



Medi(long-term)care for All: A Look into the Future of Long-Term Care Insurance—Part Two

By Stephanie Moench and Shawn Stender

In part one of this two part series, we dove into the question of how the funding for long-term care (LTC) benefits may change in the future given the increasing LTC needs of the baby-boomer generation and the recent attention that has been given to affordable LTC services. We outlined three possible future paths for LTC insurance funding and the associated implications for the private LTC industry. These paths included the following:

Scenario #1: Status quo—There are no substantial changes in how LTC services are funded. That is, LTC benefits for those not eligible for Medicaid continue to be primarily self-funded or covered via private insurance. While we assume that no federal social insurance programs are introduced to cover LTC services in this scenario, additional jurisdictions may implement their own social LTC programs, similar to what was enacted by Washington state in May 2019.¹

Scenario #2: “Medicare for All”/“single-payer” system—The way LTC services are funded changes dramatically. This could involve the United States adopting a federal social insurance program that provides materially complete LTC coverage, similar to the programs introduced in countries like Denmark and France.^{2,3} This potential future represents the alternative “end-point” to the status quo scenario.

Scenario #3: Somewhere in between—Funding for LTC services may fall somewhere between scenarios #1 and #2. The United States may not be prepared to transition to a “complete” social LTC program; however, it is possible that an involuntary, partial social program could be established to provide LTC coverage. The intent of this program would be to materially fund



LTC benefits for a large percentage of people who need services, but these social benefits would not be enough for all people.

With regard to scenario #3, it is expected that in-force LTC blocks would be materially impacted by the introduction of a partial social LTC program due to existing policyholders changing their coverage in light of the involuntary social benefit. Generally, a company’s aggregate risk is reduced when LTC insureds elect to lapse their policies or reduce benefits beyond what may have been expected when the policy was priced. However, would this still be the case if a social program were the catalyst for the policyholder behavior? Would the impact of the social benefit differ materially depending on the demographics of the in-force business? How would reserve sufficiency for existing LTC carriers change? The following case study aims to answer these questions.

All opinions and illustrations in this article are the sole opinions of the authors and do not represent the opinions of Milliman, Inc. The case study outlined below is not intended to be a political stance, but merely provides considerations for the future of LTC given the recent spotlight (political and otherwise) on the industry. All considerations regarding the future evolution of the LTC industry are speculative, and actual events may unfold materially differently under any given future path were such path to come to fruition.

CASE STUDY: HOW COULD SCENARIO #3 IMPACT A PRIVATE LTC INSURER?

The financial impact on LTC carriers of a partial social LTC program, as described in scenario #3 above (and in [part one](#) of this article), would be highly dependent on the specific characteristics of the insurers’ LTC business, as well as the regulations and features associated with the social program. As described in the following case study, we developed an illustrative social LTC program to analyze the impact on two sample blocks of in-force LTC insurance business, one “older” and one “newer.” Please note that this case study uses judgment-based (versus experience-based) assumptions, and the projected impacts are presented for illustrative purposes only. The assumptions and results of this case study should not be relied on for anything more than to aid in understanding possible outcomes of a change to LTC funding in the United States.

The impact of our illustrative social LTC program is financially favorable for both blocks of business tested. In terms of the projected loss ratio (i.e., ratio of future incurred claims divided by future earned premiums), the social program results in about a 1 percent decrease for the older business and an approximate 13 percent decrease for the newer business. With regard to pretax statutory gain or loss (i.e., statutory profit without consideration for taxes and risk-based capital metrics), the social LTC program is also materially favorable for each block. For the older block, pretax statutory profit increases by about 25 percent (or approximately \$182 million) while the increase for the newer block of business is nearly 350 percent (or about \$58 million).

DESCRIPTION OF LTC BUSINESS TESTED

The older block of business used in our analysis was priced in the mid-2000s, while the newer block was priced in the mid-2010s. Both blocks were individually underwritten, sold on a nationwide basis, and have an average issue age of approximately 55. Table 1 summarizes some additional key characteristics for each block.

