SOCIETY OF ACTUARIES Long Term Care Insurance Section

Long-Term Care News

ISSUE 31 MAY 2012

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Current Perspectives on Long-Term Care Underwriting

by Joline Allen and Bruce A. Stahl

One of the main challenges today for reinsurers and direct writers is mapping their accepted long-term care insurance applications into optimally appropriate underwriting risk classes. Underwriting manuals provide not just procedures and assumptions, but also an instructive view into how direct long-term care (LTC) writers look at risk.

Over the past five years, RGA has provided quotes on more than 50 different LTC insurance policy forms, the vast majority of which were for new business. With LTC now a viable business line for more than 25 years, we recently undertook a comparative review of underwriting manuals to assess how direct insurers today assess and underwrite LTC risk.

What we found was that LTC underwriting has become remarkably uniform in some aspects, and in others, a significant range of opinions exist. The number of underwriting risk classes each direct writer uses may contribute to the range of opinions. For context, about 35 percent of our sample used three asset classes, about 35 percent used four or more, and the remaining insurers used only two.

BODY MASS

To compare the LTC underwriting manuals, we first sought to create a means for apples-to-apples comparisons. Therefore we selected specific average male and female heights as the underwriting starting point: for men, 5 feet10 inches; and for women, 5 feet 7 inches.

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ISSUE NUMBER 31 | MAY 2012

Published by the Long Term Care Insurance Section Council 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 LTCI Web page at *www.soaltci.org.*

Long-Term Care News

ISSUE 31 MAY 2012

It's Been A Hard Day's Night

by Beth Ludden, Denise Liston, Jesse Slome and Steve Schoonveld

First and foremost, we wish to express our gratitude to Brad Linder and Bruce Stahl for their dedication to the section over the years by producing such a fine collection of *Long-Term Care News* issues. We aim to continue the direction they have established with this first issue produced by the co-editors four. First, please allow us to introduce ourselves.

Acknowledging LTC's "Fab Four" for their efforts preparing this issue and to all who gave of their time to share. Working together always makes for winning results. — *Jason B. Bushey, Chairperson*

Hello. My name is Beth Ludden and I am leading new product development for long-term care at Genworth Financial. I started my adventure in long-term care insurance at the opposite end of the spectrum in claims and have worked backwards from there having been involved in new business & policyholder services, marketing, compliance and sales. I get energized by the ways the long-term care product can help people who have the foresight to purchase it. I hope that by bringing in disparate views and ideas from both within and outside of the long-term care industry I can stimulate more interest and innovation in this product line.

Hello. My name is Denise Liston and I am the vice president of Long Term Care at LifePlans. I have been in the long-term care (LTC) industry for a "few" years and get energized when working with insurers to best manage risk–focusing on underwriting and claim management strategies. The industries' pursuit of strong risk management strategies will allow us to remain profitable long into the future. As one of the "quad-editors," I hope to grow the participation of risk management staff within the SOA and educate others to assure we are doing all the right things to insure as many people as possible, while using strong claim management protocols to meet the needs of claimants and their families.

Hello. My name is Jesse Slome, executive director of the American Association for Long-Term Care Insurance. My passion and professional expertise as a marketer of products and services and my background as a public relations professional helps me focus on building focused media attention on this important topic. Long-Term Care Insurance (LTCI) can enjoy continued growth—even with a grassroots PR effort—if strategic proactive messaging is undertaken to anticipate media concerns and deliver the right information that will resonate universally. As one of the four newsletter editors, I hope to generate the cooperation of top industry experts, leveraging the deep knowledge that exists which will enable all to achieve our shared goal—properly protecting Americans against the financial risk of needing long-term care.

Hello. My name is Steve Schoonveld and I am the head of Linked Benefit Product Solutions at Lincoln Financial Group. I am pleased to be the sole actuary within this "fab four" as this emphasizes the diversity of our section. Such diversity can allow for success as we share knowledge within forums such as this and as we focus our efforts on growing the opportunities for households to address their long-term care risks. The true sign of a mature industry is if we provide a diversity of solutions for the unique long-term care financing needs of individuals. While there are strong pockets of success, it is my intent to enable the section news to play a role towards increasing the variety of solutions that may be available to households.

