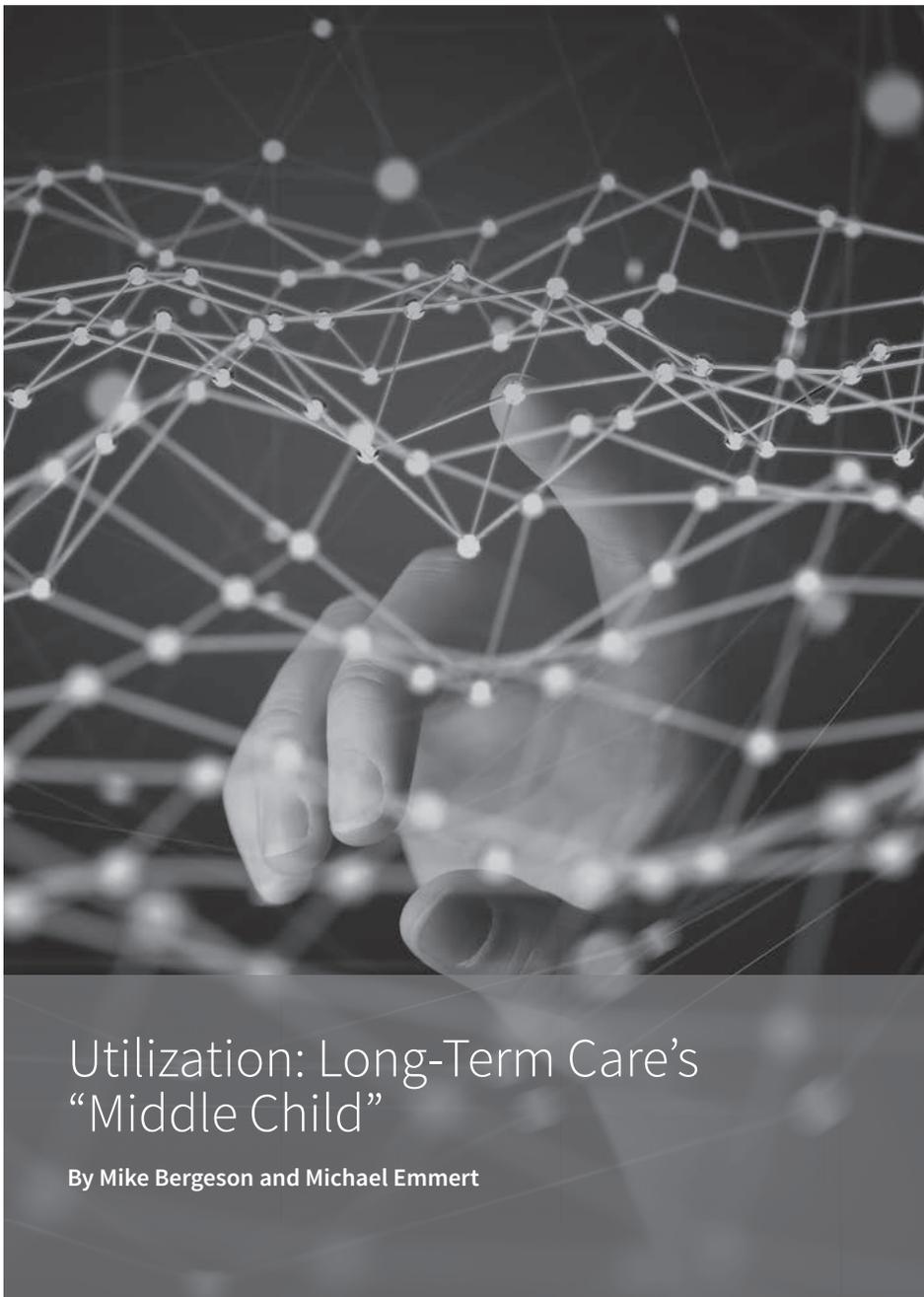


Long-Term Care News



**SOCIETY OF
ACTUARIES**

**LONG TERM CARE
INSURANCE
SECTION**



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Long-Term Care News

Issue Number 46 • December 2017

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
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Section webpage at <http://soa.org/ltc/>

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Publication Schedule

Publication Month: April 2018
Articles Due: January 2018

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Chairperson's Corner

By Rebecca Tipton and Robert Eaton

As I complete my year as the chair of the LTC Section Council, I'd like to thank all of the council members, friends of the council and SOA staff for their continued involvement and hard work to support this year's initiatives. It requires many volunteers to accomplish the work of the LTC Section.

The section council has accomplished a great deal. This past year we:

- Developed an LTC Regulator Forum to continue to educate regulators on the LTC industry and some of the current challenges. These forums have been very well attended and deemed highly valuable
- Supported the transition of the Think Tank to a "Do" Tank, which consisted of gaining approval for funding from the SOA's Research Expanding Boundaries (REX) Pool to perform consumer research specifically focusing on two of the "paying for care" concepts
- Expanded marketing initiatives which included launching a new and improved website, developing a social media strategy with a LTC LinkedIn group (<https://www.linkedin.com/groups/2768897>) and working to build more relationships with industry trade groups
- Updated the mission statement to more accurately reflect the changing LTC industry
- Developed educational sessions for several SOA conferences and other industry conferences
- Published three issues of *Long-Term Care News* covering a wide variety of LTC topics; and
- Developed and hosted two LTC webcasts and four podcasts

I am grateful for the opportunity to have served on the LTC Section Council the past three years. It's been an honor to work with such a great group of individuals and to lead the council the past year. The incoming chairperson is Robert Eaton. My best wishes to him and the section council for a successful year! Lastly, please get involved! There are many opportunities to volunteer with the LTC Section so I'm confident there's a role that will fit your interests.

FROM THE INCOMING CHAIRPERSON,
ROBERT EATON:

I am grateful for the opportunity to serve as chairperson of the LTC Section Council for the next year. My experience over the last two years has impressed upon me how fortunate we are as a section to have such dedicated and effective volunteers.

As I enter my last year on the section council, I thank the outgoing members for all of efforts. **Bob Yee** has provided his guidance and wisdom. His contributions are invaluable, as Bob brings a perspective from leading many of the industry's discussions on LTC insurance matters for many years.

Juliet Spector served, among other roles, as our first-rate newsletter editor, bringing us content from across the LTC industry. She has been incredibly generous in advising me as I took on that role, and Juliet has always been eager to give her time to our council.

Rebecca Tipton governed our section council with efficacy and purpose. Rebecca has always acted in the best interest of the LTC Section. She's been vigilant in ensuring that all decisions are made in the interest of the section council members, and that all of our actions tie back to our mission statement.

I am excited to see **Jamala Murray Arland**, **Jan Graeber** and **Matt Morton** elected to the LTC Section Council! We have the good fortune to benefit from their myriad of experiences and their professionalism for the next three years.

When this publication comes out, the LTC Section Council will have convened our 2018 planning session. Please stay tuned for emails and on www.soa.org/ltc to stay current with the section council activities. I'm optimistic for the council's mission in the coming year. ■



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Up Front with the SOA Staff Fellow

By Joe Wurzburger

Life is full of contrasts.

I write this from Caesar's Palace in Las Vegas in early October, where I am attending InsureTech Connect. InsureTech is a rapidly developing field that is already revolutionizing the property and casualty insurance field, and it is beginning to impact health and long-term care, as well. I am surrounded by more than 3,500 innovative entrepreneurs with unwavering optimism, and the enthusiasm is contagious.

Yesterday, the largest mass shooting in the modern history of the United States took place only a short walk from where I sit now. More than 50 people lost their life, and more than 500 were injured. It is impossible to properly capture the degree of tragedy in words. Fear and sadness threaten to extinguish the light from these otherwise optimistic people.

How do we make sense of these contrasts? Perhaps nothing can ever truly make sense of the tragedy that occurred yesterday. But we can find ways to move forward. Maybe more importantly, we can decide to not just move forward but also to rededicate ourselves to doing good in the world.

