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Long-Term Care News

The Newsletter of the Long-Term Care Insurance Section

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The Suitability Solution for Long-Term Care Insurance

by Denise M. Michaud and Steven G. Stauss

Insurance guru Ben Feldman taught us, "If you don't have a process, you have a big problem."

Well, we see a problem in the long-term care insurance industry because we don't have a standard process. The majority of agents and advisors, who sell a variety of products, are often at a loss for what to do with LTCI. Long-term care insurance hasn't been around long enough and sold widely enough for the industry to have established a sales methodology and suitability standards.

This presents a big problem for insurers, agents and our clients with potentially costly consequences. Insurers lose money through 'wasted' underwriting, application effort and policy modifications. Agents lose time making unsuccessful sales calls or through clients not taking their policies. For the clients, the consequences of poorly designed policies can be devastating.

How, then, do agents today go about designing and selling LTCI policies? From what we observe, they commonly use one of four methods. We call these: (1) the "statistics-say" method, (2) the "big umbrella" method, (3) the "finger-in-the-wind" method, (4) and the "you're-too-poor-to-afford-it, or too-rich-to-need-it" methods. We'll briefly describe each.

1. The statistics-say method

Agent: Well, the average nursing home stay is 2.5[1] years, so three years of coverage should be just fine.

If the agent is going to use a statistic, this is the wrong one. It only looks at nursing home stays, when the vast majority of people receive their care at home (as many as 80 percent). In addition, the 2.5 year figure is based on all stays in nursing homes, including one-to-two week recovery periods from hospitalization, and not just long-term stays for chronic conditions.

Besides, do your clients want their long-term care plans to be defined by a statistic? The agent should be asking what matters to the client and should get to know what sort of person they are. This information will help the agent design a policy that respects their client's humanity and reflects their individuality.

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1) MetLife and American Health Care Association.

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This newsletter is free to section members. To join the section, SOA members and non-members can locate a membership form on the LTCI Web page at *www.soaltci.org*. Back issues of section newsletters have been placed in the SOA library and on the SOA Web site (*www.soa.org*).

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A Word From the Editor

Making History

by Bruce Stahl

Editor
Bruce Stahl

An individual stood up at the CEO Panel Session near the conclusion of the 5th SOA LTC Section Inter-company conference and described the LTCI industry as being in a depression. One can hardly argue against that point with sales down over 25 percent. Depressions occur when corrections become necessary in an economy, and the LTCI industry is certainly finding that corrections remain necessary.

In this issue, Denise Michaud and Steven Stauss identify corrections they believe are necessary at the point of sale, both at the initial discussion of the needs and at the subsequent meeting where an insurance solution is presented to the client. Their article is worthy of consideration as it coincides with an industry that is looking to develop simpler products, products with more options and products that are able to cover more individuals even where health status might preclude them from purchasing from many carriers now.

Also in this issue, Maureen Lillis, Mary Ann Wilkinson and Philip Barackman identify corrections they believe are necessary at the other end of the spectrum, at point of claim. Maureen presents a broad view of claim processes and the items that feed and flow from them. Mary Ann and Phil present a detailed perspective on what confronts the industry with regard to claims. Both articles identify the need to reflect good information in the analysis of a claim and the plan of care. One provides a stark warning to participants in the industry, and we ought to study both articles thoroughly in order to heed that warning.

The last article, by Gary Corliss, provides a taste of the additional information that the Society of Actuaries has made available in its most recent experience study. This study provides important information that may contribute to the successful navigation of the obstacles facing the industry today.

Like generations in the past which have successfully and quickly turned economic depressions into economic strength, our industry has the opportunity to make history. These generations succeeded by increasing productivity and stimulating capital investment. We need to follow their examples by making better use of the premium dollars, investing in ways to satisfy the customers while protecting the trust they have in their own policies. These articles direct us toward a strong LTCI industry. ❋

Chairperson's Corner

Welcome New Members!

by Vincent L. Bodnar

I would like to extend a warm welcome to all of the new members of the Long Term Care Insurance Section. We greatly expanded section membership in recent months to include all persons that registered for the 2006 LTCI Conference.

The LTCI Section is an organization that does much more than sponsor the annual LTCI Conference. Among other member benefits, it facilitates year-round networking among peers, sponsors research projects, circulates a newsletter and provides LTCI industry representation for various external events and projects.

The LTCI Section is unique in that its members are professionals from many disciplines: Marketing, Actuarial, Operations, Claims, Underwriting, Compliance/Government Affairs, Management and Group LTCI. It recently organized into eight Networking Tracks representing each of the disciplines above. You are a member of the Networking Track you indicated when you completed your conference registration.

Each Networking Track is in the early stages of defining its mission, role, activities and how it plans to benefit its specific members. Some great ideas have already emerged from the tracks including discipline-specific seminars, an online directory of members, industry benchmarking surveys, employment bulletin boards and discussion forums. There will likely be other benefits and activities undertaken as volunteer energy allows.

If you are interested in getting more involved with your Networking Track, I encourage you to contact the person responsible for recruiting volunteers for your track:

- **Actuarial, Claims and Management:**
  Jim Glickman, 818-867-2223,
  Jim.Glickman@LifeCareAssurance.com

- Marketing:
  Mike Muench: 563-557-2504,
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  Carroll Stuart, 817-488-2666,
  CarrollCarroll@Comcast.net

Think Tank Meeting

I am pleased to announce that the LTCI Section will sponsor a Think Tank meeting this spring. We are still in the planning phase, but we hope to have 50 to 60 experts from a broad range of disciplines meet to identify the critical issues facing the LTCI industry and to develop a list of steps it can take to proactively address these issues. You may hear from us soon as we survey our membership and others to identify current issues. ❋

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Certainly it is important to look at statistics to get a frame of reference, and statistics are critical to actuarial studies. But if you had a chronic illness, what role would a statistic play? Would it really matter? What would matter? This is what the agent needs to focus on.

2. The big umbrella method

Agent: The cost of care is $200 per day, so you need to have a $200 Daily Benefit with Lifetime Benefit Period coverage.

The agent is 'playing it safe' by attempting to provide a large amount of coverage for the maximum coverage period. This is not a bad strategy in principle, but it doesn't take into account the client's preferences and financial capacities. What if the premium is more than the client can afford or exceeds their "premium tolerance"? What if the client can't afford lifetime coverage, but could afford a shorter period at $200 a day? Maybe the client has some assets that could enable her to partially self-insure (like a medical insurance co-payment).

3. The finger-in-the-wind method

Agent: Let's see. Four or five years should be enough. Lifetime coverage is too much; no one will need care that long.

