

Long-Term Care News



**SOCIETY OF
ACTUARIES**

**LONG TERM CARE
INSURANCE
SECTION**



Understanding LTC Policy Termination
Experience: examining the impact of
data quality

By Marianne Purushotham
page 7

- 3** Chairperson's Corner
Vince Bodnar
- 4** Editor's Corner
By Robert Eaton
- 5** Up Front with the SOA Staff
Fellow
By Joe Wurzburger
- 7** Understanding LTC Policy
Termination Experience:
examining the impact of data
quality
By Marianne Purushotham
- 11** Long-Term Care Coverage in
Europe
By Edith Bocquaire
Translated by Etienne Dupourqué
- 15** Long-Term Care Planning:
A Worksite Perspective
By Ruth Larkin
- 16** Continuing Care at Home
By Sarah Lentz Spellman

Long-Term Care News

Issue Number 41 • MAY 2016

Published three times a year by
the Long Term Care Insurance
Section of the Society of
Actuaries.

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

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

This publication is provided for
informational and educational
purposes only. The Society of
Actuaries makes no endorsement,
representation or guarantee
with regard to any content,
and disclaims any liability in
connection with the use or
misuse of any information
provided herein. This publication
should not be construed as
professional or financial advice.
Statements of fact and opinions
expressed herein are those
of the individual authors and
are not necessarily those of
the Society of Actuaries.

Society of Actuaries
475 N. Martingale Road, Suite 600
Schaumburg, Ill 60173-2226
Phone: 847.706.3500 Fax:
847.706.3599

© 2016 Society of Actuaries.
All rights reserved.

2016 SECTION LEADERSHIP

Officers

Vince Bodnar
Chairperson
Rebecca Tipton
Vice Chairperson

Council Members

Rachel Brewster
Marc Glickman
Robert Eaton
Shawna Meyer
Matthew Morton
Juliet Spector
Robert K. Yee

Affiliate Section Council Members

Christie Conway
John Cutler
John O'Leary

Program Committee Coordinators

Rebecca Tipton, 2016 Health Spring Meeting
Rachel Brewster, 2016 SOA Annual Meeting
Shawna Meyer, SOA/LIMRA/LOMA DI & LTC Insurers'
Forum Representative

Newsletter Editor

Robert Eaton

Board Partner

Sue Sames

SOA Staff

Julia Anderson Bauer
Publications Manager
jandersonbauer@soa.org

Joe Wurzbarger,
Staff Partner,
jwurzbarger@soa.org

Leslie Smith,
Section Specialist
lsmith@soa.org

Kathryn Baker,
SOA Staff Editor
kbaker@soa.org

Erin Pierce,
Graphic Designer
epierce@soa.org

Chairperson's Corner

Vince Bodnar

I'm honored to serve as chairperson for the Long Term Care Insurance Section for the second time. My first term was in 2005 to 2006. Much has changed in the industry since then. In reviewing one of my Chairperson's Corners from ten years ago that challenged us to introduce new types of products, I see that we are still an industry that is craving innovation and solutions that are more appealing to a new generation of buyers.

In 2005, the decline in new sales had just begun. At the time, I don't think that any of us recognized that it would continue for the next decade. Yet, here we are, and we continue to see that long-term care insurance has not reached the level of penetration that we all hoped it would in its heyday.

I'm an optimist. I truly believe that private financing of long-term care can assume the much bigger role that it should. There is clearly little appetite to expand public programs, and state governments are eager to find solutions that will relieve their ever expanding Medicaid budgets. There is increasing receptivity to change laws and regulations to allow for the creation of products that are more appealing to consumers and far less risky to insurers. We, as an industry, need to stretch our creativity and respond.

The section hosted the third in-person Think Tank meeting in October and has recently published a report that summarizes its outcomes and suggestions for next steps. The report is available on our section's home page (soa.org/ltc/). I encourage you all to take a look. Rather than suggest a single "silver bullet," the report lays out the germinations of concepts that can be drawn from or fitted together with other concepts to create sets of solutions. The solutions address not only financing, but also the affordability and availability of quality of care, as we view these three issues as inseparable. The report points to growing social capital and emerging technology, as well as new ways to look at pre-funding our long-term care needs. We are currently forming sub-committees for each of three "platforms" of ideas to help take them to their next steps.

The section will also look to continue the momentum that started last year to reach out to our regulatory members. We expect to host more educational sessions that are aimed at regulators via webcast and to give presentations at hearings related to long-term care in state capitals. These efforts have been well received



and we are happy to keep this important initiative going in the next year.

Please feel free to reach out to me or Joe Wurzbarger, the section's staff fellow, if you would like to participate in the next steps of the Think Tank's platforms, the regulatory outreach, or if you have any suggestions for section activities. ■



Vince Bodnar, ASA, MAAA, is chief actuary at LTCG in Treviso, Penn. He can be reached at vince.bodnar@ltcg.com.

Editor's Corner

By Robert Eaton

"Ideas, like large rivers, never have just one source."-Willy Ley

There is much at stake in the long-term care (LTC) industry, to put it lightly. For most of you reading this, you are invested in the future of LTC in some form or another: you are an actuary forecasting the expected behavior of a block of LTC insurance policies; you are a claims administrator, ensuring that payments are made in a timely manner; you run a care management organization, coordinating services to those with chronic illness. Others of us have family and friends who use LTC services and support today. And still others of us anticipate needing long-term care services in the future, a cohort which is estimated to only increase with the aging baby boomers. Our collective knowledge is greater than our individual experiences. As always, please continue to share your ideas and research in articles for the LTC Section newsletter.

The recent troubles of the Great Recession, the sustained low interest rate environment, and emerging data in an insurance industry still in its adolescence, have only proven that we LTC workers are made of pretty stern stuff. With diminishing opportunities following market exits and insurance company de-risking, we have taken the stance that risk is opportunity. Look around and you can see those opportunities being explored today.

As you will see on these pages and over the next couple of issues, there are many far-reaching initiatives from groups such as the Bipartisan Policy Center, the Urban Institute, SCAN, Leading Age, and the Long-Term Care Financing Collaborative. These initiatives seek new or innovative ways to fill our society's need to provide long-term care services and support for those who require it. We will be sharing these ideas and others on the pages of *Long-Term Care News* during the course of the year. But we don't want to do this alone.

A MEETING PLACE OF IDEAS

The newsletter has always been a meeting place of the ideas of the SOA's LTC section. While the section works to provide its members with education and research and ideas on LTC, we in turn ask you to contribute your ideas. Your ideas need not be earth-shattering, and their scope doesn't have to be grand. We are interested in your experience as an LTC professional, and in

your thoughts on the issues that matter to you and your role. If you have an idea to contribute to our LTC dialogue—about rate increases, combo market perspectives, claims handling, fraud, etc.—we encourage you to submit an article. As the newsletter editor, it's my role to provide feedback and help you bring your thoughts to print.