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Jesse said it best: Our objective, as an industry and in whatever role each of you play, is to properly protect Americans against the financial risk of long-term care expenses. It is our hope that this issue of *Long-Term Care News* brings you information to further attain that shared goal. We welcome your thoughts and comments as well as your articles for publication. ■

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Transitions

by Jason B. Bushey

In my last article, I thanked the three departing elected members of the council for their contributions during their terms. I want to take a moment now to introduce the three new members who replaced them. They are Siva Desai, Missy Gordon and Heather Majewski. Their contributions are greatly appreciated and I look forward to continue to work with them. We elect three new members each year so I encourage members who are actuaries to consider running for the council.

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As all of you know, the LTCI Section has a sizable minority of members that are non-actuaries. To help represent the interests of that minority, the council has three appointed affiliate members who are non-actuaries. They are appointed to one-year terms and can be re-appointed up to two times so they can serve a maximum of three consecutive years—the same term length as elected members. Denise Liston stepped down as an affiliate member at the end of last year's term and was replaced by Maureen Lillis. My thanks go to Denise for her contributions and I welcome Maureen Lillis and thank her for making a commitment to serve the section. Maureen joins the other two affiliate members Ron Hagelman and Winona Berdine. We will appoint one new member every year so I encourage members who are non actuaries to consider applying for this appointment.

Our newsletter, *Long-Term Care News*, is going through a transition as well. Co-editors Brad Linder and Bruce Stahl have both decided to step down. All of their efforts producing the numerous issues during their tenure are greatly appreciated. The new editorial board consists of four members: Denise Liston, Beth Ludden, Steve Schoonveld and Jesse Slome. I am grateful that the four of them have committed to producing a valuable publication for the section's membership. With three of the four co-editors being non-actuaries, one of their key goals is for our newsletter to have a broad prospective in terms of the issues that are tackled. Each of the co-editors will be introducing themselves in this issue so take a minute to read their comments.

Finally, the last transition I would like to discuss is the one that the current LTC insurance industry will make. What type of transition is to yet to be determined. Will it be a big transition to a robust market with much higher penetration rates than the current single digits? Or will it be a small transition to something similar to today's niche market? A catalyst is needed for a big transition to take place, for example, a change in the LTC Model Regulation to allow insurers more freedom in plan design to create products with broader appeal. It is up to us, members of the industry, to create that catalyst. Are you willing to work on creating a big transition?

Some kind of medical question verification is a nearly universal underwriting requirement for LTC applicants, no matter what their ages.

For men and women of those heights, minimum acceptable weights in the underwriting manuals were fairly consistent. For men, about 60 percent of the underwriting manuals used 120 pounds, and 40 percent used between 130 and 135 pounds. Minimum acceptable weights for women of the selected height were a little less consistent, with about 20 percent of insurers using 100 pounds, about 60 percent using 110 pounds, and about 20 percent using 120 pounds.

Maximum acceptable weights were somewhat less consistent. About 50 percent of the insurers set the maximum acceptable weight for 5-feet-10-inch males at an amount over 285 pounds. About 20 percent of the insurers set the maximum at between 275 and 285 pounds, and about 30 percent set it between 260 and 265 pounds. For women of the selected height, about 30 percent of the insurers set the maximum acceptable weight between 270 to 280 pounds, about 40 percent between 240 to 260 pounds, and about 30 percent had maximum acceptable weights of less than 240 pounds.

In mapping the contracts we have reinsured, we found that LTC insurers with the fewest risk classes tended to restrict acceptances to individuals with weights in the lowest maximum weight ranges.

COGNITIVE ASSESSMENTS

We also looked at the rules LTC underwriting manuals set down to determine at what ages insurers need to use face-to-face assessments versus telephone interviews.

The minimum age required by all of the manuals for face-to-face assessments is either age 70 or age 72. For telephone assessments, however, about 60 percent of the insurers have a minimum age of 65, about 20 percent have age 60, and the remaining insurers set the minimum under age 60.