This sounds like a 'wild guess.' Clients deserve more than that. Furthermore, the agent is exposing himself to possible liability charges later because the agent doesn't have a clear method for arriving at their recommendation.

4. The you're-too-poor-to-afford-it or too-rich-to-need-it method

Agent: Your assets are under $30,000 so you can't afford long-term care insurance. You should just plan on Medicaid.

This isn't helpful or hopeful. In some cases, we may find an alternative solution for this person. If we ignore this request for help, aren't we violating the core of our ethics: caring and service? (Later in this article we show how to construct a policy for someone with assets less than $30,000.)

Agent: Your assets are over $1 million so you don't need long-term care insurance; you can easily self-insure.

This is a broad statement. We cannot conclude the client doesn't need insurance if we don't know what their plans and commitments are for their money. Many wealthy clients *want* to transfer their risk even though they could afford to self-insure.

Most people we know want to protect their hard-earned money against catastrophe. They show this by buying insurance on their homes, cars and health.

With these methods the agent is directing the client without systematically considering their needs, values and financial capacities. At some point, the client may question the purpose and value of their policy because it has no relationship to their circumstances.

We would like to describe a system for producing defensible coverage recommendations for our clients. This is a system that we have developed and refined over 13 years of full-time LTCI sales and that also draws upon Denise's five years of experience as a cost analyst at a major insurer.

Using this system, we have built a large and trusting population of clients who keep their policies in force and refer many of their friends. We call it the *Suitability Solution*. In 2004, we were invited by the California Department of Health Services to teach the Suitability Solution at their annual agents' seminar in Sacramento. Our company now regularly teaches the Suitability Solution as a registered continuing education course in California.

The cornerstone of the Suitability Solution is a process that incorporates human factors: client values, concerns and goals—with financial factors: income, expenses and assets. These factors are applied to the policy components to tailor a policy that is suitable for the client.

Throughout the process we keep the end in mind: The policy must help the client realize their vision of their care and it must make use of their financial strategies. However, clients rarely have a clear vision of what they want or a clear understanding of their financials. It is our responsibility to help draw them out.

The Suitability Solution comprises three main steps:

1) Interview
2) Analysis and design
3) Presentation and agreement

Interview

The interview is best done face-to-face. The objective is twofold:

1) To identify the client's values, concerns and goals as they relate to long-term care, and
2) To get a measure of their finances and help them develop a financial strategy for their long-term care.

You arrive at this information by having them consider how their life would change if they needed care today. This exercise helps them identify what is important for them in their present lifestyle and what would be required to preserve those things if they ever needed care. We use a set of focused questions about human factors (values, concern, goals) and financial factors (income, expenses, assets, obligations) during the interview.

Analysis and Design

Back at the office, you analyze the information gathered in the interview. You develop a strategy, establish a premium cap, develop several feasible configurations, and test the configurations against the premium cap and against client values, concerns and goals. The result may be one or more recommended policy designs.

Presentation and Agreement

When you reconvene with the client, you review the policy design(s) and show how they satisfy their values, concerns, goals and financial strategies. Together, you complete the application with confidence the policy design is suitable.

Case Studies

We now look at two case studies to see how the Suitability Solution can be applied to clients with different personal goals and financial situations. Both are real-life cases. The first one, "Penelope Penniless," is about a client most agents would feel they couldn't help because of her limited income and assets. The second case, "Lori Legacy," presents a typical middle-class senior who has more than sufficient disposable income available to pay a premium.

Penelope Penniless

Interview

We interview Penelope and learn the following. She is 65 years old, has no family, and is in excellent health. She has no assets and rents a room in the house owned by her church friend, Naomi. She supplements her $1,667/month Social Security with income from a part-time job. She has $200 in monthly discretionary income, not counting her job. Naomi and the rest of her church community have reassured Penelope that she can count on them for help and support. It is very important to Penelope to remain close to her church friends, as they are her family.

Penelope is a proud and independent woman and has told us she will not accept care from her friends because she does not want to burden anyone. Further, she is unwilling to interfere with Naomi's lifestyle by having caregivers come into Naomi's home. She has already decided she will apply for Medicaid and enter the nearest facility with a Medicaid bed.

However, when Penelope needs care, there may not be any local facilities with available Medicaid beds. She could be placed hours away from her friends. Our challenge is to help her with this problem.

Analysis and Design

Our strategy is to make sure that Penelope is placed in a nursing home in her community.

Penelope needs to move into a nursing home—as a private pay patient. Paying privately will increase her choice of facilities and improve her odds of staying in the community.

Using the NAIC guidelines of 7 percent of Adjusted Gross Income (AGI), we calculate a premium cap of $117/month. This is comfortably less than her $200 in discretionary income. To

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determine design policy alternatives, we look at four primary components: Daily Benefit, Elimination Period, Inflation Option, and Benefit Period.

The cost of a semi-private room in a nursing home in her area is $200/day. Penelope's Social Security income would pay for about $55 per day. However, because her income only increases by 2 percent per year, the amount she would be able to contribute will diminish over the years. To be safe, we will select a daily benefit of $200.

Her Social Security is sufficient to pay for only eight days of care, so we have to choose a 0-day elimination period.

The inflation option needs to be 5 percent compound since she is a healthy age 65 and is likely to live well into her 80s.

Coverage	Initial premium	20% added after 10 years	Another 20% added after 20 years
Facility-only 1 year	$108	$130	$156
Premium Cap Source of money: Soc Sec increases @2% per year	$117	$140	$167

Penelope's Policy: The Suitable Solution

Type of Policy:	Facility-Only
Elimination Period	Zero Days
Daily Benefit	$200
Inflation Factor	5% Compound
Benefit Period	One Year
Maximum Lifetime Benefit	$73,000

We can do quotes for various benefit periods. However, it is clear she won't be able to afford a very long period, so let's start with one year.

The table on page six shows the premium for the above policy design. We project at least two premium increases and make sure that the money that is available to pay the premium can keep up with these potential premium changes.

Presentation and Agreement

Together with Penelope, we review our recommendation against her values, concerns and goals.

Does the policy meet her values? *Remain independent and self-sufficient, not be a burden to others*

She does not want to burden her friends with managing her care, so we make certain the policy includes a care manager provision. The Facility Only policy is affordable and gives her a period of independence and self-sufficiency.