At InsureTech Connect, attendees are determined to press on. The conference has set up a process by which attendees can contribute to organizations that are helping families impacted by the tragedy. And while it may seem a bit insignificant relative to the tragic loss of life yesterday, the entrepreneurs surrounding me truly feel their innovations will make the world a better place. So they go forward, saddened but not deterred, unwilling to allow their intent to disrupt the insurance industry be disrupted by the actions of a coward.

For those of us in the LTC industry, we need to also look for ways to make the world better. We share a goal of helping people when they need it. Historically that has meant helping people finance long-term care in the form of traditional standalone insurance products. As those products have faced challenges, we need to make sure our desire to help is resolute. Much as an entrepreneurial spirit is driving innovation in InsureTech, we need to be willing to think outside the box, not



just to help the LTC insurance industry but also the consumers who depend on it.

New creative products are already hitting the market, and other ideas are being explored through the SOA's LTC Think Tank. Concepts dreamed up two years ago as part of the Think Tank seemed at the time like space age wizardry; now I see very similar concepts being demonstrated at the InsureTech Connect expo. Innovations in medicine and technology give us hope that fewer people will need long-term care and will instead be able to continue to live comfortably in their own homes with dignity. Developments in our industry provide plenty of reasons for optimism in spite of challenges.

As long as we are discussing ways to make the world better, consider doing so in ways that expand beyond your immediate responsibilities working in long-term care. Donate blood or contribute to your favorite charity. In your professional life, make a point to genuinely thank someone or give praise for a job well done. Take a less experienced colleague under your wing and serve as a mentor. None of these things may individually change the world, but small acts of kindness add up. And maybe they'll add up to something truly remarkable.

In the long-term care industry, we have many amazing people working tirelessly to make a difference. Hopefully you're already one of them. No matter what challenges get in your way, stay the course. What we do is important, and it can't be defeated by adversity.

Embrace the contrasts in life, both personal and professional, and don't be deterred. Together we will make a difference. ■



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Utilization: Long-Term Care’s “Middle Child”

By Mike Bergeson and Michael Emmert

For the past couple of decades, the long-term care (LTC) insurance industry has been refining assumptions—especially with voluntary lapse rates, mortality and length of stay, as there were significant misses in these assumptions at the time of original pricing. Substantial progress has been made in understanding the intricacies and realities of these assumptions, and incorporating them into pricing and reserves.

With so much focus on these “big ticket” issues, utilization has been, perhaps, not studied as closely. However, utilization has its own nuances and can also have significant impact on profitability and pricing.

Today, utilization is being more closely examined. A major reason is the increasing attention on first-principles modeling, which incorporates a wider variety of individual assumptions from the outset rather than using simpler claim cost aggregates. Companies have also experienced significant changes to reserves due to utilization assumptions that were too low. As companies continue to look for ways to better manage their products, continuing to pay more attention to utilization is a natural next step. In this article, we’ll discuss key factors in accurately calculating utilization, and what they mean for LTC insurance products and premiums.

WHAT IS UTILIZATION?

At its most basic, utilization is the amount of benefits that are used when an insured goes on claim compared to the benefits available. It is typically broken into day and dollar components.

Days utilization is a measure of the number of days that services are used compared to the number of days available. For nursing home and assisted facility settings, days utilization is often extremely high as insureds in these settings need to receive care every day. However, home care services are a different story as home health care services are not always, or even typically, provided seven days a week. Often, insureds are only receiving services four to five days a week, with the remainder provided by a spouse or family member or not needed because the individual is able to provide self-care some of the time.

Dollars utilization is a measure of the actual expenses reimbursed under the policy compared to the policyholder’s daily benefit amount. Utilization can also be measured on a weekly or monthly basis depending on the terms of the policy. This article will generally assume a daily basis unless noted otherwise.

The other side of the utilization coin is known as “salvage.” While the term salvage is sometimes used interchangeably with utilization, they are actually complements of each other. Salvage is the amount of benefit that is not used, which can be represented by:

$$\text{Salvage} = 1 - \% \text{ utilization}$$

Salvage represents savings for the insurer, because it is the difference between the maximum the insurer could pay and what they actually pay. If an insured only requires five days of home health care services per week, the insurer would benefit from the salvage of two days of non-use.

With the basics of utilization covered it is important to know why utilization should be studied.

WHY DOES UTILIZATION MATTER?

Utilization is a component of the morbidity assumption, which is ultimately used in any projection of future claims. This projection could be for, but not limited to, pricing, cash flow testing, or a gross premium valuation. Actuaries rely on these projections in order to properly price and manage LTC blocks of business.

Utilization is also a key input to claim reserve calculations. Claim reserves are very sensitive to utilization and an inappropriate utilization assumption can have a material impact. For example, if a utilization assumption is understated by 10 percent, the disabled life reserve balance would likewise be understated, but the actual amount of understatement in the disabled life reserve balance would often be less than 10 percent due to extension of benefits (described more below) and the potential wear-off of salvage over time. As a result, refinements in a utilization assumption can lead to meaningful changes to reserve levels. Refinements can be either beneficial (allowing the company to release reserves) or adverse (requiring the company to hold additional reserves).

Although utilization plays a significant role in setting reserves, utilization can be difficult to estimate and set. Estimating utilization is difficult because LTC claims have low frequency. A small sample size of claims makes it difficult to develop a robust utilization assumption.

Another reason to understand utilization is for non-duplication of coverage and the possible impact on new LTC policies



being sold. There have been recent discussions regarding whether a non-duplication of coverage provision should be allowed or not. While this article does not opine on that subject, it is important for the pricing actuary to follow these discussions to ensure that the utilization assumption used in new product pricing is appropriate.

Now that we have seen why utilization is important to consider, we will look at key things to consider when developing a utilization assumption.

KEY CONSIDERATIONS IN CALCULATING UTILIZATION

Utilization seems like a simple concept, but it has a number of nuances that must be correctly taken into account to avoid miscalculations. Being aware of these nuances will allow for appropriate calculations of utilization to accurately project costs and set claim reserves.

Trend

While it would be amazing to see #utilization trending on Twitter that is not what we are referring to with trend. Trend is a combination of inflation protection and cost of services, and becomes relevant when determining dollars utilization. Since trend is generally not applicable to days utilization, it is important to study the day and dollar utilization components

separately so that trend can be correctly applied to only the dollar component.

When a plan features inflation protection, it must be accounted for when calculating utilization. In evaluating claim data to calculate dollars utilization, the daily benefit must be properly inflated from the time of policy inception to the time of claim payments. This includes inflating the daily benefit during the course of the claim when the contract specifies that inflation continues during a claim. Properly accounting for inflation is not only necessary for policies with automatic inflation, but also policies that have guarantee purchase options that allow policyholders to periodically add additional amounts of daily benefit to their policy.

Inflation protection also needs to be considered when thinking about how the dollars utilization is expected to change in the future. If the cost of services are expected to increase at a rate equal to that of the inflation protection option, dollars utilization will remain constant. However, if the cost of services are expected to rise faster than inflation protection increases the benefit amount, dollars utilization will increase over time and salvage will decrease. On the flip side, if the cost of services are expected to rise slower relative to the inflation protection

option, dollars utilization will decrease over time and salvage will increase.

Inflation protection can also change over time, such as when an insured drops or reduces their inflation protection. This can be especially prevalent in a "landing spot" scenario in which an insurer offers to offset a premium increase by decreasing inflation protection. When inflation protection is reduced by insureds, companies need to be careful to account for increases in utilization that result from the lower inflation rate in the daily benefit.

Since inflation protection is the same across all sites of care, but the cost of services may change at different rates by site, trending of dollars utilization may likewise need to vary by site of care.