If you are ready to share your ideas about long-term care, or if you're hesitant and just want to bounce a couple of things off me, please don't hesitate to write to me at robert.eaton@milliman.com. I'm pleased and excited to serve as the *Long-Term Care News* editor and I'm looking forward to working for you. ■



Robert Eaton, FSA, MAAA, is a consulting actuary at Milliman in Tampa, Fla. He can be reached at Robert.eaton@milliman.com.

Up Front with the SOA Staff Fellow

By Joe Wurzbarger

People always come up and ask me if the Cubs are going to win in their lifetime, and I always give them the same answer: “How long are you planning on living?” – Steve Stone

I am a Cubs fan. I can't help it. For many years I lived within walking distance of Wrigley Field. I was in the bleachers when Greg Maddux recorded his 3,000th strikeout, despite a nearly three-hour rain delay spent mostly in the pouring rain. I was at the infamous game when Sammy Sosa corked his bat. I was across the street at a Wrigleyville bar, unable to afford a ticket to get in the ballpark, for the even more infamous Steve Bartman playoff game (and for the record, no, I don't blame Mr. Bartman for the events that transpired that night). And even though all he talked about afterwards was the popcorn, one of my favorite moments of fatherhood so far has been taking my son to his first Cubs game.

I, along with my fellow Cubs fans, have spent my lifetime saying, “Wait ‘til next year.” So Steve Stone's quote above rings true for me. But as those of you reading this also know, his question—“How long are you planning on living?”—carries tremendous importance in the world of long-term care financing, as well.

We need to think about how long we plan on living as we seek to minimize the risk of outliving our retirement savings. One of the biggest threats to this is the daunting cost of long-term care (LTC). There are various ways people finance LTC now: unpaid care from family or friends, personal savings or income, Medicaid, private long-term care insurance, and other financial products. For the most part, however, people neglect to plan ahead with regard to how they will pay for LTC needs. While there are some good payment options today, especially for the most and least affluent members of society, most would agree that there is a lot of room for improvement in terms of LTC financing options.

With this in mind, there are a number of initiatives currently underway throughout the LTC industry aimed at addressing the challenges of financing long-term care. I'd like to highlight some of them here.

- Society of Actuaries' LTC Think Tank: Many of you heard about the Society of Actuaries' LTC Think Tank already in the March 9, 2016 webcast. Hopefully, others will stop by to hear about it at the upcoming SOA Health Meeting. What you did—or will—hear about is the output of two inspiring days of innovative brainstorming. Back in October 2015, more than 40 of the leading and most creative minds in the world of long-term care convened near Chicago. This group consisted of more than just actuaries, and the ideas generated went beyond insurance product design to include other ways insurance companies, service providers, consumers, and even disruptors can get in the game of reducing the cost burden of long-term care. Over 80 ideas were generated, and more than a dozen were identified by the group as warranting further investigation.
 - Society of Actuaries' Committee on Post-Retirement Needs and Risk (CPRNR): The SOA's CPRNR has devoted a significant amount of attention over the past two years to long-term care financing. The impact of LTC on retirement is of special interest to this group. Look for essays on this topic in upcoming issues of the *Pension Section News*.
 - Urban Institute/Milliman, Inc. Policy Modeling Project: The SCAN Foundation, AARP, and LeadingAge partnered to fund a large body of actuarial and economic modeling that was completed by the Urban Institute and Milliman, Inc. The intent was to offer workable policy solutions to the LTC financing crisis, with the purpose of the modeling work being to create new analytic information comparing various high-level insurance options (<http://www.thescanfoundation.org/ltc-financing-initiative>).
- This work was showcased at a recent *HealthAffairs* briefing. On Nov. 17, 2015, *HealthAffairs* hosted a series of panel presentations on Financing Long-Term Services and Supports in Washington, DC. Of primary focus was *HealthAffairs'* report, *Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending*. (<http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full>)
- Bipartisan Policy Center (BPC): On Feb. 1, 2016, the BPC held a live event to discuss their report, *Initial Recommendations to Improve the Financing of Long-Term Care*. This report is informed by the Urban/Milliman modeling and serves as a first step at continuing the reform dialogue rather than a definitive set of final proposals. (<http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/>)
 - LeadingAge: LeadingAge is a national association of more than 6,000 non-profit long-term care providers and a co-funder of the Urban/Milliman modeling effort. In

We need to think about how long we plan on living as we seek to minimize the risk of outliving our retirement savings. One of the biggest threats to this is the daunting cost of long-term care.

mid-February 2016, they published a report entitled *Perspectives on the Challenges of Financing Long-Term Services and Supports*. The report highlights the unsustainability of the current system of financing long-term care and the need to further explore a range of options including a catastrophic care option. (https://www.leadingage.org/uploadedFiles/Content/Members/Member_Services/Pathways/Pathways_Report_February_2016.pdf)

- **The Long-Term Care Financing Collaborative:** The Long-Term Care Financing Collaborative is a group of 25 experts from all sides of the political spectrum. The Collaborative also published a paper in February discussing public/private long-term care financing options and potential approaches to deal with catastrophic costs, supporting better individual preparation and improving the public safety net.
- **National Academy of Social Insurance (NASI):** The pre-conference session at NASI's annual policy conference occurred on Jan. 27, 2016, and addressed the myriad ongoing LTC financing initiatives with special focus on the Urban/Milliman modeling.
- **ILTCI and ASA Conferences:** For those of you who attended the Intercompany Long-Term Care Insurance (ILTCI) Conference in San Antonio, you got a chance to hear some of these same groups discuss the study and its policy implications first hand. And if you missed that, the American Society on Aging (ASA) Aging in America Conference the following week had a three-hour session devoted to the same topic.

Given the large number of different groups working simultaneously on this issue (which is not limited to those listed above), the SOA is looking at how best to play an important role in facilitating the conversation on long-term care financing. With this

effort, we hope to bring together key individuals from involved groups along with the American Academy of Actuaries and other key players to coordinate efforts and maximize the chance of impactful outcomes. If you would like to find out more about this effort or get involved yourself, please contact me at jwurzburger@soa.org.

Hope springs eternal, both for baseball fans and for those working to bring improvements to the world of long-term care financing. No more waiting 'til next year. Next year is here. ■

I'd like to thank the following people who provided guidance and/or editing assistance: John Cutler, John O'Leary, Steve Schoonveld, and Eileen Tell. ■



Joe Wurzbarger, FSA, MAAA, is staff fellow, health, at the Society of Actuaries in Schaumburg, Ill. He can be reached at jwurzburger@soa.org.

Understanding LTC Policy Termination Experience: examining the impact of data quality

By Marianne Purushotham

UNDERSTANDING AND INTERPRETING CURRENT AND PAST INDUSTRY DATA

Last year the Society of Actuaries completed a multi-phase project with the goal of conducting a comprehensive study of long-term care (LTC) experience results for the 12 year period 2000–2011. As part of this effort significant emphasis was placed in the following areas:

- 1) Securing strong industry participation in the study;
- 2) Ensuring the highest possible quality of data.

The latter goal resulted in the development and application of an extensive data validation process that was applied to all participant submissions.