Does the policy address her concerns? *Becoming an imposition, being vulnerable because she has no financial resources.*

Penelope goes into a Medicaid eligible nursing facility as a private pay patient and with a care plan in place. She imposes on no one. In California, nursing homes only need to see one year of financing for admittance. After the benefits in the policy have been exhausted, Penelope will apply for Medicaid. The nursing home must allow her to stayon as a Medicaid patient (California law). During the year she is a private pay patient, Penelope will have the opportunity to use her income at her discretion, perhaps donating money to her church.

Does the policy meet her goals? *Stay in the community.*

She will be able to go into a nursing home in her community as a private pay patient, arranging to stay there when she eventually goes on Medicaid. Being closeby, her friends would be able visit her easily and often.

Lori Legacy

Interview

From the interview we have learned the following. Lori is age 62 and in excellent health. She owns a condominium worth $300,000 and has $100,000 invested conservatively and earning 5 percent. Her income consists of Social Security and a small pension. Both are indexed to the cost of living. Her monthly expenses are minimal, and she has about $750 left over at the end of the month. She has a well-to-do son who lives locally, but the relationship is strained. Her daughter is a financially struggling single mother; she has offered to be her caregiver if needed, but lives out-of-state.

We also find out that Lori:

a) Will not impose on, or live with her son or daughter, if she needs care.
b) Wants to receive care at home, but will go into a nursing home if necessary.
c) Wants to leave her condo to her daughter.
d) Would like to leave her remaining cash to her son, if possible.
e) Will not pay more than $350 per month for her policy.

Analysis and Design

Our strategy is to make certain that she can receive care in her condo, will not burden her family and will be able to leave her condo to her daughter when she dies.

Lori has given us a premium cap of $350. We want to shelter her condo, ideally. Her living expenses are covered by her pension and Social Security and should keep up with cost of living increases. Since the income from her $100,000 investment is not needed for living expenses, we will consider using a portion of it to pay an elimination period.

To design policy alternatives, we start with a daily benefit of $200. For $200, she can hire a live-in for 8-10 hours of hourly care at today's rates. Lori is still relatively young, so we include a 5 percent compound inflation rider. She wants to stay at home, but her health could decline and require her to go into a nursing facility, so we opt for comprehensive coverage. We will treat these three factors—daily benefit, inflation rider and policy type—as constants and will vary the other components to try to get Lori the maximum coverage within her premium tolerance. We will factor in two 20 percent premium increases.

To ensure Lori is not a burden on her family, we only examine policies that include a care management feature.

The following table on page 8 shows several policy configurations generated using illustration software from a well-known insurer. (In our full analysis we examine four to six insurers.)

Presentation and Agreement

Together with Lori we review our recommendation against her values, concerns and goals.

Does the policy meet her values? *Remain independent, self-sufficient, not burden others*

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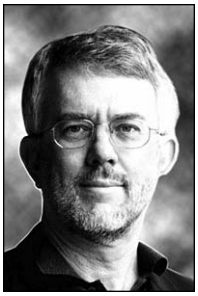
The cornerstone of the Suitability Solution is a process that incorporates human factors: client values, concerns and goals...

Benefit Period	Initial Premium	20% added after 10 years	Another 20% added after 20 years
4 years; 30-day EP	$372	$446	$536
4 years; 60-day EP	$341	$409	$491
5 years; 30-day EP	$417	$500	4601
5 years; 60-day EP	$381	$457	$549
Premium cap (2% inflation) ("Stretch" alternative	$350 ($381)	$418 ($464)	$510 ($566)

Denise M. Michaud, CLTC, is a co-founder of The Center for Long-Term Care Planning and is a licensed LTCI broker.

Lori's Policy: The Suitable Solution

Type of Policy	Comprehensive
Elimination Period	60 Days
Daily Benefit	$200
Benefit Period	Four Years (5 Years)
Lifetime Maximum Benefit	$292,000 ($365,000)
Inflation	5% Compound



Steven G. Stauss is a co-founder of The Center for Long-Term Care Planning and is a licensed LTCI broker.

With this policy, Lori will not need to burden others with the research and provision of care services. She will maintain her independence and self-sufficiency. Although Lori's stated premium tolerance is $350/month, we explore with her the possibility of "stretching" a bit in order to purchase a five-year benefit period.

Does the policy address her concerns? Stay home as long as possible, keep her home.

It gives her the security of knowing that she has the financing for four or five years of home care without using her home's equity. If she needs care longer than four years, Lori will move into a nursing home under Medicaid.

Does the policy meet her goals? *Passing her home on to her daughter, keeping the premium within her stated amount.*

Although Lori would need to "spend-down" her $100,000 before becoming eligible under Medicaid, the home is exempt. Lori can gift the home to her daughter before she dies (California rules). We keep the premium low by having Lori self-insure two months of her care (60-day elimination period).

Conclusion

The process we have described can be used by agents to improve the suitability of the policies they sell. This will result in better service to our clients and increased client confidence in our professionalism. Insurers should see a decline in money lost to underwriting effort wasted on poor-quality applications and policy modifications.

In the end, agents should also see an increase in their referral stream. ❋

LTC Claims At A Crossroads

by Maureen Lillis

The 5th Annual Inter-Company LTCI conference was a tremendous opportunity for the thought leaders in our industry to come together and exchange information on current claims practices. This was evidenced by the number of attendees on the claims track. The industry is struggling to find the right balance for optimal claims management.

Faced with the prospect of heightened claims activity, it is critical that carriers understand how to administer benefits while protecting the risk pool. Further complicating matters is the changing landscape of the custodial care delivery system and Medicare reform. Do we truly understand the impact these will have on overall claims exposure?

Our industry is based on a strong commitment to serve policyholders through prudent administration of our products in the marketplace. Establishing a clear distinction between controllable and uncontrollable events in claims management will prove to be essential moving forward. For optimal success, it is imperative that care is not controlled by arbitrary measures, but through application of specific guidelines, created to effectively meet the rehabilitation goals of our claimants. It is our responsibility to foster independence while meeting our claimants' needs and to ensure they do not become dependent on the delivery system.

Implementation of clinical guidelines and best practices, coordinated with an efficient quality management program, is an approach that may impact overall utilization through improved outcomes for care. This perspective is evidenced by the need for us to recognize the prevalence of key indicators in the management of long-term care. In establishing and applying key indicators, the best claims approach must be coordinated with consistently sound medical practices supported through care management in order to achieve acceptable outcomes in the treatment of chronic care.

Can we quantify a targeted plan of care program resulting in predictable outcomes, improve claimant satisfaction and generate cost savings? Is it time to challenge our current protocols? These questions represent complex issues for the industry. Strong claims controls are necessary, but should not be the only answer.