Table 1
Key Characteristics

Distribution by Policy Characteristic	Older Block	Newer Block
Lifetime benefit period	30%	0%
Benefit periods less than 5 years	40	60
5% compound inflation	50	5
Inflation protection other than 5% compound	40	75
Indemnity benefits	20	0
Limited premium payment term	15	0
Insureds with attained ages less than 65	55	80

DESCRIPTION OF ILLUSTRATIVE SOCIAL LTC PROGRAM

Using the program adopted by Washington state in May 2019 as a reference point, along with the design of currently offered private LTC plans, our illustrative social LTC program is assumed to have the following features and requirements:

- The program provides a two-year benefit period (BP) with \$150 maximum daily benefit amount.
- The daily benefit amount is indexed annually at the consumer price index (CPI).
- Comprehensive benefits (i.e., both facility and home care services) are covered with no restrictions on facility sites of care or formal home care services.
- Benefit eligibility triggers are consistent with those required under HIPAA (i.e., two of six activities of daily living or severe cognitive impairment).
- There is a pre-funding requirement such that benefit eligibility must be gained over a three-year period. Beyond the three-year period, there is no elimination period (EP); however, eligibility will be assessed via application, which may result in a waiting period for covered services.
- Coverage is involuntary—all U.S. citizens ages 18 and older are automatically enrolled.
- The program is funded via a sales tax (or alternative mechanism) such that most people will pay for the coverage commensurate with their ability to do so.
- Coverage requires that you must use existing private benefits before using social benefits, and, similar to private LTC coverages, duplication of benefits is not allowed (i.e., individuals may not receive private and social benefits concurrently).
- This coverage lines up well with the evolution of the private LTC industry in recent years. That is, the industry has gradually moved to offering lower benefits (e.g., less than

lifetime BPs, lower than 5 percent compound inflation, and greater than zero-day EPs). It is also comparable to what is provided under the program adopted by Washington state in May 2019, which offers a one-year BP inflated at the CPI.¹

ASSUMPTIONS AND MODELING METHODOLOGY

To project the impact of our illustrative social LTC program on our two sample blocks of in-force LTC business, we used Milliman’s MG-ALFA® software and leveraged LTC industry experience based on the Milliman Long-Term Care Guidelines. This case study was performed using claim costs, rather than first principles assumptions.

The “baseline” assumptions underlying the model are considered current best estimate. We then developed assumptions for policyholder behavior (shock lapse and benefit reductions) commensurate with the announcement of the LTC social program and subsequent eligibility for benefits under the program. In developing these assumptions, we assumed the following:

- The social LTC program is highly publicized such that policyholders are aware of the social benefits and react accordingly with regard to their private benefits (versus being unaware and thus not reacting).
- Existing policyholders generally adjust their private LTC coverage to achieve a combined private and social benefit approximately equal to the private LTC benefits they purchased at issue. Only reductions to the underlying BP were modeled, as a simplification, rather than also considering reductions in inflation and other coverage components.
- Policyholders use their private LTC benefits prior to their social benefits as required by the social program. This also enacts waiver of premium provisions in their private insurance.

Under this scenario, the majority of in-force LTC insureds with BPs of two years or less may drop their private coverage in light of the new, involuntary, socially funded benefit. Additionally,

some insureds with BPs greater than two years will likely drop their private insurance based on a better understanding of their current health status and revised expectations of future LTC needs (relative to that at policy issue). Those with richer benefits (e.g., lifetime benefits) may elect to keep their benefits as is. Note that existing policyholder behavior may vary if the social LTC program was assumed to be voluntary (similar to the CLASS Act) rather than mandatory (similar to Social Security). In particular, if coverage under the social program were voluntary, then existing LTC insureds who have been paying premiums for years may be less apt to drop or reduce their private coverage to move into a social program. Further, a voluntarily program may have a higher potential for adverse selection.

Table 2 provides a high-level summary of the assumptions related to policyholder behavior that underlie our analysis.

We note the following with regard to the assumptions in Table 2:

- Revised claim cost assumptions were developed to reflect the anticipated reduced BP. The assumed election percentages were then used to determine the percentage of existing policyholders that reduce benefits to the lower claim cost level in the projections (e.g., for policies with an original BP of three years, approximately 50 percent of policies reduce to a BP of two years in the LTC social insurance scenario).
- We determined assumptions for the level of reduced benefit based on the currently available benefits for the blocks of business modeled, such that a corresponding premium rate would be readily available.
 - » Because the lowest BP available on the sample LTC business used in our analysis is two years, policyholders who currently have a two-year benefit do not have the option to reduce their BP. For these policyholders, we only reflect a shock lapse assumption.
 - » This approach did not always allow for a reduced benefit that aligned the resulting BP (including social ben-

