revolves around marketplace acceptance. Will financial professionals want to sell it and will consumers buy it? We know there is a recognized need for LTC coverage as more than 4 in 10 retirees view LTC costs as a “major” concern. In fact, they are more fearful of LTC expenses than longevity risk, a prolonged stock market downturn or inflation.<sup>3</sup>

As financial professionals work with clients to develop comprehensive financial plans, they should be sure to incorporate coverage of unanticipated health-care costs in such plans. For all but the most affluent consumers, the choice may be to get at least some coverage rather than none.

Combination products provide the opportunity to meet multiple needs—protection against untimely death and coverage of some long-term care costs—in a single policy, likely for less than it would cost to purchase both policies separately.

Looking forward, we expect to see experimentation around affordability, with insurance companies innovating around product design.

## 3. REGULATORY AND COMPLIANCE CHALLENGES

Training financial professionals is a key priority due to the distinctions among the various products. Further, financial professionals may require in-depth education to understand how these benefits work.

The various types of combination products can be confusing, so companies put a lot of effort into their field training programs. Successful manufacturers provide advisers with a level of comfort and understanding of the products and how to sell them. Insurers also work with their distribution partners to teach selling concepts. Combination products may be a viable





product in a comprehensive retirement plan as a way to effectively shield assets from an LTC event.

Life insurance policies that fall under Section 7702(b) of the Internal Revenue Code, including those with LTC and LTC with extension of benefit (EOB) riders, have the same training and continuing education requirements for financial professionals as stand-alone LTC. Insurers should continue to work with regulators in order to provide meaningful education standards that benefit advisers as well as consumers.

#### 4. OPERATIONAL FRICTION

Operational friction is largely a function of legacy system constraints and has two major components: manual claims processing and the interaction between the base policy and the rider.

Insurers in the combination product market widely rely on a manual claims process but realize the need to shift to an automated process.

Talent management and support is an associated struggle related to claims. The claims process for the living benefit portion of a combination product differs greatly from the claims process for the death benefit. Clinical staff (nurses or social

workers) are necessary to adjudicate claims. At the time of the claim, it must be verified that the insured needs substantial assistance with two of the six activities of daily living (ADLs).<sup>4</sup>

Legacy systems built to make one death benefit payout have difficulty with the living benefit payments. Insurers commonly use “bolt on” solutions to address this issue. For some carriers, it is hard to justify making investments in system upgrades for a product that does not currently have significant scale.

When addressing operational friction, the question for insurance companies is, should they buy, build or rent? The best option will be based on where each carrier believes the overall market is heading, its own new business projections, as well as product design. Renting or outsourcing the work to a third party could be a shorter-term solution. As insurers gain scale or differentiate by product design, building or buying may be a better, longer-term solution.

#### 5. RISK MANAGEMENT CONCERNS

Risk management responsibilities are not contained within a particular unit but are spread across the organization, including product design and pricing, underwriting (risk selection) and capital management.

As industry standard assumptions are lacking, assumption setting is typically a do-it-yourself exercise.

### Product Design and Pricing

Product design and pricing is a significant issue for insurers in the combination product market. Currently, there is no actuarial valuation table for LTC like there is for life insurance and disability insurance. Due to the nature of the product, LTC experience is slow to emerge, so there is limited insured data available.

As industry standard assumptions are lacking, assumption setting is typically a do-it-yourself exercise, with insurers building their own expertise while leveraging consulting firms or reinsurers, who have more data. These firms have experience working with insurers that offer combination and stand-alone LTC products.

Funding the benefit is also a risk that must be managed, especially for EOB products. The extension piece is only paid out once the death benefit has been fully accelerated. As such, EOB products during the extension period perform more like stand-alone LTC policies, as there is little built-in cash value in the policy to fund the benefit payments. This is especially risky for fully guaranteed policies funded with a single premium.

### Underwriting (Risk Selection)

Some companies are entering the combination product market with little to no experience in underwriting LTC, notably those marketing life insurance policies with chronic illness (CI) riders. In fact, the majority of products with a CI rider do not require additional underwriting for the CI protection. In general, there are no plans to change underwriting requirements in the near term. We expect to see an increased level of automation in the process, which will increase underwriting speed with the goal of also maintaining quality.

### Capital Management

Life insurance is capital intensive, requiring careful planning. As a result, capital management is an issue. Setting reserves for combination products is not easy and is open to regulatory interpretation, especially in a “pre-principle-based reserving” environment. With no industry data to rely on, experience is limited, so there is a greater granularity of focus on individual company performance.

A final challenge for managing capital is that reinsurance options are limited due to a lack of capacity.

Despite the challenges outlined above, the outlook for combination products is positive.

Consumers are faced with meeting a multitude of current financial priorities, while simultaneously under pressure to adequately fund their retirement needs. Through combination products, the industry can help consumers satisfy multiple priorities with a single solution. The growth in new sales of life insurance combination products has been healthy the last several years, and we believe it will continue in the near term.

Consumer need for LTC is on the rise, yet the existing private LTC insurance failed to address this need. Life insurance combination products can be part of the solution to this growing problem. The opportunity for the industry is to create products that are attractive and affordable to help consumers address this financial need.

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### ENDNOTES

- 1 <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.
- 2 Although not covered in this report, there are also combination annuity products.
- 3 2016 LIMRA Secure Retirement Institute Consumer Survey.
- 4 The six activities of daily living are: bathing, continence, dressing, eating, toileting and transferring.



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