One possible solution to address this challenge is to take a hard look at innovative techniques that can help manage claims costs. This is best

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Diagram 1

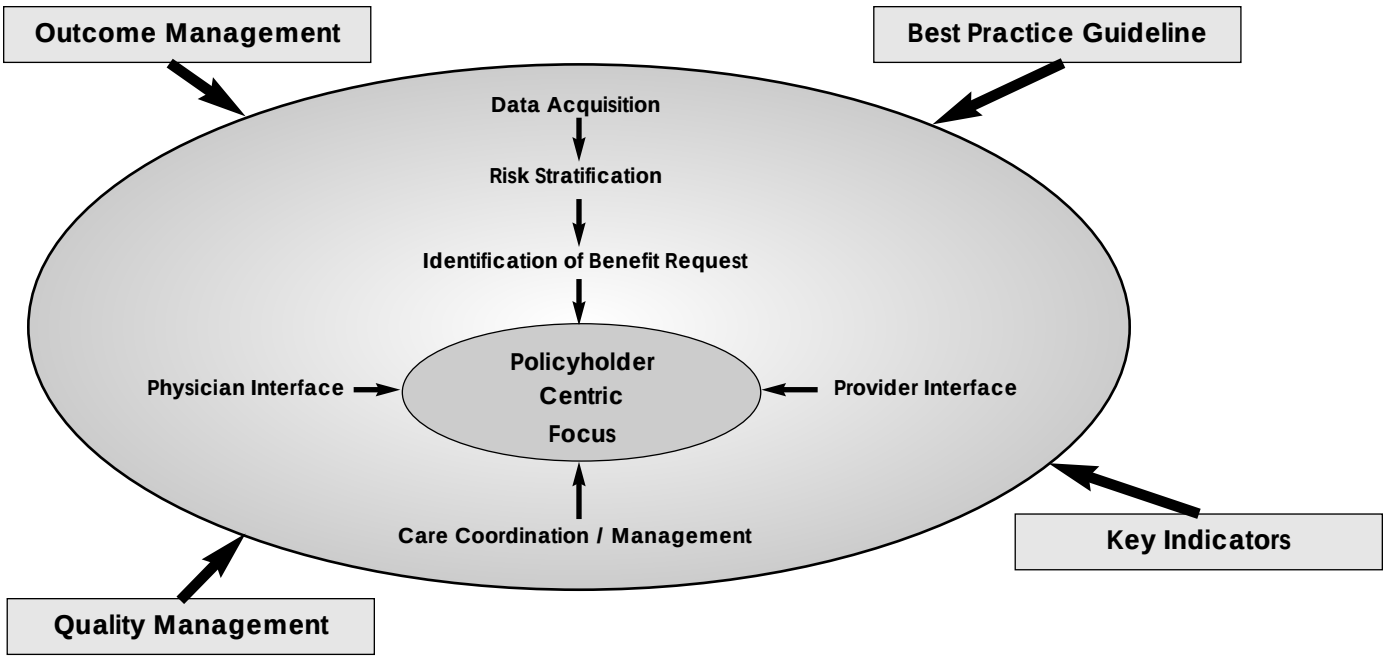

Table 1

Component	Description of Task	Measurable Outcome
Frequency of Access to Services	Efficient benefit eligibility process that includes both claims staff and objective assessment of claimant needs.	Consistent application of benefits through standardized eligibility process.
Intensity of Services	Individualized plan of care based on best practices and standardized guidelines.	Consistent coordination of services through community-based programs and integration with acute payor services, when applicable.
Provider Management	Unit Cost Savings utilizing LTC specialty network management programs with negotiated rates.	Consistent quality of care delivered through credentialing and monitoring of care delivery.
Outcome Management	Durational Savings using clinical benchmarking outcomes to reduce length of stay.	Consistent application of benefits resulting from focus on appropriateness of care.
Quality Management	Performance management protocols that encompass all aspects in the delivery of care and application of benefits.	Consistent application of program goals through satisfaction surveys and measurement of clinical outcomes.

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accomplished by the coordination of care through an integrated, systematic and comprehensive care management process. This proactive and cost effective solution is comprised of identification of benefit requests, data acquisition, risk stratification, physician involvement, claimant monitoring, support and coordination of care. These integrated medical management efforts provide seamless continuity of care thereby improving the quality, access and value of the delivered care. See Diagram 1 on page 9.

By embracing integrated medical management philosophies the actuary can better understand potential risk exposure and predict future claim trends. It is clear that these protocols must be embraced and consistently applied to achieve positive results. This is best accomplished using a sophisticated care management model that demonstrates cost savings resulting from appropriateness of care.

Through early intervention and claimant education, the care manager can direct the prospective care. Using standardized protocols and outcome management guidelines, the beneficiary has their individualized care needs met throughout the benefit period. The care manager supports the claimant with regular contact to determine if goals have been met. Revisions in the plan of care, accessing additional Medicare services and provider relationship management are key ongoing components to these programs. See Table 1 for description of potential integrated medical management components.

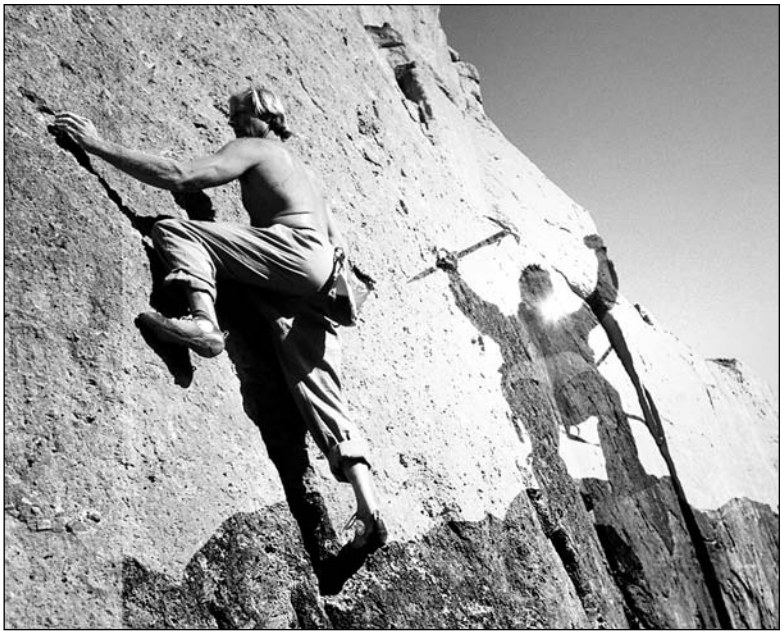
To ensure claimant satisfaction while supporting the contractual requirements of long-term care policies, it is necessary that the integrated medical management program incorporates the appropriate measurement criteria to evaluate effectiveness. State-of-the-art technology is required when implementing these programs in order for the actuary to benchmark results and validate the impact of innovative programs.