Service Periods

Claim data must be used appropriately when calculating utilization. When service periods overlap, it is important to not double-count days. Table 1 shows how miscalculating in this fashion can affect the calculated utilization. If the overlapping service periods are calculated individually, utilization will be underestimated because a portion of the daily benefit available is being double counted.

For ongoing claims, gaps in service must also be accounted for to avoid introducing errors into the utilization calculation, as shown in Table 2. In this case, utilization will be overestimated because the days of zero utilization are not taken into account. The 70 percent combined total utilization represents the combined impact of the day and dollar components.

Benefit Payment Type

Utilization and salvage vary based on the benefit payment type of an LTC policy.

Indemnity and disability (sometimes referred to as cash) policies ought to see 100 percent dollars utilization and 0 percent salvage because these policies pay the full daily benefit maximum regardless of the actual costs incurred. An indemnity policy can still have days utilization under 100 percent, while a disability policy generally has 100 percent days utilization because the full benefit is paid while the insured meets the benefit eligibility criteria.

A reimbursement policy will see varying degrees of utilization and salvage on both a days and dollars basis because services are only reimbursed for the actual cost incurred up to the daily benefit maximum and for the days in which services are provided.

Table 1
Overlapping Service Period with \$150 Daily Benefit

	Service Start Date	Service End Date	(A) Days of Service	(B) = (A) x \$150 Pool Available	(C) Claim Payment	(D) = (C) / (B) Utilization
Service 1	6/1	6/5	5	\$750	\$600	80%
Service 2	6/3	6/10	8	\$1,200	\$800	67%
Total	6/1	6/10	13	\$1,950	\$1,400	72%
Combined	6/1	6/10	10	\$1,500	\$1,400	93%

Table 2
Gap in Service Period with \$150 Daily Benefit

	Service Start Date	Service End Date	(A) Days of Service	(B) = (A) x \$150 Pool Available	(C) Claim Payment	(D) = (C) / (B) Utilization
Service 1	6/1	6/4	4	\$600	\$550	92%
Service 2	6/7	6/10	4	\$600	\$500	83%
Total			8	\$1,200	\$1,050	88%
Combined	6/1	6/10	10	\$1,500	\$1,050	70%

Table 3
Availability of Salvage by Benefit Payment Type

Benefit Payment Type	Days Salvage	Dollars Salvage	Overall Salvage
Reimbursement	Yes	Yes	Yes
Indemnity	Yes	No*	Yes
Disability/Cash	No	No	No

*In some cases dollars utilization slightly less than 100 percent may be observed on indemnity policies.

Table 3 summarizes the availability of salvage for each type of LTC policy.

Extension of Benefits

Most LTC policies have a defined pool of money available to a policyholder. This pool of money is determined based on the daily benefit, inflation protection option, and benefit period of the policy. The pool of money is available to policyholders even after the benefit period has “elapsed.” This means that if a policy has experienced less than 100 percent utilization and is still in force at the end of the benefit period, the remaining benefits will be available to the insured.

For example, a policy with a \$100 daily benefit and a two-year benefit period would have a total pool of \$73,000 (= \$100 x 2 x 365) available. If this insured only utilized 75 percent of benefits available over the two-year benefit period then \$18,250 [= \$73,000 x (1 – 75%)] would remain in the pool and would be available for use by the policyholder after the two-year benefit period.

This “extension of benefits” for policies with a pool of money policy structure needs to be considered when developing a morbidity assumption.

Table 4
Effect of Not Accounting for Transfers: \$100 Daily Benefit

Daily Cost of Care by Site of Care			
Claim Year	Home Health Care	Nursing Home	Home Health Care transfer to Nursing Home
1	\$75	\$100	\$75
2	\$75	\$100	\$75
3	\$75	\$100	\$75
4	\$75	\$100	\$100
5	\$75	\$100	\$100
Total	\$375	\$500	\$425
Utilization	75% = \$375 / \$500	100% = \$500 / \$500	85% = \$425 / \$500



One-Time Payments

One-time payments, such as those for durable medical equipment or home modification benefits, need to be accounted for when calculating utilization. These payments are generally reimbursed up to a contracted amount, often a multiple of the daily benefit level, but can be recorded in the claim data as occurring on one day.

Situs

Where LTC services take place can have a significant impact on utilization. Over the course of a claim the situs of care can also change, which further complicates utilization. One example is when an individual’s health deteriorates resulting in a transfer from a home health care setting to a facility setting. Transfers need to be accounted for in some fashion or there will be reserving misstatements, as shown in Table 4.

Table 5
Benefits Paid and Utilization by Adjudication Method Policy with \$100 Daily Benefit

Day	Cost of Care	Adjudication method	
		Daily	Weekly
Sunday	\$150	\$100	\$500 = min (\$500 total cost of care, \$700 weekly benefit amount)
Monday	\$0	\$0	
Tuesday	\$100	\$100	
Wednesday	\$150	\$100	
Thursday	\$0	\$0	
Friday	\$100	\$100	
Saturday	\$0	\$0	
Total	\$500	\$400	
Utilization		57% = \$400 / \$700	71% = \$500 / \$700

As this simple example illustrates, failing to account for a future transfer, in this case from a home health care setting to a nursing home at the beginning of claim year four, would result in significantly underestimating utilization over the entire claim at 75 percent instead of 85 percent.

While we do not know ahead of time which claims will transfer and when, it is important that transfers are accounted for when setting a utilization assumption. Companies can use either starting situs or current situs to calculate utilization.

Utilization based on current situs will display greater volatility in disabled life reserves for individual claims as they transfer. When using current situs, the mix of claims by site and how that mix may change in the future when projecting morbidity for the block needs to be considered since the mix of claims by situs today is likely not the same as what it will be 1, 5, 10 or 20 years from now.

When using starting situs the utilization will need to be either higher or lower than the current situs utilization because of the embedded impact of future transfers. For example, Table 4 demonstrates that the utilization assumption needs to be higher for a claim originating in a home health care setting to account for the possibility of transfers to higher utilization situs.

In any case, while there are valid reasons to calculate utilization rates based on either starting situs or current situs, the important thing is to be consistent. The methodology chosen will have an impact on experience studies, reserve calculations, and projections. There should also be consistency between utilization and claim termination assumptions in terms of developing the assumptions based on the starting situs or current situs of a claim.

Adjudication of Benefits

Utilization can also be affected by the adjudication of benefits, whether they are paid on a daily, weekly, or monthly basis. If

benefits are adjudicated less frequently than daily, utilization can be higher. This is because benefits that are not fully utilized during the adjudication period, either a result of days or dollars salvage, can, in effect, be used by the insured on another day during the adjudication period. Table 5 illustrates differences in utilization for a claim under daily and weekly adjudication of benefits.

CONCLUSION

While utilization may have been the forgotten child of LTC assumptions, it is nonetheless important for companies to consider because of its potential impact on pricing, profitability, and reserves. While not ignored in the past, utilization is now getting its "time in the sun" with some of the other assumptions. With a number of nuances that are easily overlooked and often a lack of good experience data to work from, it can be challenging to develop and set an appropriate utilization assumption. With the growing use of first-principles models, understanding the complexities and intricacies of utilization is becoming a valuable asset in an LTC actuary's arsenal. ■



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The SOA Explorer Tool is a global map showing locations of fellow SOA members and their employers, as well as actuarial universities and clubs.

Explorer.SOA.org



Hope for the California Partnership for Long-Term Care?

By Louis H. Brownstone

The California Partnership for Long-Term Care (Partnership), a great concept, has fallen upon hard times. Sales are almost non-existent because the insurance carriers have priced 5 percent compound inflation, heretofore a California Partnership requirement, to dizzying heights. Five out of the original seven carriers have withdrawn their membership, and only CalPers and Genworth remain.

But finally, some stakeholders have gotten together to revive the Partnership. Senator Liu of Glendale enthusiastically sponsored SB 1384, which was passed and signed by Governor Brown in September 2016. SB 1384 had three important elements:

1. It allowed for inflation options in Partnership policies besides 5 percent compound;
2. It created a new type of Partnership policy at a lower cost which covers care in all settings except a nursing facility;
3. It required the formation of a task force of interested stakeholders to advise and assist in implementing reforms to the Partnership.