Table 2
Underlying Assumptions

Original Benefit Period	Reduced Benefit Period	Assumed Avg. Benefit Reduction %	Assumed Avg. Shock Lapse %	Assumed Avg. Adverse Selection Scalar
2 years	N/A - Lapse only	0%	96%	1.05
3 years	2 years	50	45	1.06
4 years	2 years	77	16	1.07
5 years	3 years	83	8	1.07
6 years	4 years	86	4	1.06
10 years	6 years	49	0	1.05
Lifetime	10 years	11	0	1.02

efits) with the original BP. For example, policyholders reducing from a 10-year BP to a six-year BP achieve a total BP (i.e., private plus social benefit) of eight years rather than their original 10 years.

- The assumptions shown above reflect the average reduced benefit and/or shock lapse election percentage across all attained ages for a given BP. Policyholder behavior is assumed to vary materially by attained age, with the oldest attained ages having the lowest election percentages and corresponding adverse selection scalars.
- Adverse selection scalars are calculated formulaically using the assumptions for (1) shock lapse and benefit reductions and (2) relative morbidity of those who shock or reduce benefits compared to those who do nothing. The relative morbidity assumptions vary by BP from 5 percent to 50 percent. The formula used is as follows:

$$\text{Adverse Selection Scalar} = [1 / (1 - \text{Shock Lapse \%} * \text{Relative Morbidity for Shock Lapse} - \text{Reduced Benefit \%} * \text{Relative Morbidity for Benefit Reductions})]$$

- Of the assumed shock lapses and benefit reductions, 70 percent are expected to occur upon announcement of the so-

cial LTC program (in 2022) with the remaining 30 percent occurring three years later (in 2025) once policyholders are eligible for social LTC benefits.

IMPACT OF LTC SOCIAL PROGRAM AND SENSITIVITY OF ASSUMPTIONS

As previously mentioned, the introduction of the social LTC program had a favorable impact for both illustrative blocks of LTC business tested. However, the impact on existing LTC carriers may be heavily dependent on policyholder behavior. To better understand how different behavior may drive the results, we performed several sensitivity tests, as shown in tables 3 and 4. For the purpose of this analysis, cash flows were discounted to Dec. 31, 2019, using an average net investment earnings rate of 4.0 percent.

Note that each scenario in tables 3 and 4 relates separately to the performance of the Social LTC program and are not stacked or cumulative changes.

In general, this case study demonstrates that a social LTC program would likely be beneficial for existing LTC insurers. For the older block of business, the present value of pretax statutory profit is materially negative in the baseline scenario. While the social LTC program reduces the expected future losses for

Table 3
Sensitivity Tests: Future Loss Ratio

Scenario	Older Block		Newer Block	
	Future Loss Ratio	% Change from Baseline	Future Loss Ratio	% Change from Baseline
Baseline	305%	N/A	110%	N/A
Social LTC Program	302	-1.2%	96	-12.8%
25% decrease in election percentages*	303	-0.6	101	-8.5
No adverse selection	298	-2.4	94	-14.3
10% increase in adverse selection	323	5.9	99	-10.1
Five year delay in program introduction	286	-6.2	89	-19.4

* Decrease applies to both shock lapse and reduced benefit option elections.

Table 4
Sensitivity Tests: Pretax Statutory Profit

Scenario	Older Block (\$ in Millions)		Newer Block (\$ in Millions)	
	Pretax Stat. Profit	\$ Change from Baseline	Pretax Stat. Profit	\$ Change from Baseline
Baseline	\$(689)	N/A	\$17	N/A
Social LTC Program	(507)	\$182	75	\$58
25% decrease in election percentages*	(553)	136	60	43
No adverse selection	(492)	197	80	63
10% increase in adverse selection	(596)	93	66	49
Five year delay in program introduction	(499)	190	100	83

* Decrease applies to both shock lapse and reduced benefit option elections.

this business, the program is not beneficial enough to produce a positive pretax statutory profit, even under the most favorable sensitivity scenario tested.

For the newer block of business, the impact of the social LTC program is more material (i.e., a larger percentage change in future loss ratio and present value of pretax statutory profit). This phenomenon is likely driven by the materially younger attained ages underlying this block, which results in a larger portion of policies expected to reduce or drop coverage in light of the social program. Further, because LTC is a long-duration product, changes may be amplified for business with younger insureds, particularly in terms of persistency and interest impact over the projection period. Additionally, the benefit period mix is less rich on the newer business so higher benefit reduction and shock lapses are assumed, which magnifies the favorable impact of the social LTC program.