What does it take to succeed in long-term care claims? The dilemma can be addressed through a clear commitment to policyholders by assisting when they need benefits. As an industry, we must come together with the experts that have proven track results and implement the protocols that are necessary for our aging population. ❋

Claims – The Final Frontier?

by Phil Barackman and Mary Ann Wilkinson

Authors' Note: The views expressed in the following article are those of the authors and do not necessarily reflect the views of General Re Life Corporation, its parents, subsidiaries and/or affiliates.



Some of the pioneers did not make it to their California destination. That thought crossed my mind recently as I (Phil) was skiing just a few miles from Donner Pass, named after a group of emigrants who became trapped in the Sierra Nevada mountains during the winter of 1846-47. Nearly half of the party died. That experience has become legendary as one of the most tragic in the record of Western migration. The Sierras were the final hurdle for the Conestoga wagons, which crossed our great continent long before interstate highways and four-wheel drive. The Donner party had come 2,500 miles in seven months only to lose their race with the weather by just one day, and then only 150 miles from their destination of Sutter's Fort (Sacramento), California. It's a sobering thought that making it most of the way wasn't good enough after having already overcome many setbacks.

Were the Sierras to the pioneers what claims may become to the LTC industry? Having weathered (for better or worse) challenges related to marketing, underwriting, persistency, interest rates and regulation; is *claims* the final frontier for the LTC industry?

Can any business be considered anything but a pioneer that does not know the actual cost of its product? Starting with the obvious, the benefit cost is not fully known at the policy level until any claims are fully incurred and paid. The last transaction for many policies will be a claim check. Developing a robust understanding of LTC ultimate claim costs is going to be a very long-term endeavor, given today's young issue ages, the fact that claims increase with attained age, and the extremely high persistency of the business. A further complication is that much of the claims experience to date is not based on today's plan designs or underwriting.

Therefore, and somewhat understandably, it is morbidity assumptions, not actual paid experience, that currently color much of what we perceive as LTC claim reality—for actuaries and non-actuaries alike. Actuaries at least have the technical ability to understand just how little actual claims experience has been paid in relation to what will be paid on today's inforce. However, after morbidity assumptions are chosen they tend to take on a life of their own, and like other perceptions of reality, become resistant to change.

Academically, claims must be the "final frontier" for any insurance product. But for most products, that frontier has already been crossed. The viability of current product designs has already been demonstrated.

Okay, so why the fuss about claims now? In the last couple of years, there has been a developing focus on claims in the LTC industry. One used to hear, "We'll worry about claim issues later. We have more immediate challenges." Now, one is more likely to hear, "Claims are growing, and we have some concerns about what we're seeing."

Financial results may be relatively unaffected by emerging problems with claims experience during the first years of a new program. Those results are more sensitive to valuation methods and assumptions than actual experience. Unfortunately, some insurers view financial results as the primary indicator of the health of their business, and somewhat understandably, because their constituents do. However, financial results are actually more of a trailing indicator for LTC. To determine how LTC is really performing, monitoring activities should include routine claim incidence and continuance experience

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analysis, in addition to actual-to-expected loss ratio analysis, and gross premium valuations.

Reflect on the fact that once a claim has been incurred, only the *continuance* assumption is relevant, *incidence* is thereafter history. Claim cost assumptions used in pricing may prove to be adequate in the long run, but the underlying *continuance* assumptions may not prove to be adequate, leading to understated claim reserves. This can occur when actual *incidence* is more favorable than anticipated, but actual continuance is less favorable. The best time to fully develop *incidence* and *continuance* assumptions is when a product is initially priced, so that experience analysis and valuation is not handicapped by only partially understanding what pricing anticipated.

Although industry morbidity experience in total appears to be on track in looking at NAIC Experience Report summaries, the possibility of weak claim reserves for some insurers may color those results. We've seen several instances where claim reserve strengthening has been needed, because the actual *continuance* is proving to be longer than originally assumed, especially for claims that persist beyond just a few months. Weak claim reserve is a multi-edged sword in that it not only defers losses by understating *actual* incurred claims, but also understates *actual-to-expected* incurred loss ratios, therefore masking or understating the need for a rate increase.

Actuaries tend to be rational and quantitative in their outlook. That's a great strength, but it can also lead to a potential blind spot in developing models and choosing assumptions.

The Schedule H test may uncover a claim reserve problem, but sheds little light on its nature and magnitude. For long-tail business, the amount of inadequacy generated during one year says little about the ultimate shortfall. The Schedule H test is necessary by regulation, but not necessarily sufficient for understanding the amount of (in)adequacy.

One of the most important types of LTC claim analysis involves developing and reviewing actual-to-expected claim termination rates. Actual length of claims is interesting, but any such measure is biased on the short side, whether looking at closed or open claims.

Claim termination rates decrease dramatically over the first several months of a claim. Therefore, claim duration is a key variable in such analysis. Cause of termination shifts from a high portion of recoveries over the first several months to mortality as the primary cause, thereafter. "Slicing variables" are needed, which reflect the characteristics insured and coverage, including underwriting class and plan options that may affect the experience. Primary cause of claim may also be a useful parameter in major diagnostic groupings, bearing in mind that the initial cause is not necessarily the current cause. At a minimum, separate analysis of claims that involve cognitive impairment versus those that do not is recommended, because of CI's longer continuance.

Unavoidably, credibility becomes an issue when looking at thin slices of experience. Credibility improves upon aggregating the experience, but comparisons to expected may suffer from variances in the underlying mix of business, unless the expected continuance assumptions are developed in sufficient detail. Was that pricing adjustment for incidence, continuance or both?

Beyond the first 12 months or so of claim duration, it may make sense to base continuance on a modified mortality table, rather than a confinement-based assumption that was developed a couple of decades ago. Individuals are living longer today, and the growth of home care and assisted living facilities may also make such older sources obsolete. (We've seen stand-alone home care claims for which this approach was the only one that reasonably fit the experience.)

Actuaries tend to be rational and quantitative in their outlook. That's a great strength, but it can also lead to a potential blind spot in developing models and choosing assumptions. In economic modeling, there's a tendency to downplay the significance of input factors that cannot be (or simply have not been) measured. For example, every actuarial pricing model assumes that underwriting classifies risks into the appropriate "buckets." Underwriting is somewhat of a mystery to many, because it does not easily lend itself to mathematical modeling nor can it be reduced to tight rule-based logic—where actuaries like to play. Just as LTC actuaries have needed to learn more about underwriting, the time has come to learn more about the claim process. Claim experience reports are not the full story. Please pardon the insistence that you really need to see how basic human behavior impacts LTC claims, both on the part of claimants, and also those who are managing the claims.