The Partnership proposed several inflation options as alternatives to 5 percent compound inflation, all built around a minimum of 3 percent compound inflation:

- a. A plan with a choice of 3 percent, 4 percent, or 5 percent compound inflation;
- b. A plan with age-based inflation rates, starting a 5 percent compound and reducing to 3 percent compound inflation at age 70;
- c. A hybrid product which would include 3 percent compound inflation.

- d. A new home and community plus plan without nursing facility coverage which would include 3 percent compound inflation.

At this point, these are merely proposed plans. The Partnership has promised that it will be flexible in approving different structures of plans. One such flexible idea is to approve as low as 2 percent compound inflation for home health care only policies. There will be less emphasis on all carriers conforming to a specific structure in their plans, so that some of the unique concepts in their non-Partnership policies can be brought over to Partnership policies.

These structures could include a total pool of money benefit, rather than a monthly benefit. It could also include a dollar elimination period, rather than a daily or monthly benefit with an elimination period calculated in days. Another idea is to have a pool of money which could cover many non-essential benefits in one bucket. Carriers would be encouraged to file structures currently in their non-Partnership plans in order to ease their filing process and obtain speedy approval.

There's a great deal of bad experience that has to be overcome in order for the carriers to come back to the table.

On the new home and community plan, the minimum daily benefit would be 50 percent of the cost of a nursing facility, now \$150/day. This would reduce the cost of a Partnership policy by about 30 percent from its minimum daily benefit of \$210. One possible structure would reduce the home care benefit to as low as about \$100/day while keeping other community care at the higher daily benefit level. Actuaries may find that the cost of the coverage may not be much different from the cost of a comprehensive policy, but the premiums at \$150/day could be more affordable for the middle class. Remember that the purpose of the Partnership is to provide lifetime coverage through a private/public partnership that would be affordable for the middle class. People are increasingly avoiding nursing facilities, and this policy covers them where they want to be covered.

In addition, a Senate spot bill has been introduced which would give new Partnership plans "urgency status." This would create a swift path for plan approvals, which have still been very slow in California. There are at least fifteen insurance policies with long term care benefits available in virtually all states which have not been approved in California. "Urgency status" would



eliminate this logjam for Partnership filings, so that approvals would hopefully happen in several months rather than several years or not at all.

The Department of Health Care Services is now putting its finishing touches on revised regulations. These will soon be open for public review before they are finalized. However, insurance carriers will be invited now to file Partnership plans in order to speed up the approval process.

The Task Force had their first meeting on April 3, 2017 and have had two additional meetings as of September 27. About twenty enthusiastic people attended each meeting, either in person or remotely, and there was good analysis by Brenda Bufford of the Partnership and others who participated. New proposals have been offered with 3 percent compound inflation with premiums as low as \$100/month per person. This would make premiums affordable for people with moderate income and assets.

Even better, these plans would in effect offer lifetime protection for this target audience, unlike previous buyers with substantial assets and income. For example, if a person had \$100,000 in assets, he or she could purchase a partnership plan with a benefit limit of \$100,000. Once that person became sick, he or she could use up the benefits in the policy, apply for Medi-Cal, protect the \$100,000 in assets, and be covered for the rest of his or her life. With Medi-Cal waivers, he or she may be able to stay at home

for at least most of the period of care. What a bonanza! Lifetime protection, preservation of assets, and possible home care. That's what we all want in a long term care insurance policy!

Will carriers file? Their reception to the Partnership has been pretty cold with the exception of Genworth, the one carrier that's still in the Partnership. The five carriers that have withdrawn from the Partnership have done so because either sales were extremely low, costs were extremely high, or because they exited the industry. There's a great deal of bad experience that has to be overcome in order for the carriers to come back to the table.

I believe they should file. Urgency status would greatly reduce their filing cost. Policies would be saleable even with 3 percent compound inflation. Lower premiums and some education money will help galvanize agents and the public. A private/public partnership continues to be the most viable solution to our growing long term care crisis. Washington, D.C. won't provide a solution. California is in the best position to lead the nation. ■



Louis H. Brownstone is Chairman of California Long Term Care Insurance Services, Inc and ex-chairman of the National LTC Network. He can be reached at louis@cltcinsurance.com.

Rate Increase Approaches Impact LTC Policyholder Behavior

By Ray Nelson

Premium increases on in-force long-term care (LTC) insurance policies have been a minefield for the LTC industry for nearly the past 20 years. As a company that works closely with LTC insurers, state insurance departments and policyholders, we understand the difficulties that LTC rate increases impose on all parties involved. Rate increases are hard on everyone involved:

- The policyholder bears the heaviest burden. Often at an advanced age, the policyholder is forced to make difficult choices between paying the higher premiums or accepting reduced benefits in order to mitigate the premium increase.
- The companies spend an enormous amount of time and resources to coordinate a very complicated, labor-intensive effort that involves many departments/personnel/communications and can last several years from start to finish.
- And finally the state regulator needs to evaluate the actuarial justifications of the requested increase, consider the financial/solvency needs of the company, while yet protecting the consumer insureds (and field complaints from all parties throughout the process).

Our experience has been that most everyone involved with rate increases at the companies and states have been doing their absolute best to help policyholders through these difficult but necessary rate increases. There have been great improvements in the information and communications provided to policyholders at the time of rate increases. Companies have worked hard to improve on the availability of meaningful benefit modification options, as well as the ability to communicate individual customized alternatives within the premium increase notifications.

The landscape surrounding LTC insurance premium increases has been continuously evolving since such inforce rate increases became more commonplace in the early 2000s. Many aspects of LTC rate increases have changed in recent years.



For example, in the beginning, insurers generally pursued rate increases with a simplified, straight-forward structure that requested a level increase percentage across all in-force policies. Now many insurers take a more targeted approach to premium rate increases. Often higher rate increase percentages are requested for plan designs or issue ages that are impacted most by the changes in experience and assumptions that are driving the needs for the increase. In turn, smaller increase percentages, (or even no increases at all), are requested in other segments of the block that are not impacted as greatly by changing assumptions.

Evolution in the area of LTC rate increases has not been limited to insurance companies. State insurance department regulators are placed in the very difficult position of balancing the financial/solvency needs of the insurer while still providing meaningful consumer protections to LTC policyholders. In walking this fine line, several state insurance departments have also modified their approaches to reviewing company rate

increase filings and seemingly their philosophies with regards to rate increase approvals in recent years.

STATE APPROACHES

As more legacy LTC blocks have encountered the need for sizable rate increases, there has seemingly been some evolution of state regulatory approaches when reviewing medium to large LTC rate increase requests. For a long time, it seemed as though most states fell into one of two categories when reviewing such filings. The first category consists of states that would review such filings and, provided the state was satisfied the requested increase was actuarially justified, would ultimately approve the entire requested increase. The second category would be those states that would perform similar reviews of the filings, but would generally attempt to protect consumers from larger rate increases by limiting the company to an increase that was smaller, (sometimes significantly so), than requested. In most cases, these states would request that the insurer pursue the remainder of the increase at a later date (usually one year). This resulted in more frequent, but smaller, rate increases for policyholders in these states. It is important to note that states approving the entire rate increases were trying just as hard to protect policyholders as the states limiting the increases. States approving the full increases believe that although the larger increase is painful for policyholders, in the long run the policyholders is better off to be aware of the full increase so they can best manage their decisions around paying the higher premiums versus modifying coverage.

In recent years, a subset of states has taken a hybrid approach that somewhat blends the philosophies previously discussed. In an effort to limit the one-time impact to policyholder premiums, yet provide the policyholder with more complete information about upcoming rate increases, there are now several states that will approve a rate increase but ask the insurer to phase-in the increase to policyholders over a selected number of years. The entire rate increase schedule of the current and future premium changes is communicated to the policyholder during the rate increase notification process. The intent is that policyholders are well informed of the entire rate increase amount, yet receive some protection from having their premiums increase by very large amounts all at one time.