LIMRA partnered with the SOA on a phase of the project that focused on examining LTC policy termination experience including both voluntary lapse and mortality results. This work

was completed in June 2015 and was based on data submitted by 22 LTC carriers representing approximately 75 percent of the LTC lives inforce over the study period. The analysis was limited to individual LTC products due to the scarcity of data provided for the group market.

An additional area of emphasis for the policy terminations work was to better understand the impact of data quality on reported results given the continued difficulty for insurers in accurately distinguishing voluntary lapse activity from deaths given the generally older age of insureds in this market. Since in most cases there is no nonforfeiture benefit at the time of lapse and no death benefit paid on these policies, there is no compelling reason for a policyholder to contact the insurer to cancel their policy. So in many cases, premium is discontinued and if a death is not reported, the assumption is made that the policy terminated due to voluntary lapse.

The impact of this phenomena has been noted and discussed in past SOA LTC experience study reports. The industry generally agrees that LTC products have exhibited among the lowest lapse rates of any products offered by life and health carriers (with ultimate lapse rates commonly assumed to be under 1 percent). However, at the same time, average voluntary lapse rates derived from data submitted by carriers to the SOA studies imply levels higher than generally accepted as well as mortality rates lower than generally accepted.

In order to better assess the past and current impact of this issue on industry reported policy termination experience, SOA, LIMRA and the LTC Experience Committee focused initial validation efforts on obtaining an understanding of differences in the level of effort being made to distinguish voluntary lapse

Figure 1: Reported Voluntary Lapse Rates Impacts of Improving Quality of Data over Time 2000-2011

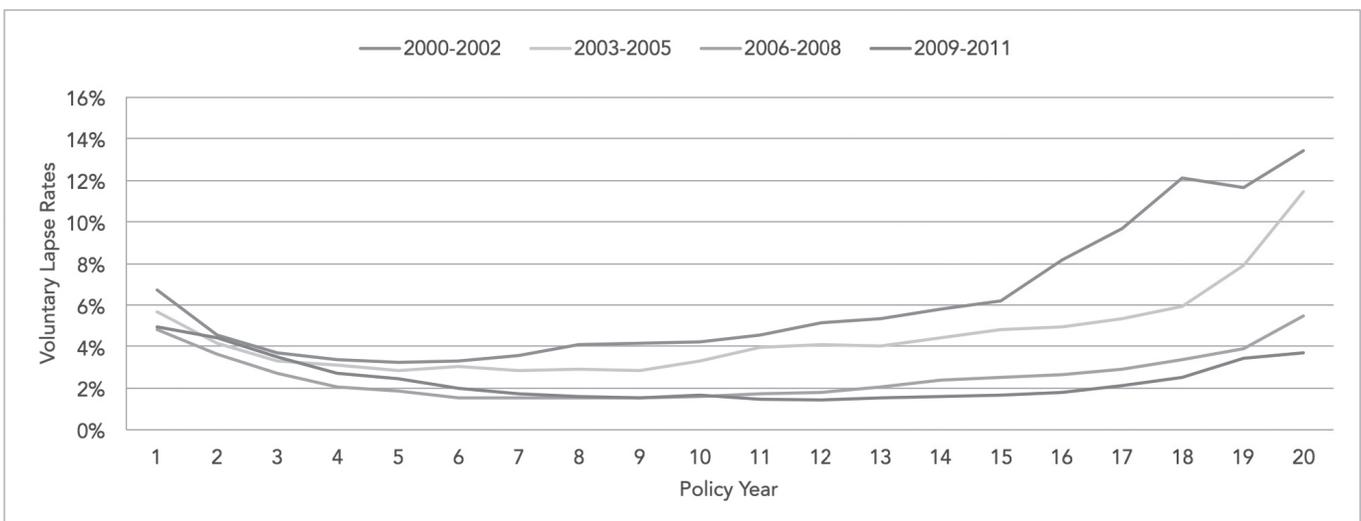


Figure 2: Reported Mortality Rates Impacts of Improving Quality of Data over Time 2000-2011

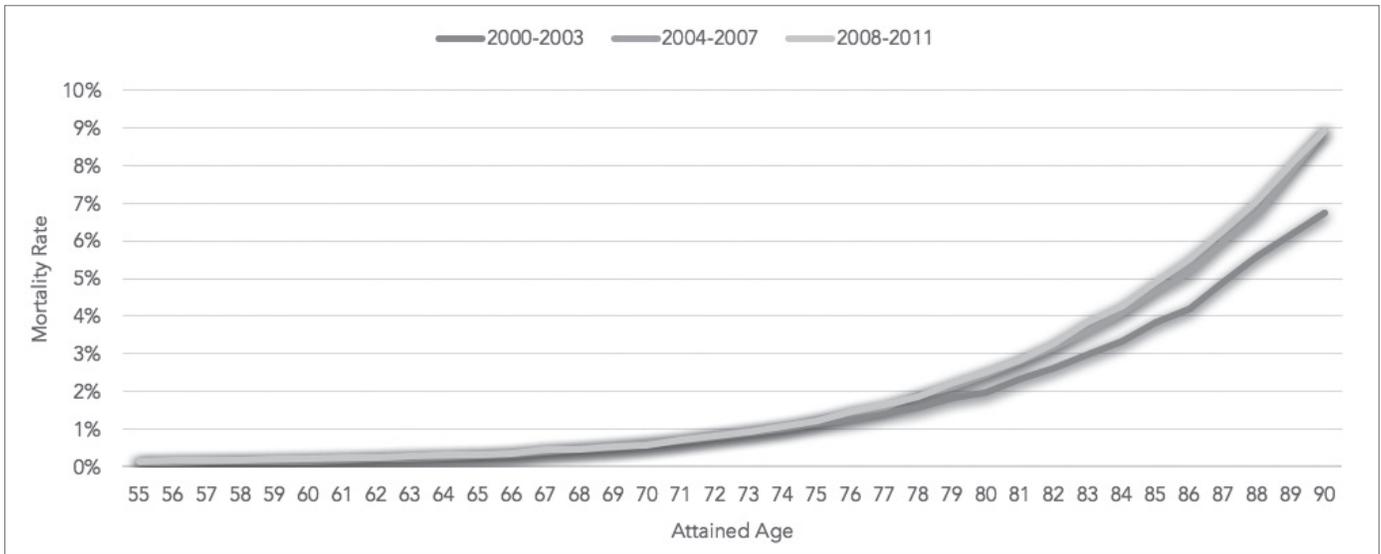
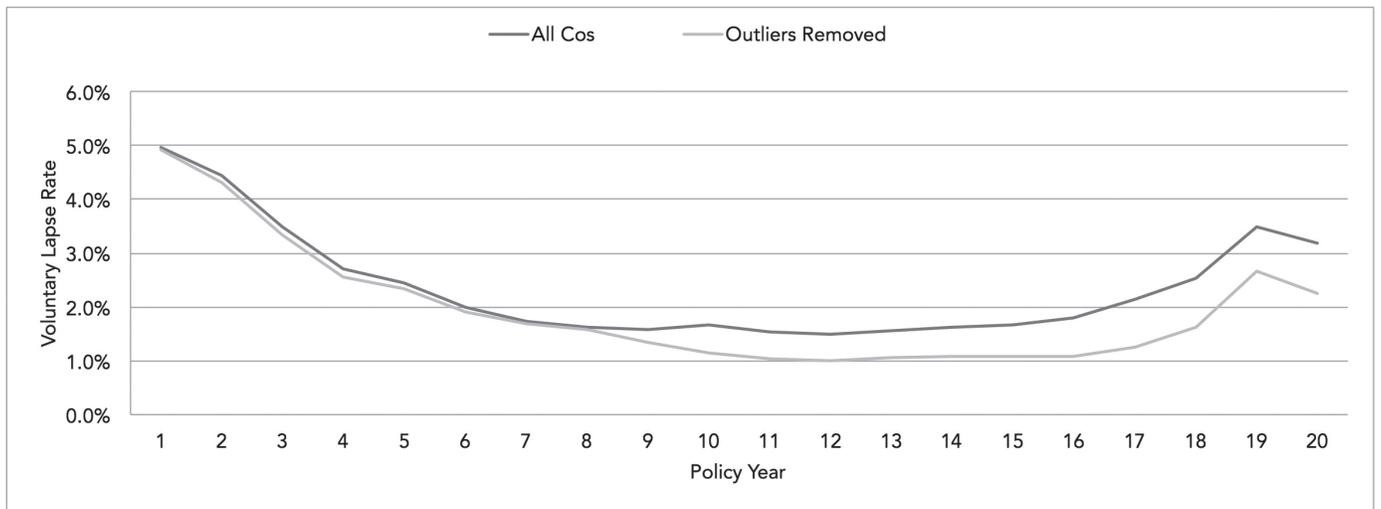