For example: contrary to ideal modeling assumptions, insureds do not have digital displays on their foreheads which indicate how many ADLs they fail or their level of cognitive impairment. For an underwriting assessment, one can (in theory) ask the applicant to demonstrate ADLs and cognitive ability, and they have an incentive to cooperate. For claim assessments, however, there is no incentive for an insured to demonstrate any lack of impairment that might disqualify them from receiving a desirable benefit. Unfortunately, benefit triggers require honest cooperation on the part of the insured, and are more easily gamed for claims than for underwriting. Also, assessors that tend to give the subject the benefit of the doubt in underwriting are even

more pressured to do so when claim dollars are involved. In developing assumptions and plan designs, benefit triggers have been generally considered to be objective and readily determinable. The fact that they are definitely not is a growing challenge facing the LTC insurance industry as *actual* claims increasingly affect financial results.

To a large extent, national long-term care studies use telephonic interviews in the assessment process. Participants' self-reporting may be relatively unbiased given the lack of any financial interest in the outcome. There may even be some bias toward under-reporting severity of impairment. Denial is a coping mechanism, and most individuals like to put their best foot forward when interacting with strangers. General population studies may still be our best source of "objective" data on ADLs or CI. The question then becomes one of how much to adjust such studies for the impact of human behavior when given a financial stake in the assessment outcome.

A major heads-up for a "trust without verification" approach to claims appeared in the *American Journal of Bioethics*, "Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public".[1] This study reported that 26 percent of prospective jurors believe that it's okay for a physician to lie to an insurance company to help a patient to receive an insurance benefit, and no less than 11 percent of physicians, also.

An interesting claim caught my attention recently. A person age 50 has "profited" from their indemnity LTC policy in the amount of $60,000 per year for the last two years. The current daily benefit is $180 of which only $15 per day is spent for one hour of home care. The maximum benefit is unlimited, and inflation protection is included. The coverage was issued in one of the states that are known to be more reluctant to approve LTC rate increases. Rationally, one might comment that if the person met the benefit trigger, then why all the fuss? For starters, how many reimbursement-type claims have you seen for which the insured receives only one hour of unskilled care per day? This claim is suspect, perhaps involving fraud or simply loose management. Some LTC insurers do not have well-defined criteria for flagging suspect claims for further investigation.

Even under the reimbursement model, a claimant may "profit" in non-monetary ways from their claim. A couple of examples include receiving companionship and the convenience/status of having, in effect, a maid and chauffer. If the insurer is not actively managing the claim, then someone else is—the insured, the insured's family or the care provider. Claims do not go unmanaged! But, why would the insurer *not* actively manage an LTC claim?

- Lack of experience and preparation – little or no experience with other lines that require active claim management (such as disability) and therefore the insurer is ill-equipped to do so.
- Lack of adaptation – initial policies covered only nursing home confinement, which required little management. The claim operation evolved as more of a claim processing (check cutting) operation than a claim managing operation.
- Lack of anticipation – failure to think through the necessary claim processes and to identify what could go wrong is especially punishing to "pioneers." Management by reaction to disappointing financial results may suffice for other established lines of insurance, but not LTC. Coverage cancellation is not an option and rate increases are difficult to come by.
- Lack of alignment – a claim management administrator that was not given sufficient marching orders (from the administrator's perspective), failed to provide the anticipated services (from the insurer's perspective), or had cross-incentives in the fee structure.
- Lack of business perspective – claim management involves saying "no" when it is appropriate. This is part of the fiduciary responsibility of only paying the appropriate claims. There is always a potential legal risk and cost for saying "no" to an insured. Consider whether the threat of a lawsuit drives claim management decisions. Claims managers may be uninformed of the likely greater cost of frequently paying claims that do not meet the benefit triggers, or that involve a level of services that is excessive in relation to the actual care need.

What to do?

As claim management issues become more evident, I expect that many insurers will first strengthen claim management in an attempt to make current policies work as originally anticipated. More "manageable" policy design and wording may ultimately be necessary, which would represent a rational retreat from the liberal benefits and options that have naturally evolved in a challenging market. However, because sales are also a challenge, insurers are not falling over themselves to be first to market

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Denial is a coping mechanism, and most individuals like to put their best foot forward when interacting with strangers.

with such a product. (Perhaps if it were called LTC-Lite?)

Meanwhile, in a new operation it would be helpful to hold regular meetings to review the details of all new claims. In a larger more established operation, be aware of silo-centric perspectives, political realities, and the fact that any changes to existing operations are costly, impact budgets, and affect those that are held accountable for them. Pilot projects supported by senior management, and focused on no more than a small part of the claim process at one time, will probably be more effective for achieving headway in such situations. Remember to put yourself in the shoes of others and try to anticipate and address their legitimate concerns.

In reviewing many LTC claims across many insurers, here are some fairly common opportunities for improvement to claim management:

Self-reported impairment with no objective substantiation. Objective substantiation includes obtaining documentation from multiple sources whenever possible, in addition to the face-to-face assessment, such as assessments performed by a registered nurse. Although sometimes overlooked, therapist notes and hospital discharge summaries often provide valuable information. In the home setting, substantiation should not rely on simply checking off boxes based on a kitchen table conversation or phone interview. Substantiation should include observing and documenting how the insured performs various ADLs, and developing a good understanding of how they managed before, and why they cannot now. For example, simply by requesting the claimant to show the bathroom allows the assessor to note whether any assistive devices are present or lacking, facilitates observation of the insured's gait, ability to transfer, as well as to understand and retain simple commands. Currently, nurses infrequently use these techniques in performing face-to-face assessments. If benefit triggers are gatekeepers to desirable benefits, then self-reporting, reporting by the family, and even reporting by the insured's physician cannot be taken at face value without objective substantiation.

Plan of Service (POS) versus Plan of Care (POC). Although this could be the subject of an entire article, a POC is more comprehensive and detailed than a POS. A POC should include not only what care-services are provided by whom, how and when, but also supportive community resources, restorative services and therapeutic goals. A typical POS identifies the needed services, including frequency and intensity, based on a limited snapshot of the insured at the time the claim was opened. Also, a POS does not typically address how such covered services integrate with other services, providers or payers. For example, a POS would not request the insured's physician to consider therapy to improve function when appropriate. However, a POC should routinely include that as well as assistive devices that foster independence when appropriate.