Insurers that use cognitive telephone assessments for younger-age applicants tend to have fewer underwriting classes. Also, one-third of the manuals that do not require face-to-face cognitive assessments for applicants of ages 70 and 71 do require cognitive assessments by telephone for applicants under age 60. Interesting differences such as this one may prompt an observer to wonder why insurers appear to be less aggressive at some issue ages than at others, yet the differences may simply point to the insurers' confidence in the tool being used.

DEPLOYMENT OF OTHER UNDERWRITING TOOLS

Some kind of medical question verification is a nearly universal underwriting requirement for LTC applicants, no matter what their ages. At younger ages (defined by each insurer), verification is usually acceptable through a telephone interview. The minimum age at which insurers require actual medical records for verification, however, varies significantly. About 40 percent of the LTC insurer underwriting manuals we reviewed require medical records for applicants either over age 70 or 72, about 30 percent require them for applicants over age 65 or 66, and the remainder require them for all applicants.

Not surprisingly, LTC insurer underwriting manual age requirements for face-to-face assessments of physical independence tended to correlate highly with their face-to-face assessment requirements for cognitive impairment. However—and this is surprising—the correlation is not perfect. After all, it would seem logical for an insurer to ask a nurse or paramedic to do both assessments while with the applicant.

Finally, about 60 percent of the LTC underwriting manuals we reviewed required the conducting of prescription drug searches on all applicants as part of standard underwriting, and about 20 percent required that MIB searches be conducted. Interestingly, we noted that LTC insurers that conduct MIB searches on applicants also had lower minimum weight requirements. Whether this is coincidence, or whether insurers requiring MIB searches are giving greater weight to the MIB results than to the applicant's weight, is an interesting point to ponder.

UNDERWRITING IMPAIRMENTS

We selected 10 medical conditions to show the range of ways insurers now underwrite LTC when the applicants have medical impairments. The 10

impairments we chose to examine were: osteoarthritis, sleep apnea, stroke (including transient ischemic attack [TIA]), amputation, alcoholism, chronic obstructive pulmonary disease (COPD), angina, Crohn's disease, depression and osteoporosis.

Our selection was not at all scientific; rather, it was arrived at to illustrate the many differences we see in how LTC insurers assess medical impairments when underwriting the coverage.

For each of the 10 conditions, we assigned three categories of expression: "mild," "moderate," and "severe." Insurers showed the most underwriting consistency for "severe" expressions of the impairments. Each declined to cover the most severe incidences of amputation, alcoholism, angina, depression, sleep apnea and stroke. "Severe" osteoarthritis, COPD, Crohn's and osteoporosis were seen as acceptable underwriting risks by only a very small number of insurers, and those insurers will, as a rule, apply the highest premium risk factor available.

Most of the underwriting manuals deemed "moderate" levels of impairment for eight of the 10 conditions (except stroke and amputation) to be acceptable risks to underwrite.

For acceptable "moderate" risks, we found that insurers assigned most of them the second lowest premium rate factor (for insurers with only two underwriting classes, the second lowest premium factor was also the highest one), with and about 10 percent to 20 percent assigned them the third lowest premium rate factor.

The most underwriting variation was found in conditions that mapped into the "mild" category. Nearly two-thirds of the insurers assigned "mild" osteoarthritis their lowest premium rate factor, and no insurer assigned the lowest premium rate factor to "mild" cases of stroke, COPD, or Crohn's. For the remaining six medical conditions, between 10 percent and 30 percent of the insurers assigned the "mild" status to the lowest premium rate class. The remainder were assigned the second-lowest premium class factor. (Again for those insurers with two underwriting classes, the second lowest was also the highest one.)

CONCLUSION

LTC insurers today appear to use reasonably consistent underwriting tools when considered in light of their underwriting risk class structure. However, their assignment of premium rate factors appears to be diverse, particularly for mild forms of medical conditions. Such diversity is beneficial to the market, as it permits a broader range of insurability. On the other hand, insurers are wisely reassessing and optimizing their rate factors and how they assign acceptable cases. ■

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Looking Back on CLASS: Considerations of Market Failure and Missed Opportunities

by Mark R. Meiners

Mark R. Meiners, Ph.D., is a professor of Health Economics and Policy at George Mason University. He specializes in the areas of aging and health with emphasis on financing and reimbursement issues and has led the Partnership for Long-Term Care, an innovative state-based long-term care insurance program, since its beginning in 1987. He can be reached at *mmeiners@gmu.edu*.