The financial impact of the social LTC program on an even older block of business (e.g., in-force LTC business priced prior to the 2000s) was not tested as part of this case study. We analyzed a sensitivity test of delaying the social program implementation by five years (to 2027) as a means of approximating how the program might impact an even older block of LTC business; however, because the sample blocks underlying this case study are still paying materially more premiums relative to claims during this five-year period, the delay has a favorable impact. Lengthier delays are too speculative and were not sensitivity-tested.

CONCLUSION

While the case study performed demonstrates that a social LTC program similar to that adopted in Washington state could be beneficial for both consumers and LTC insurers, it is still un-

clear whether this type of program would be the best fit for the current social, political and economic environment in the United States. Additionally, there are a number of unknowns, including funding and program features, which would need to be addressed by regulators and actuaries before a social LTC program could be established. Nevertheless, there is a significant need for LTC, and the private LTC industry will continue to evolve to meet this need. ■



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ENDNOTES

- 1 Second Substitute House Bill 1087, 50B RCW 66th Washington State Legislature (2019).
- 2 Vrangbaek, K. The Danish Health Care System. Retrieved August 30, 2019, from <https://international.commonwealthfund.org/countries/denmark/>.
- 3 Durand-Zaleski, I. The French Health Care System. Retrieved September 11, 2019, from <https://international.commonwealthfund.org/countries/france/>.



Recent Developments in LTC Rate Increase Litigation

By Nolan B. Tully, Sandra K. Jones and Steven H. Brogan

A relatively consistent flow of premium rate increase litigation has been filed against long-term care (LTC) carriers over the past several years. Following the plaintiffs' bar having early success in a limited number of LTC rate increase class actions in the early 2000s, the tide turned definitively in favor of carriers in what we think of as the first generation of such litigation, where the plaintiffs' bar focused primarily on an alleged duty to disclose possible rate increases and challenging the language of the contract itself. Despite the industry's overall success, premium rate increase litigation has attracted an increased level of sophistication from the plaintiffs' bar, which shifted to more creative theories based on extra-contractual representations (e.g., marketing materials) in what we view as the second generation of premium rate increase litigation. While the industry remains mostly successful in warding off rate increase litigation, a new trend may be developing as recent cases focus on more nuanced contractual limitations and rate increase implementation issues.

FIRST GENERATION PREMIUM RATE INCREASE LITIGATION

First generation premium rate increase complaints typically asserted claims of some combination of breach of contract, fraud, bad faith, violations of unfair trade practices statutes, and unjust enrichment, supported by allegations that the carriers knew the policies were underpriced at the time of sale, intended to close blocks knowing that doing so may lead to financial losses, and intended to raise premiums to encourage "shock lapse."

Alvarez is one of the industry's early generation class action victories and it set the tone for the industry's defense against challenges to insurers' contractual right to raise premiums. In *Alvarez*, the plaintiff's complaint was a typical bait-and-switch theory.



The plaintiff argued that the representations that (i) the policy was "guaranteed renewable," that (ii) premiums "may" change, and that (iii) the premiums had been expertly priced were "half-truths" that breached an alleged duty of disclosure. The district court granted the carrier's motion to dismiss and the Third Circuit affirmed that decision, holding that an LTC insurer "did not have any duty to disclose the possibility of future premium increases or the underlying actuarial assumptions for that possibility."¹ The policy at issue in *Alvarez* explicitly stated that the premiums were subject to change at any time after payment of the first premium. The court highlighted that the policy "was guaranteed renewable, not guaranteed affordable," and "neither the policy nor the promotional materials represented or implied that expert actuaries calculated the premiums."² The court noted, "[w]e have difficulty understanding how he can claim to have relied on a provision that explicitly allows such increases to believe that premiums would never increase."³