A typical POS identifies the needed services, including frequency and intensity, based on a limited snapshot of the insured at the time the claim was opened.

Managing the benefit not the claim. Once the insured has been determined to meet the benefit triggers, the intensity of services is all too frequently managed by the insured, their family or the provider. Managing the claim involves a POC for which the type and intensity of services is consistent with the type and level of actual impairment. For example, if the insured needs assistance with bathing and dressing only, then a two-hour visit may be appropriate, but not a six- or eight-hour visit. Also, a POC should be reviewed frequently during the early weeks of a claim. The economic implications of allowing extra hours beyond what is needed due to infrequent POC updates or to satisfy the insured's or family's desires is not always well understood by the person developing the POC or approving the claim.

Absence of communication with critical medical and therapeutic professionals to determine degree of impairment and prognosis. Often there is little or no communication with hospital discharge planners, therapists, insured's primary and specialist physicians to determine the insured's prognosis and therapeutic goals. This is a missed opportunity to substantiate both initial and ongoing eligibility, and to develop an appropriate POC that optimizes a claimant's ability to regain partial or full functional independence.

Poor understanding of how to apply policy language. Sometimes this involves ADL definitions, such as whether or not someone who has the ability to sponge bathe is bathing impaired. Or, what "severe cognitive impairment" or "threat to safety" mean in terms of specific claim situations. What cognitive assessment score is used, either as a necessary or sufficient factor, in determining whether an insured meets the cognitive

benefit trigger? What additional factors, if any, go into that determination? If benefits are paid starting with mild cognitive impairment, then the length and cost of claims will significantly exceed expectations. Another example involves the problematic "stand-by" definition of ADL impairment. For example, if someone requires stand-by for transfers because of fear of falling, but there is no documented history or clinical rationale, then the LTC coverage becomes "fear of falling" insurance. Clearly, an attitude is not an insurable event.

Lack of critical thinking in document review to establish eligibility. This involves taking time to identify and fully research any inconsistencies in the information provided by the insured, the insured's physician, family and the assessing nurse or therapist. If such inconsistencies are ignored, then obviously administrative expenses are reduced, but so too are opportunities to identify fraud and prevent unwarranted claim payments. This is an area where lack of economic alignment between the administrator and the insurer may involve conflicting incentives.

Balancing honest policyholder advocacy with responsibility to pay the claim as stated in the policy. Nurses are caregivers, nurturing by personality, training and experience. Consequently, they tend to develop a policyholder advocacy perspective, which can supercede their ability to appropriately manage a claim. While nurses bring positive skills to LTC claim management, this dynamic needs to be acknowledged and managed, along with the need for any claim operation to treat policyholders fairly and consistently, but at the same time, not pay benefits beyond what has been promised in the policy.

Absence of policies and procedures to drive decision-making. Few businesses can operate effectively without written policies and procedures. Yet surprisingly, these are frequently lacking, especially in smaller or medium sized operations. Without them, an insured has a better shot at making a case for not having received fair treatment. Also, polices and procedures are necessary for effective training of new personnel, to promote consistency across the operation, and to assess existing staff's (or administrator's) performance. Consistency, of course, is an important element to avoiding unfair trade practice issues. Also, the observant agent is likely to advocate repeating that one-time exception or liberal decision for future claims.

Aversion to liability that results in inappropriate claim approvals and benefit payments. This results from an unbalanced perspective regarding the cost of legal liability versus the cost of paying excessive benefits. Hallmarks of this approach are weak or nonexistent contestability procedures, no fraud screening or claims investigation, paying based on any information that can substantiate eligibility while ignoring any counterindications, and paying when benefits are demanded even though supporting information is inadequate.

Missed opportunities to coordinate with Medicare covered services. By not proactively pursuing Medicare payment for eligible services, insurers are needlessly overpaying. Generally, Medicare does not pay for ongoing chronic conditions, but many LTC claims hold the potential for at least partial Medicare payment during the first 60 to 100 days. The POC should anticipate and coordinate transition from Medicare to LTC benefits, including the continuation of any therapy, which is proving to increase independence. Besides needlessly paying for benefits, another important reason to initially use a Medicare eligible provider is that typically non-Medicare eligible providers do not include occupational and physical therapy, which is of critical value for restoring the claimant to partial or full independence and earlier claim termination.

In summary, the LTC insurance business has not yet completed its journey. Claims may yet represent the greatest challenge. However, even though the Sierras presented an insurmountable obstacle to some pioneers, others were better prepared. Some even discovered gold there, which turned the obstacle into a great opportunity. Claims is the final frontier for LTC. It will not be easy, but it doesn't need to be the Donner Pass of the industry either. Don't let it happen to the insurer(s) you work with! ✵

Endnotes

1) Werner M, et al., Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public, *American Journal of Bioethics*, Vol 4, No 4 / Fall 2004, pp 53-59.

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Fourth Intercompany LTC Report Published

by Gary L. Corliss

In mid-December, the Society of Actuaries Long-Term Care Experience Committee released its fourth report. The complete report can be found on the SOA Web site as follows:

www.soa.org/ccm/content/areas-of-practice/special-interest-sections/long-term-care-insurance/1984-2001-ltc-ins-inter-study

This document is the fourth intercompany study by the SOA LTC Experience Committee. Previous reports were published January 1995, February 2000 and September 2002. The four reports of this committee sponsored by the SOA and the Long-Term Care Persistency Experience Report of 2004 jointly sponsored by LIMRA and the SOA are the only publicly available and published reports of experience on lives insured under private LTC insurance plans in the United States. This report, as well as the previous three, is based on data gathered for policies issued back to 1984. Data in this report has been combined and analyzed from 20 organizations (24 insurers) that provided information to further the public and private knowledge of long-term care insurance.

Data has been collected on policies issued from January 1, 1984 through December 31, 2001. Claims incurred on policies during this time frame were followed from claim inception through the earlier of claim termination or June 30, 2002. Allowing a six-month period to report incurred claims allows for the capture of most of the incurred but not reported claims as of year-end 2001.

Insurers were asked to provide information on 100 percent of the policies issued unless their volume would potentially alter the intercompany nature of the study. Under those circumstances, such an insurer was requested to submit a substantially representative portion of their issues that would allow an unbiased contribution but still protect the confidentiality of that company's experience.

Exposure records increased almost 50 percent from the 2000 report, reaching 3.9 million exposure records with 12.5 million exposure years. Parenthetical percentages below show comparable distribution in the previous study.