Figure 3: Reported Voluntary Lapse Rates By Policy Year 2009-2011 Experience



from mortality at the company level. Most companies have now implemented a process to better identify deaths by accessing the Social Security Death Master Files on a periodic basis and using this information to update and sometimes correct the cause of policy termination. And it does appear that the quality of reported data has improved over the experience years as these procedures are incorporated. (Figures 1 and 2)

This information led us to focus our attention on the most recent experience years where industry reported voluntary lapse rates appear the closest to current industry views. (Figure 3)

Similarly, for mortality experience, the analysis was focused on the more recent experience years where there appeared to be a

higher quality of data provided by companies. Actual reported mortality experience for study years 2004-2011 was first compared to expected mortality experience using the 2012 IAM as the expected basis. This is the most recent published annuity payout mortality experience table and is based on an older age insured population most comparable to LTC policyholders. No adjustments for mortality improvement impacts have been incorporated at this point.

The first observation—the evidence of underwriting selection effects on LTC mortality results—was noted based on a comparison to the 2012 IAM as well as to other industry tables examined as part of this work. (Figure 4)

Figure 4: Actual to Expected Mortality Ratios by Gender and Policy Year Expected = 2012 IAM Experience Period = 2004-2011

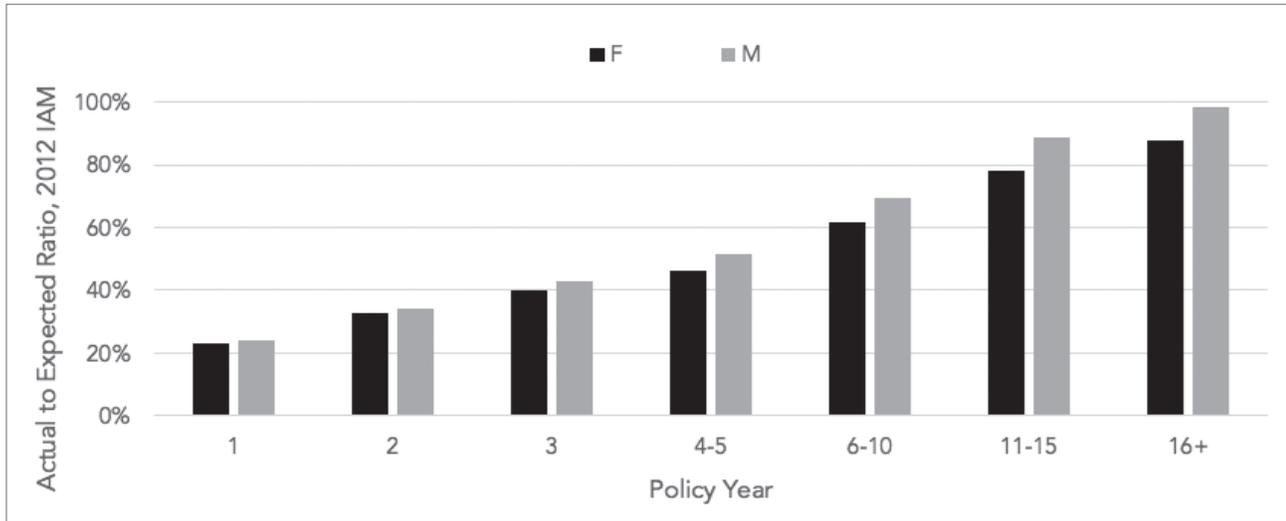


Figure 5: Actual to Expected Mortality Ratios by Attained Age (Females) Expected = 2012 IAM Experience Period = 2004-2011