Unlike *Alvarez* and other first generation cases, the court in *Armour* reached the issue of whether the filed rate doctrine applied and granted the carrier's motion to dismiss on that basis. The filed rate doctrine, which originated from litigation surrounding utility rates, is one of several key defenses to actions challenging premium rates filed with and approved by state insurance regulators. The filed rate doctrine holds that once a premium rate has been filed with and approved by the department of insurance (DOI), it is unassailable in the courts because the legislature has vested the DOI with exclusive authority to set premium rates. Most jurisdictions have adopted the filed rate doctrine in some form and many have applied it to bar challenges to premium rates filed with state insurance regulators. There are two prongs to the filed rate doctrine. The doctrine's nonjusticiability prong requires courts not to "enmesh" themselves in the ratemaking process to avoid disturbing the work of the regulatory agencies, which "are deeply familiar with the workings of the regulated in-

dustry and utilize this special expertise in evaluating the reasonableness of rates.⁴ As applied, the first prong bars courts from considering the reasonableness of approved rates or awarding damages based on the difference between the rate charged and an allegedly lawful rate.⁵ The second prong, the “nondiscrimination” principle, ensures “regulated entities charge only those rates that the agency has approved or been made aware of as the law may require.”⁶

Armour was an important victory for the industry because it dispensed with the plaintiff’s argument that the filed rate doctrine does not apply when an insurance commissioner may only disapprove rates, as opposed to setting rates. In *Armour*, the plaintiff asserted causes of action for fraud, negligent misrepresentation, violations of the contractual duty of good faith and fair dealing, breach of contract, unjust enrichment and negligence. The theme of the plaintiff’s case was that the carrier intentionally designed its LTC policies with flawed actuarial assumptions and sold the policies without disclosing that premiums could increase due to the allegedly known actuarial defects. The carrier moved to dismiss the action, arguing that the plaintiff’s claims were barred by the filed-rate doctrine, among other defenses. The court agreed and noted that “[d]espite the sometimes harsh and seemingly merciless effect of [the filed rate] doctrine, courts have not wavered in its application.”⁷ The plaintiff argued that the commissioner does not have the power to set rates; rather, the commissioner has only the power to disapprove proposed rates. The court disagreed with this distinction, noting that the difference “between the power to establish and fix rates, as opposed to the power to disapprove the rate, is irrelevant for purposes of the filed rate doctrine.”⁸

SECOND GENERATION LITIGATION PREMIUM RATE INCREASE LITIGATION

The focus in second generation rate increase actions has been on using extra-contractual representations as the primary basis for plaintiffs to contend that rates cannot be increased. For example, in *Toulon*, the plaintiff alleged that applicants for the LTC policies in question were required to complete a personal worksheet at the point of sale that contained statements that fraudulently or negligently led those applicants to believe that the premium rates for their policies would either remain the same or increase only slightly over time (the statements included, *e.g.*, “Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?” and that rates had not been previously raised on this form, and only by 15% on a similar form). The plaintiff alleged that one or more of these “representations” was false and led her to purchase coverage. Thus, although the plaintiff also relied on the legacy bait-and-switch theories, *Toulon* was unique in that the plaintiff also focused heavily on extra-contractual matters. Ultimately, the court dismissed the action, holding the carrier had no duty to disclose planned rate increases. With respect to the personal worksheet, the court emphasized that the content of the worksheet was mandated by an insurance regulation and, in any event, that the

worksheet was explicit that the insurer had the right to increase premiums.⁹

Toulon was followed by *Newman*, another putative class action filed in the Northern District of Illinois. In *Newman*, the plaintiff’s complaint focused primarily on extrinsic representations allegedly made to Newman and a putative nationwide class of insureds in the company’s marketing materials. In that way, *Newman* is part of a trend in which the plaintiffs’ bar has shifted its focus to arguments that focus on extra-contractual representations. In *Newman*, the plaintiff selected a “Reduced-Pay at 65 Option” at the point of sale. For those who selected this option, the schedule page reflected a reduced premium that would apply “on and after age 65.” Although the carrier had reserved the right to increase premiums on a class-wide basis in several places throughout the policy, the plaintiff claimed that the company’s marketing brochure for her coverage promised to freeze premiums at half the amount of her pre-age 65 premiums at age 65. The plaintiff’s contract underwent a rate increase which, despite the reduced pay option, increased the plaintiff’s premium to more than it was before the reduced pay option kicked in at age 65. Plaintiff brought causes of action sounding in breach of contract, and statutory and common law fraud.