The demise of the CLASS Act has left some questions to ponder for private long-term care insurance. Why did CLASS get as far as it did given obvious weaknesses? Could it have been fixed if the political environment had allowed for technical corrections? What lessons were learned that might help the private market do a better job for middle-market consumers most in need of LTC insurance (LTCI)?

My perspective on these questions comes from my long involvement in leading the development and implementation of the LTCI Partnership Program that is now operating in 40 states across the country. As the original public-private long-term care insurance strategy, State Partnership programs shared with CLASS the public policy goal of helping consumers prepare for the risk of catastrophic long-term care costs. But the programs are quite different in their approaches. CLASS was intended to overcome aspects of private long-term care insurance market failure while partnership insurance is built directly on current private market LTCI offerings that meet federal and state requirements. Partnerships have faced an additional market failure challenge within the context of the broader private LTCI market that CLASS might have helped remedy; the lack of sales in the middle income market most at risk for impoverishment from catastrophic long-term care costs.

The most obvious aspect of market failure addressed by CLASS was also its biggest challenge. CLASS tried to provide insurance to those who would not be insurable in the private market. CLASS was designed for all workers, but is especially valuable for those who can afford, but cannot obtain private insurance because of pre-existing conditions.

The problem of adverse selection hung over CLASS from the very beginning. Those tasked with fixing the details of the program were required to come up with alternative options to address this challenge. Technical adjustments explored by the federal Department of Health and Human Services (DHHS) team head included tightening the enrollment rules to avoid gaming eligibility and increasing the work requirements to make it more difficult for those with disabilities to enroll. The Joint Academy/Society of Actuaries CLASS Act Task Force had called for a substantially increased minimum requirement of 20 to 30 hours of scheduled work or a comparable requirement (Schmitz, 2011). Other challenges were the proposed limited cash benefit structure paid for a lifetime ("long and lean") and how to keep premiums affordable in the face of these legislative mandates.

The CLASS legislation had called for the U.S. Department of Health & Human Services (HHS) secretary to be presented three options from which one is to be chosen. But in her public statements about the need to fix CLASS, DHHS secretary Sebelius offered one especially intriguing comment *"... we're looking at ways to make the program appealing for Americans with a wide range of long-term care needs. A CLASS program that does not take a "one-size-fits-all" approach will not only serve people better, it will also be attractive to a larger number of people (Sebelius 2011)."* This seemed to imply there could be what the final DHHS report later referred to as a "family of options" within the CLASS structure. In the end, it apparently was not possible without further legislative support (Congressional Research Service, 2011). In the context of more general opposition to health reform by the Republican controlled Congress this support was not seen as forthcoming.

The idea that there could be a family of options within the CLASS structure makes a lot of sense, but it is also risky because that could mean directly competing with the private insurance market. The CLASS Act was able to become law in part because CLASS benefits are so different from what is favored in the private market that it was not seen as a threat. The strongest private insurance advocates see viable public option alternatives as unwelcome. The strongest advocates for CLASS don't like private insurance. This is an old debate that has tormented the development of the

Partnership program throughout its development and implementation (Meiners and McKay, 1990). Still, many private insurance producers had come to feel the publicity around CLASS would help get the public's attention focused on the need for long-term care insurance, giving the market a positive boost, helping them overcome what has been an undersized market that had experience significant declines in its growth rate in recent years. But not everyone feels this way (Blasé and Hoff, 2011).

Everyone on all sides of the issue acknowledge that the long-term care insurance market is underdeveloped relative to its potential and certainly relative to the need. Part of the problem has to do with consumers being able to afford the coverage and part has to do with them being eligible to buy the coverage. Just how restrictive the private market has been in underwriting policies has been the subject of very limited research. One study estimated that if everyone applied at age 65, between 12 percent and 23 percent would be rejected (Murtaugh, Kemper, & Spillman, 1995). This suggests there are far more insurable risks than insured people. On the other hand, another study estimated that at least one older person in seven who had been rejected may not represent more risk than those accepted (Temkin-Greener, Mukamel, & Meiners, 2001). This, too, suggests there are more good risks than what the private market now covers. A number of prominent insurers have left the market recently and the number has generally been in decline over recent years (Lieber, 2010). Good risk selection is one of the keys to profitability so the incentive for those that remain in the market is to error on the conservative side.