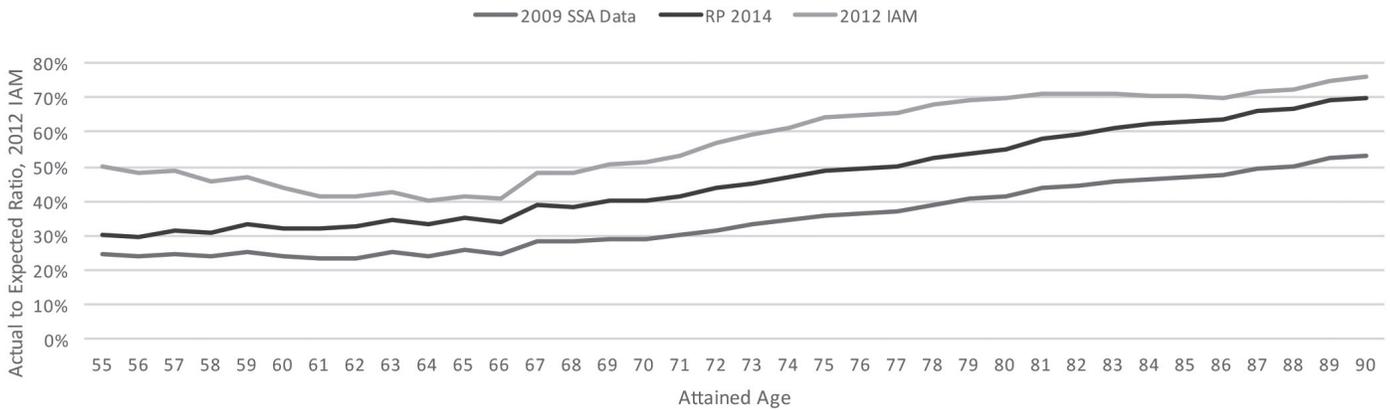
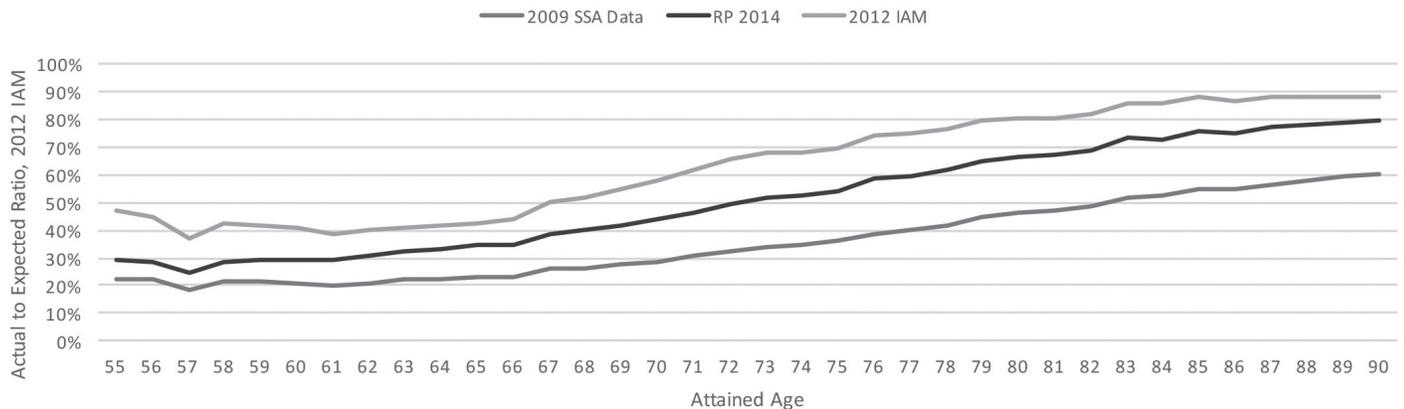


Figure 6: Actual to Expected Mortality Ratios by Attained Age (Males) Expected = 2012 IAM Experience Period = 2004-2011



Removing policies in years 1-6 to eliminate the data with the greatest potential selection impacts, we then compared actual mortality experience by attained age and gender to two recent standard mortality tables—one for individual payout annuitants and one for the pension population—the 2012 IAM and the RP 2014. In addition, the results were also compared to recent Social Security Administration reported mortality rates (2009 SSA Data).

The second observation (as shown in Figures 5 and 6) is that overall, the 2012 IAM appears to provide the closest fit to the most recent actual LTC experience by attained age and gender and could serve as a reasonable starting point for any development of industry standard LTC mortality tables. For females, A/E ratios vary from 50 percent for attained ages in the late 60s to 70 percent beginning in the late 70s. For males, A/E ratios vary from between 40 and 50 percent between ages 55 and 65 to close to 90 percent beginning in the late 70s.

Encouraged by this study's evidence of improving data quality over time, the SOA provided additional information by making the aggregated industry data for mortality and lapse experience available for download from its website. This was the first study of its kind to be published as an industry summary report accompanied by aggregated industry data provided in the form of MS Excel-based pivot tables.

It is our hope that this approach will better serve study participants and the industry as a whole in allowing for more in-depth examination of the data and results. We look forward to continuing to advance industry knowledge as more detailed and better quality data continues to emerge. ■



Marianne Purushotham, FSA, MAAA, is corporate vice president, Strategic and Developmental Research at LIMRA in Windsor, Conn. She can be reached at mpurushotham@limra.com.

Long-Term Care Coverage in Europe

By Edith Bocquaire

Translated by Etienne Dupourqué

Editor's Note: This article is excerpted from a longer paper that can be found on www.soa.org/ltc.

The need for long-term care (LTC) services in Europe continues to rise, as in the United States, with the aging of the populations. According to Eurostat data, the 75 or older population in Europe could increase by 64 percent between 2015 and 2040. Germany and Spain should reach a dependency ratio¹ exceeding 50 percent in less than 50 years. In contrast, the U.K. should just exceed 40 percent.

LTC coverage in each country is still marked by its past, with a hybrid of Beveridgean and Bismarckian systems, as well as the conservative traditions of some countries, and family traditions of European countries.

- In the Bismarckian model—named after the German Chancellor Otto von Bismarck—LTC protection depends on labor and social contributions. Insurance helps contributors (and their families) with proportionality of benefits to contributions, and contributions by employees and employers. Versions of this approach are found in Germany. Like most other countries, this model provides a safety net for individuals under the poverty level.
- In countries with the Beveridgean model—named after the British economist William Beveridge—social protection is supported by the national government, unrelated to employment, and it strives for egalitarianism through uniform benefits. The social protection is financed by taxes. This model is also referred to as “social democratic,” and while it is primarily funded by a central government, it decentralizes implementation to municipalities. The Spanish LTC system also has elements of a Beveridgean model.
- Conservative traditions provide greater recourse to a market-based system. The U.K. government, as in nearly all countries, has put in place a safety net for the poor. A version of this system can be found in the U.K., where health care is provided through a national tax supported system.
- The family tradition model in southern Europe has long left LTC responsibilities on families. This collective choice has been progressively challenged with rising female employment rates.

LONG-TERM CARE SYSTEMS IN GERMANY, SPAIN, AND THE UNITED KINGDOM

The following table illustrates the ratio of the number of beneficiaries of dependency benefits to the over-65 population of each country.

	Germany	Spain	U.K
1: Beneficiaries of at least one Long-Term Care benefit in 2014 (estimated, in million)	2.4	0.7	1.3
2: Total population 2014 (million)	80.8	46.9	64.3
3: Over 65 in 2014 (million)	16.8	8.4	11.3
Ratio 1/3	14%	8%	12%

MODEL 1: LONG-TERM CARE COVERAGE PRINCIPALLY THROUGH PUBLIC PROGRAMS

Public LTC coverage is financed either by taxes, as in the Nordic countries, or through social LTC insurance schemes.

GERMANY

General principle

A 1994 law established LTC as a mandatory fifth branch of the Social Security program. Priority is given to home care over institutional care. The amount paid to disabled people and the frail elderly is fixed (and is not adjusted due to income or assets) but varies depending on the level of disability, whether care is provided at home or in an institution, and whether the beneficiary receives benefits as cash rather than in-kind services. Where charges exceed the allocated amount, the recipient is responsible for the payment of the difference and, if he or she cannot, local social assistance makes up the difference.

Although the majority of Germans fall under the public insurance plan, about 10 percent are covered through private insurance, which is compulsory for people who have private health insurance. Supplemental private insurance is also available and covers about 4 percent of the population (some of whom have private, and some of whom have public insurance).