Although the lower court dismissed the case, principally because the policy reserved the carrier’s right to increase premium in several places, the class action ultimately settled after the Seventh Circuit reversed the lower court’s decision and sent the case back down for further proceedings. The Seventh Circuit held that the language used to describe the unique “Reduced Pay at 65 Option” payment option in the schedule page of the contract was ambiguous (*i.e.*, subject to more than one reasonable interpretation). Specifically, the Court reasoned that the policy arguably promised in the schedule page to freeze premiums “on and after age 65” for those policyholders who selected the Reduced Pay at 65 Option. The Seventh Circuit recognized that MetLife had reserved the right to increase premiums on a class-wide basis in several places throughout the Policy, but reasoned that the language could be read to mean that MetLife had the right to raise rates for those who selected the Reduced Pay at 65 Option only up and until age 65.¹⁰ In other words, the Court would not allow MetLife to point to its right to increase to resolve the ambiguity the Court had identified with the Reduced Pay at 65 language in the schedule page.

A POSSIBLE THIRD GENERATION

The Plaintiffs’ bar has attempted to expand the Seventh Circuit’s ruling in *Newman* to support what may emerge as a third generation of premium rate increase litigation. So far, plaintiffs’ efforts in this regard have been unsuccessful, but a new trend may emerge where plaintiffs acknowledge the carrier’s general right to increase premiums and yet attack the manner in which a rate increase was implemented. For example, in *Gumm*, a case filed by a putative class of certificate holders, the plaintiff argued that the policy required the carrier to apply premium rate

increases on its group policies equally across a nationwide premium class (which, the plaintiff argued, could be defined only by age). The plaintiff in *Gunn* relied heavily on *Newman* in support of his argument in opposition to a motion to dismiss filed by the carrier.¹¹ In *Newman*, the Seventh Circuit noted that “class” was undefined and, thus, the four references in the policy to the carrier’s right to change the premium on a class-wide basis could not resolve the ambiguity the court identified in the “on and after age 65” language in the Reduced Pay at 65 Option.¹² In *Gunn*, the lower court rejected the plaintiff’s arguments and dismissed the complaint based on the filed rate doctrine.¹³ The plaintiff appealed the decision to the Seventh Circuit, where the appeal is fully briefed and currently awaiting decision.¹⁴

Finally, a complaint was filed last month in the District of Connecticut asserting claims similar to those raised in *Gunn*. As is common in the industry, the approved premium rate increase at issue was larger for policyholders who selected rich policy benefits. The plaintiffs allege that a carrier impermissibly increased premium based on sub-classes when the policies allegedly only permit a premium rate increase based on a single, nationwide class (i.e., that the premium rate increase must be the same rate for all policyholders). This new case is in its infancy, but demonstrates a possible continued trend toward challenging the meaning of a class-wide rate increase.

CONCLUSION

As carriers focus on methods to help policyholders mitigate premium rate increases through reduced benefit options and policy buy-outs, potential litigation focused on implementation issues confirms the importance of clear communication with regulators and policyholders. The filed rate doctrine is a formidable defense to premium rate increase litigation, including those cases challenging the applicable premium classes and how an increase will vary based on various policy benefits. Ultimately, these complaints challenge the reasonableness of filed and approved premium rate increases and ask the court to overturn decisions made by insurance regulators. The file rate doctrine bars such challenges. Nonetheless, to strengthen that key defense, carriers should continue to describe the premium rate classes carefully during the rate filing and approval process, including how an increase will vary based on various policy benefits. And, especially when offering arguably novel mitigation options (e.g., policy buy outs), clear disclosures and carefully crafted policyholder communications remain key to reducing confusion and potential policyholder litigation. ■



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ENDNOTES

- 1 *Alvarez v. Ins. Co. of N. Am.*, 313 F. App'x 465, 469 (3d Cir. 2008).
- 2 *d.*
- 3 *Id.*
- 4 *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 19 (2d Cir. 1994).
- 5 *See, e.g., Horwitz v. Bankers Life & Cas. Co.*, 319 Ill. App. 3d 390, 408 (2001).
- 6 *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 488 (8th Cir. 1992).
- 7 *Armour v. Transamerica Life Ins. Co.*, No. CIV. A. 11-2034-KHV, 2012 WL 234032, at *3 (D. Kan. Jan. 25, 2012).
- 8 *d.* at *4.
- 9 *Toulon v. Cont'l Cas. Co.*, No. 15 CV 138, 2016 WL 561909, at *3 (N.D. Ill. Feb. 12, 2016), *aff'd*, 877 F.3d 725 (7th Cir. 2017).
- 10 *Newman v. Metro. Life Ins. Co.*, 885 F.3d 992, 999 (7th Cir. 2018).
- 11 *Gunn v. Cont'l Cas. Co.*, No. 18-cv-03341, 2018 WL 8620962 (N.D. Ill. Sept. 13, 2018).
- 12 In *Newman*, the Seventh Circuit did not hold that the language in the policy that reserved the right to increase premium on a class-wide basis was ambiguous—rather, it held that the class-wide premium rate increase language may not apply to Reduced Pay at 65 policyholders because the policy arguably promised in the Schedule Page to freeze premiums for those policyholders “on and after age 65.” *Newman*, 885 F.3d at 999 (“In short, none of the four references in the policy to MetLife’s right to change the premium suffice to disabuse a reasonable person of the understanding that purchasing the Reduced Pay option took her out of the class of policyholders who were at risk of having their premium increased after their post-age-65 anniversary. The policy language is thus at least ambiguous, because it can be read reasonably to fix such a person’s premium, if she had opted for the Reduced Pay option.”).
- 13 *Gunn*, No. 18-cv-03341 (N.D. Ill. Sept. 3, 2019).
- 14 *Gunn v. Cont'l Cas. Co.*, No. 19-2898 (7th Cir.).