Having seen these different approaches for some time now, I was curious what, if any, impact would the different rate increase philosophies have on policyholder behavior. Do policyholders accept rate increases, or modify coverage and premiums, in a similar manner when the rate increase is approved and implemented differently? Does the level and timing of rate increase approvals drive different behaviors? Can we conclude anything about the level of consumer protection that is ultimately provided with these approaches?

BACKGROUND

We have been able to view the rate increase approval experience and monitor policyholder activity for a particular LTC block's recent medium to large size rate increase in an effort to look at such impacts. This block began the filing and implementation of the national rate increase about four years ago. Although there is still some ongoing implementation activity, the vast majority of the block has received all or part of the increase that was initially filed (roughly 94 percent of the filed increase is now approved). In general, policyholders fell into one of the three state categories previous described:

- Entire rate increase was approved and implemented at one time.
- Entire rate increase was approved, but implementation was in a scheduled series (usually two or three steps) with the policyholder informed of entire series of increases at each communication.
- Smaller increase was approved, requiring one or more catch-up filings, policyholder only able to be informed about the approved partial increase at each step.

A similar number of policies fell into each of the above categories, with each category containing at least 7,500 impacted insureds.

RESULTS AND OBSERVATIONS

In general, policyholder reactions to the rate increase studied here have varied based upon the category of state approval as previously described. Table 1 shows that policyholders receiving a one-time approval of the entire rate increase and those receiving notification of the entire series of rate increases have modified coverage, (either by modifying benefits or by accepting contingent nonforfeiture), at a slightly higher ultimate rate than those policyholders receiving only partial rate increase notifications.

Table 1
Percentages of Policyholders Choosing to Modify Coverage by State Approval Category^{1,2,3}

	Benefit Modifications	Contingent Nonforfeiture	Total Modifying Coverage
All Policyholders	20.2%	9.1%	29.2%
One-Time Approval	20.0%	9.4%	29.4%
Pre-Approved Series	22.8%	7.9%	30.7%
Partial Approval(s)	17.6%	9.9%	27.5%

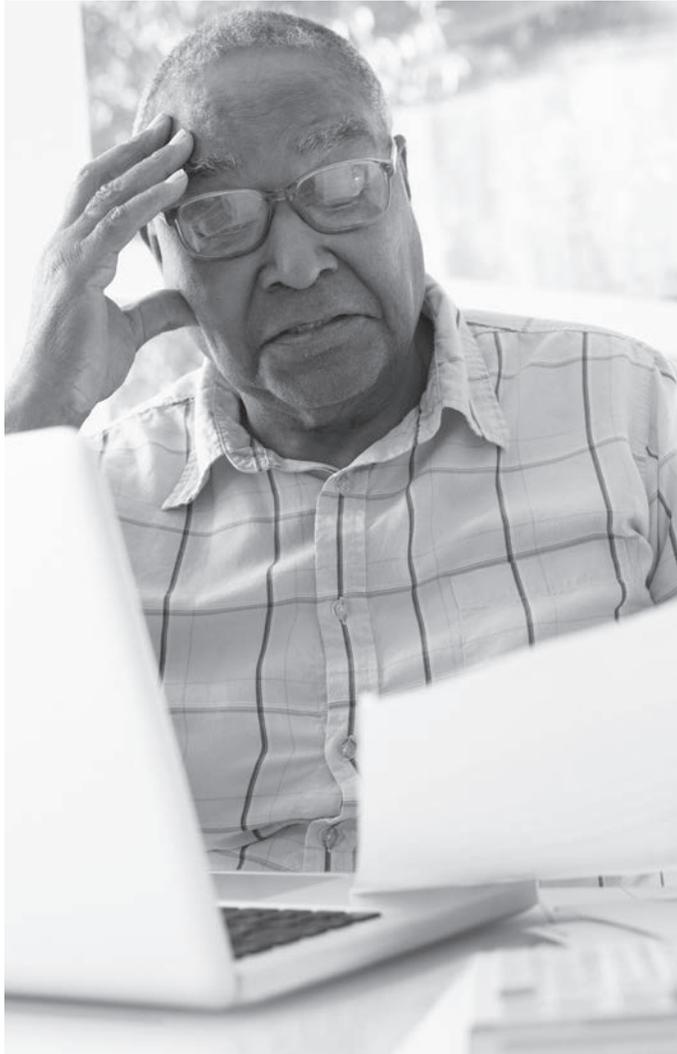


Table 2
Pre-Approved Series of Increases: Coverage Modifications by Series Step

	Benefit Modifications	Contingent Nonforfeiture	Total Modifying Coverage
All Policyholders	22.8%	7.9%	30.7%
Step 1 of Series	14.3%	4.7%	18.9%
Step 2 of Series	7.4%	3.1%	10.4%
Step 3 of Series	6.0%	1.4%	7.5%

As one might expect, policyholders that were shown the multi-step increase were much more likely to make a coverage modification early in the process.

Table 3 shows a similar breakdown of data, in total and by round, for policyholders in states where only Partial Approvals have been granted and passed along to the policyholder, and the company pursues catch-up increases in additional rounds.

Table 3
Partial Approval States: Coverage Modifications by Series Round

	Benefit Modifications	Contingent Nonforfeiture	Total Modifying Coverage
All Policyholders	17.6%	9.9%	27.5%
Round 1 Increase	10.1%	5.9%	16.0%
Round 2 Increase	9.1%	5.0%	14.1%
Round 3 Increase	4.3%	1.7%	6.0%

The data shows that while the ultimate percentages of policyholders modifying coverages was roughly similar between these two groups of states, the pattern of when the modifications occurred was meaningfully different. When policyholders were aware of the entire series of the rate increase, they were 82% more likely to modify coverage in Step 1 versus Step 2 (18.9 percent versus 10.4 percent). In Partial Approval states, policyholders were only 13 percent more likely to modify coverage in Round 1 versus Round 2 (16.0 percent versus 14.1 percent).

In general it would seem that if policyholders are going to make benefit modifications in the short term, it would likely be in their best interest to make such modifications sooner in order to save on premium dollars over this period. One could even conclude that the one-time larger rate increase results in the best outcome for policyholders that ultimately modify benefits, as it appears to cause policyholders to make their modifications right away, and hence save on premiums they would pay in the next year or two before making the

It is interesting to note that policyholder reactions to larger one-time rate increases appear to be substantially similar, (in terms of the total percentages that modify coverage in one form or another), to those receiving the pre-approved, reduced increases that are spread-out over two or three years. However, slightly more of the coverage modifications for one-time approvals were in the form of accepting contingent nonforfeiture benefits than was true in the case of the pre-approved series.

One interesting contrast in the data is shown when looking at the results for states in the latter two categories broken down by round/step of the rate increase mailings. For states that approved the entire rate increase via a series, which allows for communication of the entire series to the policyholder, Table 2 illustrates the breakdowns of policyholder reactions both in total (as a percentage of initial notification mailings) and then by each individual step (as a percentage of the notifications that occurred in the individual step).

modifications that are done after step/round 1 in the other state categories.

The data shown here may also be considered by some companies with older, pre-rate stability blocks that are still in need of rate increases. Companies in this situation will sometimes forgo a larger rate increase with the plan being to file for a series of two or three smaller increases. The data appears to show that roughly the same percentage of policyholders will ultimately elect to modify coverage regardless of the pattern of increases. Therefore, it appears to be in the best interest of the policyholders who will modify coverage, to have their company file the full increase initially so these policyholders can make their coverage choices/changes at an earlier stage.

CONCLUSIONS

The results presented for this case study are likely to vary from block to block, and company to company, and in particular based upon the magnitude of the rate increase and policyholder demographics. However it is reasonable to assume that similar patterns of results and variances by state category would occur for other rate increases of other blocks.