The law covers all forms of loss of autonomy regardless of age. Since January 2013, the law distinguishes four levels of dependency according to which services (personal care or home care) are needed. Beneficiaries of public funds may choose between benefits in kind, delivered at home or nursing facilities, and cash benefits, or may take a combination of the two. To receive LTC insurance benefits, applicants have to be insured for at least two years. However, insureds through a private fund may collect indemnity benefits for specific services.

The four disability levels are:

- Level 0: people who, because of dementia, a mental disability, or psychological disorder, are severely limited in the exercise of Activities of Daily Living (ADLs), without the level of aid needed for a person described in Level I;
- Level I: those in need of care at least once a day for bodily care, feeding, and mobility;
- Level II: people whose dependence is heavy and need help at least three times a day for basic care and at different time of the day;
- Level III: those whose dependence is absolute and permanent and need help 24/7.

People receiving home care, and unable to perform most ADLs, may be entitled to an additional allowance. Since 2013, persons under the care level “0” may also be eligible.

In addition, LTC funds support the costs of specialized equipment (a hospital bed, for example) and costs related to home modifications, subject to a deductible. Two thirds of beneficiaries opt for cash payment and live at home. Of these, one third receives care from private operators, while others are assisted by a family caregiver paid in part through LTC insurance.

Financing

The Social Security program requires compulsory LTC insurance. As a result, any person affiliated with the national health plan or with a private insurance plan is automatically affiliated with his or her Social Security health insurance coverage.

The LTC branch is funded by a payroll tax rate of 2.05 percent (as of January 2013) shared equally between employees and employers. To compensate the employer’s share, a holiday was removed beginning in 1995. People who do not have children pay

an additional contribution (0.25 percent) and retirees participate in the financing of LTC Insurance by paying a contribution proportional to their assets. Financing of social services is provided by the municipalities.

MODEL 2: LONG-TERM CARE COVERAGE COMBINED WITH THE SUBSIDIARITY PRINCIPLE

The second model of LTC coverage, used in Spain, includes a “hybrid system” with several elements supporting a basic income. Benefits are usually capped, and public financing complements the revenues and assets of the dependent elderly.

SPAIN

General principle

The 2006 Law No. 39 on the promotion of personal autonomy and care for dependent persons provided for the implementation of a national LTC program which covers all forms of dependence irrespective of causes (age, illness, etc.). Under section 33 of the law, the amount of aid is determined according to the resources of the beneficiary.

The law defines three stages of dependence and subdivides each into two levels. The law also determines the list of benefits in kind (from technical devices facilitating home stay to residency in a specialized establishment) which are proposed to the dependent by local social services and, if unavailable, by accredited private providers. The law favors in-kind services over cash, which is granted only if direct services cannot be provided.

The System for Autonomy and Attention to Dependence (SAAD) expands and supplements the public program by providing prevention services or reimbursement for services.

The benefit is most often used to pay for home care, as 1.4 million people—including a large majority of women (77 percent)—live alone. But this service is also used to cover the costs of accommodation in a specialized institution. Benefits are adjusted based on the beneficiary’s income, such that some participants must pay up to 90 percent of the cost of home care and up to 65 percent for other services.

Financing

Financially, the law provides for the cooperation of national and local governments, with financing by local governments to be at least equal to the national government’s share.

National contributions are divided into two parts: first a contribution for the dependent person and also an amount negotiated with local authorities. Furthermore, beneficiaries participate in the financing of the program according to their ability to pay (based on their income and assets).

LTC coverage in each country is still marked by its past, with a hybrid of Beveridgean and Bismarckian systems, as well as the conservative traditions of some countries, and family traditions of European countries.

MODEL 3: LONG-TERM CARE COVERAGE BASED ON SOCIAL ASSISTANCE

The third model, adopted by the U.K., is based on a means-tested minimum safety net. The following description applies mainly to England as benefits differ in other regions. Scotland, for instance, provides free personal care.

UNITED KINGDOM (England)

General principle

The 1990 Law on the National Health Service and Community Care Act made a clear distinction between health care, which is the responsibility of the National Health Service, and Long Term Services and Supports, which are part of the social care system, and entrusted to local authorities.

Individuals 65 or over who need LTC services can receive the benefit of assistance called “Attendance Allowance.” The amount of this benefit depends on the degree of dependency and is not subject to means testing. In 2013 the weekly benefit was £53 or \$79.15. This benefit is paid after a six months waiting period and is meant to be an income supplement. Three quarters of beneficiaries receive the maximum amount. Assistance from professional caregivers can also be reimbursed.

The National Health Service contributes toward the health care component of LTC by paying an additional aid of £101 per week for nursing facility costs.

Local authorities may support some LTC costs based on a person’s needs as well as resources, including their home. Local service coordinators must plan and manage how services are provided, but they do not have an obligation to provide them directly. The coordinators may use private providers or can reimburse the beneficiary for the needed services.

For expenses associated with nursing homes in general, costs are fully borne by persons whose assets exceed £26,500 (in 2013). Below £26,500 of assets, the amount of aid corresponds to the difference between the price charged by the nursing home and the income of the elderly, plus a £1 copay for every £250 of assets.

Financing

Funding is provided by the national government through tax.

CONCLUSION AND DEVELOPMENTS

Long-term care policies vary widely in Europe. Each country developed its program based on its unique history, politics, and cultural values, resulting in three major social models. The European Union so far has not intervened in the matter. The only

regulations that deal with the issue involve the coordination of programs:

- A regulation coordinating social security systems. LTC cash benefits are exportable, but not benefits in kind, when an insured person changes member country residency;
- A regulation on the mobility of patients mentions LTC only for the exclusion to the scope of its regulation. This exclusion is an important part of the political compromise that has prevailed.

In Spain the law on assistance to dependent persons is not yet fully implemented. Germany provides better LTC management for the elderly. The U.K. system is particularly complex, and the organization of services by local authorities results in a wide disparity of services provided to the elderly population.

Points of convergence

There are some similarities between the three programs:

- An emphasis on home care
- The development of cash benefits instead of benefits in kind, in the form of allocation of hours of services. This allows better control by the financing entity (national government, local government, and social security) and greater flexibility of use by the beneficiaries, especially for caregivers;
- A trend towards the free choice of providers, even for benefits in kind granted under the auspices of public authorities;
- A more limited role for private insurance. The role of private insurance is generally small in terms of the population covered.

In Germany, besides mandated and supplemental health insurance products, the life insurance industry has also developed LTC insurance products. The annuity model has become prevalent, just as in other European life insurance markets. Private LTC insurance premium depends solely on the issue age (in particular, it cannot depend on gender) and is capped at the maximum public insurance premium.

In Spain, several products and benefit types have emerged; benefits may take the form of a lump sum and/or temporary or lifetime income. Nevertheless, and despite the efforts made, penetration of this insurance is low (less than 2.5 million covered).

In the United Kingdom, the products offered are varied and innovative: in addition to pure risk contracts (which often take the form of single-premium annuity contracts), in many cases LTC insurance is backed by a savings product that requires a signif-

ificant capital contribution. In addition, some contracts provide against the risk of dependency longevity; these contracts have the particularity to cover the already-dependent person who pays a single premium to an insurer in order to have a life annuity (Immediate Care Plans).