New To LTC

By Jared Nepomuceno



I began my actuarial career as an annuity modeler at an insurance company and journeyed into Long-Term Care (LTC) two years ago at Milliman. I then joined Ernst and Young, continuing to focus on various LTC assignments. With these three positions, I have gained an in-depth knowledge of different ways to model LTC cashflows, file for rate increases, develop assumptions, and financial reporting.

My first LTC modeling project was to help an LTC carrier convert its legacy claims cost model to a first principle approach. I have had opportunities to apply my modeling skills to various LTC advisory and audit projects, using different modeling platforms and employing various modeling approaches. Early on, I learned that LTC products are very complex as they offer wide ranges of protection options to insureds, such as inflationary riders, elimination periods, benefit periods, reimbursement types, coverage types, waiver of premium riders, etc. These protection options make LTC complex to model for the following reasons. Inflationary riders vary by compound or simple inflation and can be applied for various durations. Elimination periods are the length of time an insured must wait before claiming benefit payments. Insureds also have the options to select different benefit periods which define how long benefits will be received. Additionally, waiver of premium riders allows insureds to waive premium payments upon disability.

From an assumption perspective, LTC is a hybrid between life/annuity and health insurance as it involves morbidity risks in addition to mortality and lapse risks. First principle modeling breaks down mortality into active and disabled life mortality. Disabled life mortality or claim termination rates can be separated into recoveries and disabled deaths. Morbidity risks can be broken into incidence and utilization. Incidence refers to the frequency at which healthy insureds become disabled, while utilization is the amount of benefits an insured utilizes each month. I find it very challenging to quantify LTC model results due to the complex interactions among morbidity, mortality and lapse risks.

From a modeling methodology perspective, LTC modeling has evolved from a claims cost approach to a complex first principles approach. This is due to the increasing need for carriers to understand the changes in their liabilities. Claim cost modeling limits carriers' abilities to understand changes in their liabilities because it only tracks total lives and uses claim costs that contains morbidity assumptions. Therefore, it is difficult to attribute which assumptions are causing changes to carriers' liabilities. In a First principles models components of claim costs (e.g., claim incidence rates and claim termination rates) are input into the models separately to allow the tracking of number of new claims, ongoing claims and terminated claims; mortality can be split into active and disabled life components. Some models can even track the different care paths and transition among care paths. Learning the LTC First principle modeling enables me to acquire an in-depth understanding of every perspective of an actuarial model.

As a young actuary, LTC modeling and financial reporting are the two areas I have valued the most in my career so far. The complexity allowed me to gain strong technical skills and actuarial conceptual knowledge which apply to other insurance products. I continue to expand my knowledge into recent emerging products including Life/LTC combination and Annuity/LTC combination products. These products have gained popularity as consumers seek alternative private LTC insurance solutions. From an actuarial perspective, these products require the understanding of both life (or annuity) and LTC modeling concepts. All in all, I am very passionate about developing innovative solutions that allow model users to gain insights into their model results more efficiently. This is one area that I would like to continually develop throughout my career. ■



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SECTION

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SECTION COMMUNITY

As the population continues to age, the need for long-term care (LTC) is not going away. Tune in to [our latest podcast](#) to hear Stephanie Moench and Shawn Stender discuss the future of the LTC insurance industry as envisioned in their recently published article “Medi (Long-Term) Care for All: Part One.”

Get access to more info at SOA.org/sections/long-term-care