CLASS makes long-term care coverage available to those who cannot pass insurance underwriting. This is not a problem the partnership programs are able to address. Partnership programs do focus on the challenge of selling to the "middle mass" segment of income and wealth spectrum. A Society of Actuaries' study on retirement identified this segment as representing 83 percent of households generally suited for a LTC insurance product (Society of Actuaries, 2010). The average household income of this group in the years leading up to retirement (55 – 64) is $75,000 with average assets net of home values at just over $100,000.

Most sales tend to be made at the high end of the market because that is where there is more discretionary income. Unfortunately the bulk of the potential market is not high end. The remaining 17 percent comprise the "middle affluent" segment, averaging pre-retirement household income of $132,000 and net assets of $390,000. While this segment is much more limited, there are still enough of them to hold the focus for the relatively few agents who specialize in LTC insurance.

Agents are commission driven to sell higher benefit amounts per policy. High end sales are easier and more lucrative for agents. From 1990 – 2010 the average benefits duration of policies sold has been in the range of five years (Cohen, 2011). The few sales made in the middle mass market still tend to be high-end products. In 2005, for example, the average benefit duration was 5.1 years for those with incomes of $25,000 – $49,000 and 5.3 years for those with incomes of $50,000 – $74,999, compared to 5.6 years for those with incomes of $75,000 or more (LifePlans, 2007). This has been a

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troubling form of market failure, especially if purchasers with lower incomes are giving up inflation protection to get the extended coverage that was a common trade off in the early years of the market.

The net result is a much smaller market and slower growth than is needed to help much with the public policy problem of getting people prepared financially to deal with long-term care expenses. It is the middle mass market that is most at risk for spending through their resources if long-term care is needed (Meiners, 2009).

Allowing more options within CLASS could have helped balance the adverse selection problems and contributed to the public policy goal of significantly increasing the number of people who have purchased long-term care coverage.

Both CLASS and partnership programs are focused on getting attention and coverage accepted as important to the middle mass market. Arguably the partnership "short and fat" approach (full coverage for most of the risk during the early years of need) provides a better value per premium dollar spent, than the CLASS "long and lean" approach (lifetime coverage at a low daily benefit relative to the cost of care), all else equal. But the success of partnership programs has been limited by industry resistance to making the "short and fat" products a priority. This has been a troubling form of market failure. Since its inception, the partnership has tried to encourage products that offered comprehensive benefits, but for limited periods of time (preferably in the range of the dollar equivalent of one to three years of coverage), as a way to broaden sales to the middle mass market. For reasons outlined earlier, there has been little interest or enthusiasm for selling products that cover less than three years of benefits. Yet, people could benefit from as little as a year or two of coverage to help them when a long-term care crisis hits. If they can afford more they should buy it, but many cannot. The benefit strategy promoted by partnership programs could have been included in CLASS as a way to stimulate more affordable insurance coverage whether or not the consumer can pass private insurance underwriting. Making the one- to three-year equivalent products a priority of the CLASS program could have served to stimulate this important segment of the market in both CLASS and private insurance.

CLASS could also help with market failure at the other end of the benefit spectrum. For many years lifetime protection was a major focus of the insurance industry. But lifetime benefits are only available when packaged with front-end coverage. This makes that coverage expensive. A CLASS catastrophic benefit design would be attractive to buyers from along the wealth spectrum who are willing to self insure large amounts of their long-term care expenses, but want a stop-loss insurance policy to back them up. A true catastrophic benefit structure would allow purchasers the peace of mind that their long-term care losses would be limited to an amount they could afford. With this as one of its options, CLASS could attract insurable risks that otherwise would self insure.

CLASS benefit designs that address these two areas of market failure could be offered as alternative options to the "long and lean" CLASS with all enrollees joined into a single risk pool. The new CLASS options should be significantly less expensive than the original CLASS option. Each option is attractive to different market segments and the combined risk pool could be much larger. Under this proposal, private insurance covering three years and more, the favored segment of insurance producers, would be left to the private market. This might have relieved some of the political opposition to such a proposal.