The data shows that when a rate increase is approved in smaller, separate steps, policyholders do change behavior, which is not necessarily in their best interest. Decisions on benefit modifications are generally made at the same rate, but the decisions are deferred to later steps meaning these policyholders pay additional premiums in the interim years for benefits that will later be reduced/modified. In other words, policyholders who receive the most information about their ultimate rate increase upfront are better served in the long run by being able to make informed, and earlier, decisions in regards to their LTC coverage and premiums.

In addition, there are significant inefficiencies for both the companies and regulators when multiple smaller rate increase filings are required to obtain the needed result. Companies must prepare multiple filings and pursue multiple implementations/communications with policyholders, while state regulators also must perform multiple rate filing reviews.

Last but not least, delaying necessary rate increases can hurt the financial solvency of LTC insurers in the short term and may lead to larger cumulative increases for policyholders in the long term. Both of which are detriments to protecting LTC policyholders. ■



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ENDNOTES

- 1 The percentages in the two state categories where multiple increase mailings are required are measured as total policy changes from any round/step in the rate increase process divided by the number of mailings made in round one of the process.
- 2 In order to better account for the fact that policyholders in One-Time Approval states have experienced the entire rate increase, but some policyholders in the other categories have not yet done so, we have excluded data from a few states that are less complete in the implementation process (particularly those in Partial Approval states where catch-up increases are still being pursued and the policyholders have incurred only a portion of the increase).
- 3 The details and makeup of the particular LTC block studied yielded contingent non-forfeiture benefits that were generally more attractive than what might be seen in many other LTC blocks which likely elevated the frequency of this particular election.

To Cede or Not To Cede: Overcoming the Hurdles to Ceding Legacy LTCI Risk

By Bruce Stahl

For insurance companies with legacy long-term care insurance (LTCI) blocks, whether or not to cede that risk is becoming an increasingly important question. More than a few LTCI issuers active in the 1990s and early 2000s would benefit from such ceding, as these portfolios are generally low-profit or unprofitable and keep capital tied up that might be better deployed otherwise.

These deals, however, could involve several significant hurdles. Here are some:

1. **Negative ceding commission.** Mutually agreeable transactions are becoming increasingly difficult to craft. Even as recently as ten years ago, insurers that sought to cede their legacy LTCI risk expected to be paid outright or to do so at little cost to them. That is no longer the case: an LTCI cedant now must be willing to pay to offload the risk.
2. **Policy language.** Legacy LTCI policy forms language was for the most part far less clear than today's language. That lack of clarity has resulted in higher benefit payouts for these older legacy policies, as claims decisions in the past (and likely into the future) have favored more liberal interpretations. This has contributed to the poor performance of these portfolios and may negatively impact valuation.

For example: the original pricing may have assumed that benefits would only be restored if a policyholder recovered fully, but the actual policy provision language may only have required that the policyholder cease receiving formal care for 180 consecutive days. Essentially, insurers had issued LTCI policies with nearly unlimited benefits, limited only by six-month intervals when benefits are not paid.

Because of this disparity between pricing assumptions and policy language, making a calculation of future risk is more difficult to shape.

3. **Original underwriting concerns.** An assuming company may be concerned whether long-term risks could exist due either to weak underwriting or past underwriting exceptions. Underwriting exceptions are a clear danger: they can mean higher overall claims experience as well as risk that could impact performance well into the future.

LTCI underwriting has become stronger over the past few decades, so an assuming company may want to consider the strength and effectiveness of the original underwriting relative to the existing underwriting tools and underwriting conventions in the market at the time, to determine if there may have been more or less potential for adverse selection.

4. **Investment income.** If cedant and assumer investment and interest rate expectations are too far apart, a deal may not happen. The ceding company is often invested in long-term debt instruments purchased back when yields were higher, and the company assuming the risk will need to invest assets at current new money rates. This means an assuming company would have to invest a larger amount in lower-yielding instruments or choose riskier, higher yielding instruments in order to achieve investment yields that will support the block. Holding riskier assets, however, means holding more capital, raising the cost to cede.
5. **Differences in persistency assumptions / expectations.** Even though legacy LTCI lapse and mortality rates are generally substantially lower than had originally been assumed, differences between a ceding and assuming company's persistency assumptions and expectations can still occur. Policies with weaker underwriting might reasonably be expected to have had higher mortality as well as morbidity risk, and policies with more comprehensive benefits or with automatic increasing benefits might experience even fewer lapses. If an assuming company and cedant have substantially different persistency expectations—specifically, if the assuming company believes the business will have significantly higher persistency than does the cedant—a deal may not be possible.
6. **Premium rate increases.** New rate increases along with the accumulation of past rate increases can often have an impact. Even if state approvals of premium increases were not a concern, policyholder behavior could still be a wild card, particularly if multiple past rate increases have been implemented. Some assuming companies may reasonably believe that more premium increases, either in count or amount, may prompt even more claims incidence or longer use of benefits. Multiple premium increases may also prompt adverse selection, perhaps with even more of the healthier policyholders lapsing their policies or reducing their benefits (“partial lapses”), and those expecting to file claims keeping their original benefits. Partial lapses may require an assumption of higher utilization, where utilization is the percentage of actual expenses being



reimbursed by the policy relative to the maximum payable by the policy in a given period.

7. **Rating agency / investment analyst perspectives.** Often, rating agencies and analysts view it positively when an insurer cedes its legacy LTCI risk. Not only does it free up capital for higher-profit investments, it also takes away the negative perception that accompanies legacy LTCI business. Unfortunately, that negative perception is frequently a hurdle for the assuming party, which may need to explain to the rating agencies and investors why assuming legacy LTCI risk is suitable for its risk portfolio.
8. **Reserve credit.** When ceding business, statutory accounting principles require that 100 percent of the risk be transferred to the assuming party in order for the cedant to reflect reserve credit. This full transfer of risk can be a hurdle, because it means that an assuming company cannot restrict the benefits it reimburses.
9. **Cedant counterparty exposure.** A cedant will require assurance that the assuming company is well managed and financially strong. If the assuming company lacks the financial or management strength to carry and administer the assumed risk long term, the cedant may have to recapture the risk, and at the very least, would suffer reputational damage with investors.

10. **Administration.** In this case, the assuming party will have the hurdle. The cedant may be a counterparty risk for the assuming party if the cedant continues to administer the business and adjudicate claims, instead of either retaining administration or using a third-party administrator. In either case, the assuming company would need assurance that the business will be administered effectively and according to the terms of the policies. If an administrator fails to fulfill expectations, the assuming company would likely face additional expenses or liabilities in order to correct the problem.

The assuming party may want to establish clear parameters in advance. Disagreements will arise over issues such as eligibility of a claim, fraud, or administration, and the assuming company will want to minimize or avoid such surprises. Needing to address these matters may delay or discourage a potential party from assuming the business.

Any one of these obstacles may be hurdled, but trying to jump over them all without tripping can be a challenge. ■



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Case Study: Improving Financial Projections for Long-Term Care Insurance with Predictive Analytics

By Missy Gordon and Joe Long

Making financial projections is at the heart of what actuaries do. The techniques for doing so have continued to evolve over the years, but the goal is always the same: predict the future as accurately as possible. Nobody can predict the future so there will certainly be fluctuations in financial performance, including the need for additional reserves and capital, but we strive to minimize that fluctuation. In the world of long-term care (LTC) insurance, this is especially challenging for two fundamental reasons: a long projection horizon and complex interactions.

First, the “crystal ball” needs to see 30 years or more into the future as these policies are typically issued to preretirement individuals, but the benefits are often not used for many years into the future. Company data may be limited or nonexistent

at advanced ages, which often requires extrapolation and the need to supplement with industry data.