- 22 percent of the exposure was in the first policy year
- 21 percent of the exposure was in the second exposure year
- 15 percent of the exposure was in the third exposure year
- 10 percent of the exposure was in the fourth exposure year
- 69 percent of the exposure was on individual insureds (73 percent)
- 31 percent of the exposure was from group insureds (27 percent)
- Average issue age of all insureds in the data base is 61 (63)
- Average issue age of individual insureds is 67 (68)
- Average issue age of group insureds is 47 (49)
- Average attained age of the insureds in the database is 64
- Female insureds represent 59 percent of the exposure (60 percent)

The number of claimants almost doubled from just over 50,000 in the 2000 report to 95,000 claimants in this report. Benefits paid increased from $1.3 billion in the previous report to $4.1 billion in this report. Although decreasing as a percentage of policies claimed, the majority of claims continue to be attributable to the use of nursing home care.

- 80 percent of the claims were for nursing home care (91.5 percent)
- 15 percent of the claims were for home care (8.5 percent)
- 5 percent of the claimants received both NH & HC benefits
- 75 percent of all claims (open and closed) have a claim duration of one year or less (75 percent)
- 87 percent of claims in the database are closed
- Average attained age on incurral date of claim was 79.9 years (78.8)
- Female claimants incurred 70 percent of the claims and 70 percent of the benefit dollars (66 percent)

Each section of this report covers one or more of several areas for which sufficient data is available. The areas that are included in this report are:

- Gender
- Issue Age
- Attained Age
- Elimination Period
- Benefit Period (Limited vs. Unlimited)
- Policy Duration
- Individual vs. Group
- Nursing Home vs. Home Care
- Issue Year Groupings
- Experience Year Groupings
- Underwriting Type
- Benefit Escalator Clause
- Distribution Source

The compiled data continues to verify some long held expectations relative to long-term care:

- Incidence rates rise steadily by attained age and policy duration
- Mortality rates increase steadily by attained age and policy duration
- Morbidity and mortality selection is apparent in early policy durations

Other general results of interest:

Incidence Rates
- Overall incidence rate is 69 percent (up from 60 percent)
- Select period may be at least 10 years
- Reductions over time in previous reports may be leveling off

Claim Continuance
- Increases with increasing age at claim until about age 89, then decreases
- Average length of claim is 393 days

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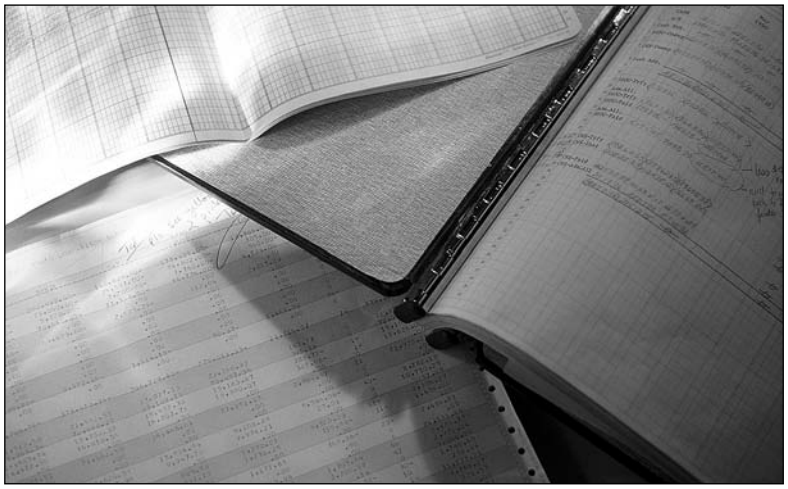

- o 68 percent of nursing home claims end in death
- o 49 percent of home care claims end in recovery

Cause of Claim
- o Alzheimer's claims continue to be the most frequent, longest and most expensive as well as trending upward
- o Alzheimer's is the leading cause for nursing home care claim
- o Alzheimer's is the leading cause for home care claim after age 75
- o Cancer is the leading cause of home care claim through age 75
- o Cancer and injury are large for home care, but are short in duration

Mortality
- o Overall mortality rate is 1.1 percent
- o Male mortality is 40 percent greater than female (49 percent)
- o Mortality is considerably lower than the 83 GAM, A2000 and the new 2001 VBT
- o Disabled lives mortality is 20 times that of Active lives
- o Disabled lives mortality for LTCI is 150-200 percent greater than for disabled lives under disability insurance
- o Select period may be at least 10 years
- o GSI mortality appears less than both full and simplified underwriting (in the past, it was higher than full but lower than simplified underwriting)

Voluntary Lapse Rates
- o Average annual lapse rate has been 7.4 percent
- o Average annual rate was 7 percent for the data solely for the current study period
- o Rates decrease for the first nine policy years
- o Group insurance lapses start out higher than individual, then are lower after the first six years
- o Rates for insurance solicited by enrollers is noticeably lower than for all other types of distribution

Total Termination Rates
- o Average annual total termination rate is 8.9 percent
- o Average annual rate is 8.1 percent for the data solely for the current study period
- o Inputted mortality rates from total and voluntary termination data indicate that mortality is much lower than current life industry mortality

Home Care
- o Average number of weekly home visits were 3.8 per week (down from 4.29 visits per week in the previous study, but higher that the 3.25 days per week in the study before that one)
- o Arthritis claimants use the most days of care per week (4.7 days)

Limited versus Unlimited Benefit plans
- o Incidence rates are not consistently higher for either longer or unlimited benefit plans compared to shorter benefit plans
- o Voluntary Lapse Rates do not differ significantly between maximum benefit periods in this report compared to the previous report

Preparations have already begun for the next LIMRA/SOA LTC Persistency Study and the next SOA LTC Intercompany Study. For those companies which have not contributed, they may contact Gary Corliss to be added to the mailing list for the next set of instructions. ❋

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Articles Needed for the News

Your help and participation are needed and welcomed. All articles will include a byline to give you full credit for your effort. *Long-Term Care News* is pleased to publish articles in a second language if a translation is provided by the author. If you would like to submit an article, please call Bruce Stahl, editor, at 856-566-1002.

The next issue of *Long-Term Care News* will be published quarterly as follows:

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Preferred Format

In order to efficiently handle articles, please use the following format when submitting articles:

Please e-mail your articles as attachments in either MS Word (.doc) or Simple Text (.txt) files. We are able to convert most PC-compatible software packages. Headlines are typed upper and lower case. Please use a 10-point Times New Roman font for the body text. Carriage returns are put in only at the end of paragraphs. The right-hand margin is not justified.

If you have questions, or if you must submit in another manner, please call Joe Adduci, 847-706-3548, at the Society of Actuaries.

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