In the case of Immediate Care Plans, the beneficiary receives a fixed monthly sum until the end of his care, and in the case of plans based on a property, Release Equity Plan (Reverse Mortgage in the U.S.), the beneficiary receives a loan on the property with the possibility of the loan being repaid after death.

Diversity of funding

When analyzing LTC financing more generally, regardless of payer, it appears that in most countries financing is diversified involving all resources: national and local taxes, social security, and private sources whether through the beneficiary’s resources or private insurance.

Private funding is significant in Germany and in Spain where benefits follow a fixed guideline. Private funding is low in the Nordic countries where the ceiling for households’ participation and a minimum benefit for the “remaining life expectancy” protect the poor, both at home and in institutions.

Expense projections

Public expenditure management of LTC in 2010 averaged about 1.5 percent of GDP in OECD countries, excluding institutional residence expenses. Projections give a very significant increase in these costs by 2050. The baseline average for OECD countries should reach 2.4 percent.

A variety of definitions

Apart from financing, which will be a major challenge in the coming years, it would be helpful to agree on a shared set of definitions for LTC and its measurement. As examples:

- A distinction of functional dependency and cognitive impairment. With the exception of France and the U.K. that mandate an age requirement, other countries aggregate physical and mental disability, or criteria for “duration and care “and “care utilization”, as proxies for Activities of Daily Living.
- Countries differ in their definitions not only of the level of dependency, but on the nature of service and the delivery system. In Sweden, for example, LTC is supplied not according to the concept of dependency, but according to one’s needs;
- The recognition and evaluation of the level of dependency differs by country:

Germany	Based on the assessment of local health care funds, using national guidelines (a grid) Classifications from Level 0 (low) to Level III (high) dependence Case specific for high dependence No age or income requirement Enforces Filial Support laws
Spain	Classification of dependency from Level I (mild) to Level III (high) based on BADL (Basic Activities of Daily Living) corresponding to 10 activities. Beneficiary participation based on revenue level. Recovery of assets
U.K.	Regional evaluation based on a national standard of need evaluation Age and income requirement Limits assistance to a maximum asset level

ENDNOTES

¹ A measure showing the number of dependents (aged 0-14 and over the age of 65) to the total working age population (aged 15-64).



Edith Bocquaire, Certified Member of the Institut des Actuaire, is a consultant in Paris, France. She can be reached at ebocquaire@orange.fr.



Etienne Dupoirque, FSA, MAAA, is a consultant in Bellows Falls, Vt. He can be reached at etienne@dupourque.com.

Long-Term Care Planning: A Worksite Perspective

By Ruth Larkin

In the past, employer sponsored long-term care (LTC) programs typically involved a group policy, offered as a stand-alone voluntary benefit, off-cycle from other benefit options. They were fairly “turnkey” and offered a limited number of options and choices, making it simple for the employee to make a selection and move on. After the initial open enrollment, these plans continued to hold a place in the employee benefits portfolio for new hires and the occasional late entrant enrollee, but they mostly sat dormant.

Over the past several years, most of these traditional group plans have closed. There are many reasons for this development, which include morbidity, mortality, lapse rates, interest rates, underwriting concerns, and the unique regulatory environment challenges of a group policy. On the surface, the industry looked like it was collapsing, leaving employers and advisors to wonder if this risk makes sense for them to address in their employee benefits strategy.

For those of us on the inside, we know that the data emerging from 40+ years of experience was pointing us in the direction of a paradigm shift. The carriers, the plans, the underwriting, the pricing and the platforms for these LTC programs had to change substantially to reflect the experience, the economy, the consumer’s preferences, and the regulatory process. The new employer sponsored LTC market that has emerged now includes group and individual (often referred to as “multi-life”) policies, preferred underwriting, spousal discounts, and more robust plan choices.

Today’s worksite has also evolved and changed, with three distinct generations of employees, each embracing different life-style, benefit and financial priorities, as well as different preferences for the use of technology and communication. With seven out of ten of these employees reporting that financial worries are their most common cause of stress, employers are moving past pure benefit program strategies and taking on a more holistic approach to supporting the needs of their multi-generational workforce.

This has given rise to the concept of Financial Wellness programs in the worksite. Employers looking to address workplace stress and productivity are integrating these Financial Wellness programs into their benefit plan offering to educate and empower the employee in the areas of budgeting, planning and saving. The result is less financial stress, better health and better benefit plan decisions that align their needs, priorities and finances.

For the Gen Xers and Baby Boomers, “retirement readiness” is a more pressing concern, and these programs are proving to have a very beneficial effect, according to a recent article in USA Today and a report by the Consumer Financial Protection Bureau (CFPB). In addition to income planning, these employees need to clearly understand the risk, cost and potential solutions to covering out-of-pocket expenses for health care and personal care in retirement.

A comprehensive Financial Wellness strategy includes these discussions, and an integrated benefits program includes a LTC plan so employees have the option to obtain this protection to cover this significant gap in their retirement. Adding an LTC option to the benefit portfolio provides employees with the education they need to make informed decisions at an earlier age, as well as access to this protection under the most advantageous underwriting criteria and gender rate neutrality.

For the LTC industry, these financial wellness programs are re-invigorating the awareness of this planning and the interest in employer sponsored LTC plans. For the employer, they significantly enhance the benefit portfolio without requiring premium contributions.

LTC planning and program implementations have and will continue to have a significant impact in the employer worksite. Employers know that the need for this protection is rising, and their mature employees still need access to these programs. As the market continues to evolve and change, so will the options and platforms used to deliver this protection. Today’s worksite LTC advisor also continues to evolve and adapt their capabilities and decision support tools to support these new plan options. ■



Ruth Larkin, CLTC, is regional sales leader at J. Manning and Associates headquartered in Chicago, Ill. She can be reached at Ruth@JManningLTC.com.

Continuing Care at Home

By Sarah Lentz Spellman

AN OVERVIEW

At its core, Continuing Care at Home (CCaH) is a life care membership program offering the same type of program offered in life plan communities (formerly known as continuing care retirement communities or CCRCs) that offer life care contracts. CCaH is designed for consumers who choose to live at home as they age, yet want the security that a life plan community offers. In return for payment of an entrance fee and a monthly fee, the member or participant is covered by a package of long-term care services designed to enable the older adult to remain independent and living at home as care needs increase. An initial screening of applicants (underwriting) is required, and only those not in need of services and with no degenerative diagnoses such as Alzheimer's Disease or Parkinson's are appropriate for the program. Access to services is typically related to a deficit in at least one of five to seven Activities of Daily Living (or ADL).

The typical package of services is comprehensive and addresses the social, spiritual, recreational and health needs of members, often including the following:

- Care coordination
- Home inspections
- Annual physical
- Access to campus
- Fitness center membership
- Social & educational opportunities
- Emergency response system
- Homemaker and personal care services
- Home nursing
- Live-in services
- Meals
- Transportation

- Adult day program
- Assisted living
- Nursing home
- Referrals for home maintenance, housekeeping, lawn care, etc.