Additionally, the interactions among variables can be complex, requiring careful construction of the assumption configuration in order to capture the underlying relationships, which can become a daunting task. Company data may also be too limited to capture the true nature of these complex interactions, requiring the use of industry data to understand these relationships.

Traditionally the role of actuarial judgment is often quite large in these efforts to develop projection assumptions, reducing the objectivity and provability of the results. The evolution to using predictive analytics can empower actuaries to quantitatively assess the predictive power of internal versus industry data and determine the “right” balance between the two.

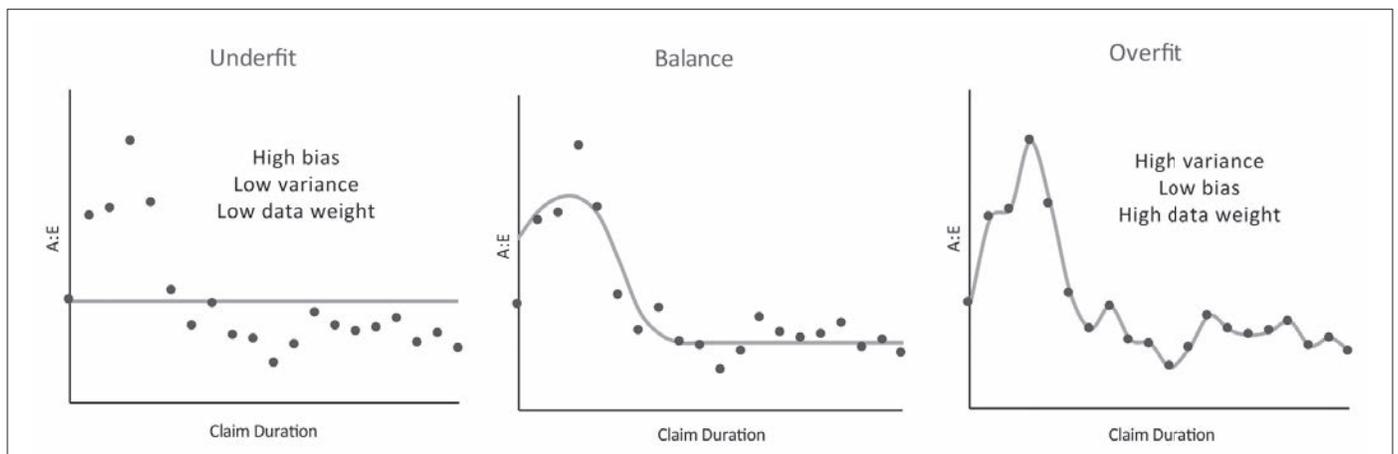
This article is the first of a series that walks through the progression from developing LTC projection assumptions using traditional methods to doing so using predictive analytics. Here we introduce the general concepts. Subsequent articles examine the financial impact of transitioning to predictive analytics in incremental steps, in the context of a case study, for one company where we made this transition.

A BALANCING ACT

In developing a projection assumption, an actuary of even the largest LTC carriers needs to strike a balance between company and industry data.

Trusting the internal data too much may lead to unstable assumptions due to the statistical unreliability of small sample sizes. This is especially true in a business where claims can vary wildly from period to period because of the low frequency and

Figure 1
Illustration of Bias-Variance Trade-off



high severity nature of the claims. However, leaning too heavily on industry data may result in assumptions that are inappropriate for a company's specific blocks of business. In either case, the result is fluctuation against financial projections.

The traditional way to solve this problem is an "actual-to-expected" or "A:E" study. In such a study, experience is compared to an expected assumption (e.g., a benchmark based on industry data), and the actuary applies judgment about data credibility to decide how far from the expected basis to move based on the data. In the traditional approach, balancing the mix of internal and industry data and selecting appropriate variables requires a strong dose of actuarial judgment.

The traditional method has several challenges. First, it is cumbersome. Typically, an actuary uses Microsoft Excel to develop the updated assumption, which can become complex and calculation-intensive. It may be a manual or iterative process, where an expected assumption needs to be updated after determining the A:E adjustment for a given variable before going on to consider an A:E adjustment for another variable. This creates opportunities for human error or assumptions that are not easily reproducible. More importantly, key aspects of the process are judgment-based, including which variables to use, how complex or granular to make the variable interactions, and the amount of weight to give the company's experience. Additionally, the A:E approach typically does not tell us how well the assumptions will work in the future—fit is determined based on the data used to develop the assumption, so a perfect fit does not necessarily mean it will work well for future experience.

When developing a projection assumption it is important for an actuary to give the "right" amount of weight to the experience, while not overreacting to random fluctuations in the data. If one gives too little or too much weight to the data, the assumption will not project future experience well and will lead to financial fluctuations. This is an important concept known as the bias-variance trade-off, which Figure 1 illustrates.

A projection assumption with high bias and low variance tends to be a simple one (e.g., few variables or limited interaction) that gives low weight to the data and typically under-fits the data. Using a single, aggregate A:E adjustment factor may be an example of under-fitting. The projection assumption is highly dependent on the historical mix in the data such that the financial projections will not vary for different mixes of business. The projection assumption may be inappropriate for projecting segments of the business or if the projected mix differs from historical.

On the other hand, a projection assumption that over-fits the data tends to be a complex one (e.g., many variables with granular interactions) that gives high weight to the data and results



in high variance and low bias. Using seriatim A:E adjustment factors is an example of over-fitting. Slight changes in the projected mix will produce wild variations in the financial projections.

The goal is to develop a projection assumption that balances the bias and variance, which the traditional method does using actuarial judgment.

IS THERE A BETTER WAY?

Various predictive analytics techniques can be used to automatically traverse this bias-variance trade-off by determining the "right" amount of data weight that minimizes deviations between future experience and our projections. As our goal is to project future experience as accurately as possible, these techniques provide a robust approach that aligns with our objectives.

... it is critical to question outputs and understand what the model is actually doing.

This in turn reduces the judgment-based decisions relative to how much weight to give the data, which variables to include, and how complex the variable interactions need to be.

One such technique is a penalized generalized linear model (GLM). A GLM develops adjustments to an expected benchmark by giving full weight to the data, but then a penalty is applied to dampen these adjustments. We can think of this penalty as a data weight lever that we use to determine the “right” amount of weight to give the data. A large penalty would give essentially no weight to the company data, leaving the industry benchmark unchanged. On the opposite side, a small penalty gives considerably more weight to the company data and potentially produces large adjustments to the industry benchmark. Using a penalized GLM, the “right” data weight is determined through an automated process that tests a range of data weights and chooses the one that minimizes deviations between unseen experience (data not used in the development of the assumption) and projection assumption.

Using a penalized GLM is a great way to get started with predictive modeling, as it can help us incrementally move from a traditional A:E study to one that uses predictive analytics. We can set up the GLM model in a way such that the only difference from the traditional A:E approach is how much weight is given to the data. The assumptions developed from an A:E and penalized GLM can then be compared side-by-side to get managers, regulators, and auditors comfortable with the new approach.

A penalized GLM approach is very flexible, enabling you to expand and analyze new variables and interactions in the future. Updating a penalized GLM is also simple, and because of the automated process, it is highly repeatable with minimal effort after the initial learning curve and setup. This is in contrast to the cumbersome manual processes often used with traditional A:E methods, which can be slow, prone to human error, and not usually repeatable.

WHAT CHALLENGES REMAIN?

There are challenges that a penalized GLM does not solve, of course.

Actuarial judgment is needed to decide how to extrapolate trends to a future state where there is little to no relevant experience. While the more robust assumptions attributable to penalized GLMs can certainly help in some cases, high levels of variability are to be expected in situations where experience is lacking.

Although industry experience is growing in volume, it can vary wildly across companies because of differences in underwriting, marketing, administration, and plan design. Actuaries working with industry data require great care to ensure they have a solid understanding of the definitions used in the data and their consistency across companies. It is essential that industry data capture key variables to develop a benchmark tailored to a company’s situation. Actuarial judgment is imperative in reviewing the industry data for reasonable relationships before assuming that it is an appropriate expected basis for a company’s situation.