Some, but not all, CCaH programs offer members access to the amenities on the sponsor's life plan community campus, such as dining, fitness and social activities. Most of the existing programs also offer a complement of social programs to foster relationships and support among members. Innovative technologies, along with traditional service options, are utilized to support members in their homes for as long as possible. Services may be provided by sponsoring organization employees or by sub-contracted vendors that are credentialed to ensure quality operating standards.

Care coordination is critical to member satisfaction and program success. Each member is assigned a care coordinator who is typically available to meet him/her at the start of program membership. The care coordinator gets to know each member personally, and, as a result of developing a positive, trusting relationship, becomes a valued advocate when a member's health changes. It is the care coordinator who will regularly assess a member's health and functional status, recommend needed services and obtain and manage those services on behalf of the member. The care coordinator will help to alleviate the burden of care from families for their loved ones and, with the member's permission, can communicate regularly with family members.

The pricing structure of CCaH programs is a life care model, offering a member a guarantee of future services for a one-time entry or membership fee paid when a person joins the program and monthly fees that begin the first month of membership. Entry fees vary depending upon the age of a person when he/she joins the program—higher for an older person and lower for a younger person. The monthly fees are designed to increase annually to reflect the overall operating experience and cost of living, but typically do not increase as a member needs care, thus protecting a member's assets from what is known as "spending down."

Actuarially sound pricing is key, of course. A clear definition of the package of services that will be offered and the cost or price of those services are required by the actuaries, along with an understanding of the refundability of entrance fees, the criteria a member must meet to qualify for services, the complement of administrative staff and related expenses, the daily cap on expenses and other specific financial information on which the pricing will be based. A 5 to 15 percent margin is included in

the pricing formula, which serves as a ‘risk buffer’ in the event of adverse experience. While Type A contracts predominate, it is not unusual for a consumer to be offered a choice of pricing options that may include:

- A variety of co-pays for future services;
- Home care only;
- Long-term care insurance policy credit;
- Limited total lifetime benefit amount;
- Limited daily spending caps; and
- Refundable membership fee.

One program has designed a pricing approach that incorporates an entrance fee paid over time. This same program offers a variety of pricing options similar to LTC insurance, including several benefit period options, daily expense caps and elimination periods.

ACTUARIAL RISK IS MANAGEABLE

There are three more significant risks. The first is when organizations mistakenly believe that a market exists when it doesn’t. The second is an admissions screening risk; and the third is managing the delivery of services (expenses) to the contract. While the second two directly link to the actuarial projections, they are, in fact, operational issues and deserve to be considered as such.

- Credible, objective market research is required. And, not every market will be large enough to support a CCaH program, nor will every market have consumers who are interested in this type of program. Early market share testing should incorporate the actual market share that existing programs have been able to capture and should consider the distinctions between those market areas. Statistically sound consumer research (which is more likely to be accomplished through telephone surveying rather than mail surveys) is necessary to understand consumer interest in the concept, followed by focus group research to gather intelligence regarding price sensitivity, services of interest and preferred pricing plans. A sponsor considering the development of CCaH must be willing to abandon the development of CCaH if the market indicators are negative—rather than plowing forward under the mistaken impression that “people will buy in, once they understand the program.” While the financial risk associated with a start-up is significantly less than the risk accompanying the development of a facility or campus, the reputational risks are critical to consider. And steady enrollment of new members with the ability to reach a critical mass is important to ensuring a successful program.



- Screening risk means that no matter how good the actuarial projections were or are, making decisions to admit members who don’t meet the health and risk criteria will drive the program into a crisis. Experience shows that CCaH programs will reject (on a percentage basis) more applications for membership than a life care or life plan community will reject. And that’s the way it should be. It is important to remember that all service expenses are incremental for a CCaH program and adverse selection can be detrimental to the financial health of the organization.
- It is critical that only those services and related expenses that are clearly defined in a member agreement are paid for by the CCaH program. Program management should think creatively when developing a service plan, however, the creativity must be kept within the confines of what has been priced by the actuaries. For example, a program pays for items such as ramps and other home improvements for its members, but these items were not included in the package of services priced by their actuaries. This type of spending outside of the member agreement could have adverse long-term financial implications for the program.

According to Dave Bond, FSA, MAAA, managing partner of CCRC Actuaries, “The key focuses of CCAH management with respect to financial success are enrollment goals, underwriting standards, program administrative expenses and health care utilization and cost. It is important that the management team constantly monitor all four components, because results will be different than expected. These are relatively small programs in terms of risk theory and risk management. But more importantly, the CCaH

operator should understand that adverse experience does not necessarily mean financial failure, as there are an array of potential remedies that can be implemented, including annual fee increases, and if necessary, administrative expense reductions, managing just as life plan communities have done over the years.”

CONCLUSION

Continuing Care at Home (CCaH) is neither a potential jackpot nor a risky gamble. Much like most of the services provided to seniors in this country, it is a serious effort to meet consumer needs and expectations. As most market research underscores, only a small percentage of older adults in the United States plan to move from their homes as they age, yet many will need supportive services in order to remain as independent as possible. Continuing care at Home is but one way that innovative and entrepreneurial providers are seeking to help mold the future—in most cases building on core strengths while recognizing the key differences between the business that has been developed over time and the demands of a new and distinct service line.

Like most innovations, CCaH attracts replicators as well as skeptics. Both have a role in helping to shape, refine and strengthen what has to date been a successful model of innovative care. We believe that the model is entering a new stage of maturity, not just in terms of overall experience and the utilization of health care related services, but as a platform leading to expanded roles for the care coordination expertise that has been incubated, new product variations that are responsive to housing market trends and new approaches to engender community among members.

There are, of course, risks, just as there are for every service or program. Managing that risk is part of what leaders do every day. Providers interested in CCaH should focus first on determining whether a market exists in their area and then proceed to design an actuarially sound and consumer responsive product. ■



Sarah Lentz Spellman, LNHA, MAS, is a principal at CliftonLarsonAllen in Plymouth Meeting, Penn. She can be reached at sarah.spellman@claconnect.com.



LIVING
to 100

SOCIETY OF ACTUARIES
INTERNATIONAL SYMPOSIUM

Jan. 4–6, 2017
Orlando, Florida

Save the Date

Registration for the 2017 Living to 100 Symposium will open soon. This prestigious event brings together a diverse range of professionals, scientists and academics to discuss longevity.

Learn more at LivingTo100.SOA.org.



2016 SOA Health Meeting

June 15–17, 2016
Philadelphia, PA

Be a part of the leading
event focused on health
industry topics.

Register by May 13
and save \$200.

HealthMeeting.SOA.org



SOCIETY OF ACTUARIES

475 N. Martingale Road, Suite 600
Schaumburg, Illinois 60173
p: 847.706.3500 f: 847.706.3599
w: www.soa.org

NONPROFIT
ORGANIZATION
U.S. POSTAGE
PAID
SAINT JOSEPH, MI
PERMIT NO. 263