Predictive analytics are powerful tools that require great responsibility. The results must be carefully reviewed to ensure the relationships make sense, for which actuaries are particularly well suited. There can be a temptation to treat any automated process as a black box and simply accept the results, but it is critical to question outputs and understand what the model is actually doing.

STEPPING STONE TO FURTHER EVOLUTION

Once a company gets comfortable with penalized GLMs, it can lead into more powerful machine learning techniques (such as tree-based algorithms) to navigate complex interactions and understand which variables are most important. As a powerful, simple, and well-understood technique, penalized GLMs are a great first foray into the world of predictive modeling.

In our next article, we will dive into a case study and share the results and our experiences in making this transition to predictive analytics to develop LTC claim termination projection assumptions. ■



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Q&A with Experienced Insurance Professionals New to Long-Term Care: Kristine Tejano Rickard and Jeff Ferrand

No matter how much research one does when changing industry segments, it can be a bit of a gamble. As the Vegas dealer deals everyone at the table their poker hand, someone new to long-term care insurance learns about the nuances of policy language, the need for policyholder rate increases, the prevalence of fraud, increasing regulatory oversight, and new products being offered. The astute poker player will examine their hand, and decide which cards to lay down. Leaders new to our industry must decide which issues will be priority for their organization and which issues will need to wait for the next hand. We are all looking for the winning hand that will keep us in the game. Kristine Tejano Rickard and Jeff Ferrand, Fuzion's General Counsel and Chief Fraud Officer, respectively, have different but strong backgrounds that help them know how to play their cards and are keeping their organization and this industry at the table.

On-going communication and education are our biggest tools to lift this shadow...

Tell me a bit about what you did before long-term care insurance. What got you started in the insurance field?

Kristine Tejano Rickard (KTR): Like most people, I fell into the insurance industry. In college, an opportunity to enter a

risk management program became available, so I decided to try that path and became a professional liability underwriter. During that time, I became very interested in complex claims, so I decided to go to law school. Upon graduation, I joined a law firm as an insurance coverage attorney and subsequently went to work for a few different insurance carriers specializing in professional liability claims and property and casualty operations.

Jeff Ferrand (JF): I attended a small liberal arts college and went straight to law school upon graduation. Anyone who knows me, recognizes I enjoy a fast pace. I had my sights set on being a litigator; becoming a successful courtroom lawyer was definitely a career goal. Initially, I gained invaluable experience with my first role after law school in insurance defense as a litigator at a boutique law firm with a specialty in insurance coverage and fraud defense. I represented carriers in a wide array of matters but my firm's practice was best recognized for its insurance coverage and first-party fraud defense. Over the first decade of my career in private law practice, I developed a great working relationship with investigators, special investigation units (SIU), and government entities. However, my litigation responsibilities also carried with them a large time commitment and a lot of time away from family. After many years of that lifestyle, it was time to look for a new way to practice law.

What attracted you to the long-term care insurance (LTCI) industry?

KTR: When I was first introduced to the LTCI industry, I saw a space where I could make an impact. Regulators are looking for new ways to stabilize long-term care insurance, and I saw the opportunity to bring my diverse experience and fresh perspective to a mature industry. The LTCI environment can be very challenging but I feel my previous experience can help transition the LTCI segment into a place where we could overcome some of the complex struggles the industry is facing.

JF: I came to Fuzion and the LTCI industry to develop an SIU/Fraud Mitigation Program. I was attracted to the opportunity to strengthen efforts in fraud mitigation and to build something that could marry my fraud expertise with the analytics initiatives that I learned were already underway at Fuzion. Once I was on board and started reviewing cases, I was interested with how much potential fraud existed and was encouraged about the mitigation efforts that could be put in place. I found there was a huge opportunity to make an immediate impact, and it was great to be able to use my past expertise to develop a program that could deliver immediately. With the integration of some investigative strategies more widely used in my property and casualty industry, coupled with analytic-based fraud identification, we have seen big impacts made in short periods of



time. It's really encouraging for the entire industry. It is also satisfying to know that my team's work has the opportunity to protect potentially vulnerable senior policyholders from fraud and abuse.

What were some of the biggest challenges you faced when transitioning to LTCI?

KTR: Having an appreciation for the evolution of the LTCI market and how it got to where it is today has been my biggest challenge. It has been helpful to gain an understanding of the perspective of senior lifestyles at the time these policies were written (decades ago) compared to senior lifestyles today now that the policyholders are ready for benefits. This understanding is vital since many assumptions which were developed at that time do not exist today, or exist in a manner that was different decades ago when policies were written.

JF: I agree with Kristine. It took a little to time to gain a full appreciation for the evolution of the industry. Many of the policies were written so long ago; lifestyles and senior care were very different than they are today. However, more difficult for my role was the need to change an underlying belief that mitigating fraud is futile and too difficult to make an impact. I have spent a lot of time and effort demonstrating internally and externally the breadth of fraud, waste, and abuse in LTCI and

proving that we can make a difference. This includes empowering front-line claims handlers with the ability to identify fraud and appreciating their results.

What skills from your previous insurance experience benefit the LTCI industry the most in your present role?

KTR: In my role, my job responsibilities are focused on risk management. I have the ability to impact the LTCI industry by implementing best practices for our carrier clients. This comes from a highly developed risk management lens that I have acquired through ensuring regulatory compliance, overseeing the litigation process, and managing complex claims. This includes a heavy emphasis on policy language analysis and understanding contract law.

JF: In my previous career track, I represented insurance companies at trial. This capitalized on and continued to strengthen my analytical and case building skills. Years of experience in this area has shown me how to collect diverse types of evidence and pull it together to make a case to enable the right decision to be made. Additionally, I really enjoy sharing information with others and giving individuals training and tools to do their best work. Communication has always been one of my strengths and I put a lot of effort into structuring training and

other fraud awareness activities to enable and incent claims handlers to identify potential fraudulent activities.

What do you see as the #1 challenge facing the LTCI industry and what is your organization doing to address it?

KTR: Managing the concerns of a multitude of constituents is one of our industry's biggest challenges, for both carriers and regulators. Carriers and regulators are constantly trying to balance what is necessary to maintain the viability of long-term care insurance and also consider the interests of the policyholders. Carriers today are plagued with the issues that are coming to fruition based on decisions from long ago. Assumptions were made about senior lifestyles that have since changed. We all know that many of the variables that underlie the premiums charged early in the life of LTCI policies did not develop as forecasted. This is casting a very dark shadow on our industry now when the actuarially necessary rate increases have to be implemented to support what is needed to pay future claims. On-going communication and education are our biggest tools to lift this shadow and overcome this major obstacle.

JF: For me, the uniqueness of long-term care is a big challenge. While I certainly have been able to draw from experiences in other insurance lines, some strategies and tools that may work in other insurance lines do not yield the same results with long-term care insurance products and typical LTCI claim adjudication processes. This provides an opportunity to innovatively apply my past knowledge to newer analytics-based methodologies and work closely with Fuzion's veteran claims handlers and leaders to overcome this challenge.

What excites you the most about the contribution you are making to the LTCI industry?

KTR: Having the ability to have a direct impact in an industry that is looking for solutions is very exciting to me. We all know the difficulties the LTCI industry is facing. I am excited to be with an organization that is looking beyond the traditional approach to LTCI and working to develop solutions to help keep LTCI products viable for many years. By encouraging innovation, we are developing new approaches to manage our business and how LTCI carriers can thrive.

JF: One of my favorite aspects of my transition is having the opportunity to work with other LTCI leaders toward solutions to improve the state of our industry, especially in the area of fraud. I have been fortunate to have worked with great people at every step of my career; however, there is something special about the LTCI leaders that I have worked with thus far. They have been so welcoming and driven to collectively find solutions to the problems that plague our industry. ■



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