Allowing more options within CLASS could have helped balance the adverse selection problems and contributed to the public policy goal of significantly increasing the number of people who have purchased long-term care coverage. If CLASS were successful with its family of options, private market options will emerge to challenge the new CLASS options and competition will ensue. This would serve the public policy goal of getting significantly more people to prepare financially for the risk of long-term care.

One of the remarkable things about the CLASS legislation is that it passed at all. It was also not surprising to see it struggle without further technical corrections. Many key details were left to the secretary of HHS to resolve and there were considerable "devils is in the details."

One widely acknowledged benefit of CLASS was to be an increase in public awareness about the importance of insuring against long-term care risk. Another important benefit is CLASS coverage

for individuals who do not meet the underwriting requirements of private LTCI. However, the CLASS benefit structure is not right for everyone, so allowing the DHHS secretary to consider options like those proposed here should have been considered.

In the same spirit, it is also important for the states and the federal DHHS to continue to support state partnerships and educate consumers about all available long-term care insurance options. If the public education effort is successful and premiums are perceived as reasonable and reliable, larger risk pools will help balance out concerns about selection in both programs. CLASS would attract healthier risks than expected and partnership insurers will sell more "short and fat" products to middle-income purchasers, a part of the market that has been underdeveloped. This would be a step toward solving the nation's public policy challenge around long-term care. ■

Mark your calendar and plan to attend the 2012 Health Meeting. We're heading to the Big Easy—and planning more topical sessions to provide you with the latest updates on important health issues. Expect top-notch speakers and numerous of networking events—and the opportunity to earn lots of CPD credit. There'll be plenty to see and do in New Orleans while you're there: Chill out in a blues or jazz club; check out the city's well-known architecture; take a riverboat tour or carriage ride; or—head to the outskirts to see sprawling plantations and the incredible wildlife.

Here's what last year's attendees had to say:

"Thought provoking and extremely worthwhile." **"Gained great industry insight!"**

"Excellent content and thoughtful delivery." **"Ample opportunities to earn professionalism credit."**

"Sessions were great! Loved the smaller groups and wide range of topics!"

http://HealthSpringMeeting.soa.org.

Managing the Risks of the Long-Term Care Insurance Reinstatement Process

by Loretta Jacobs

As many long-term care (LTC) insurance blocks of business mature, new business management challenges are beginning to appear. One such emerging risk relates to the reinstatement process, which is the process by which a lapsed policy is reactivated and put back in the same position as it was before the lapse occurred. Since LTC insurance lapse rates have historically been low, insurers have not typically placed significant focus on the management and mitigation of the reinstatement risk exposure. However, a recent increase in litigation activity and regulatory scrutiny related to this process has led insurers to strengthen their risk management controls over it.

LTC insurance reinstatement requests primarily arise from one of three reasons, with only the first being specifically contemplated in LTC insurance regulation. First, a policy may be unintentionally lapsed because the policyholder is cognitively and/or functionally impaired at the time the premium billing notice is sent and is not reasonably capable of paying the bill. Second, a policy may be unintentionally lapsed for a variety of other reasons, including the policyholder claiming not to have received a billing notice, the insurer claiming never to have received monies the policyholder sent, or the policyholder submitting the premium to the insurer sometime after the end of the grace period. Finally, a policyholder who has voluntarily lapsed coverage may simply have a change of heart and request to reinstate the policy.

COGNITIVE AND/OR FUNCTIONAL IMPAIRMENT REINSTATEMENT SITUATIONS

The NAIC Model LTC Regulation, and essentially every state with explicit LTC regulations, recognizes the need to protect LTC insureds from unintentional lapses of their LTC policies when they most need them (i.e., when they are eligible for LTC insurance benefits). The robust protection against unintended lapse typically includes requiring an initial billing statement and a 30-day overdue billing notice to be mailed to the insured, plus a policyholder option to name at least one individual to receive a similar 30-day overdue billing notice alerting the named third party that the insured's premium is overdue and the policy is in danger of lapsing. Finally, termination of the policy cannot occur any earlier than at least 35 calendar days after the overdue notice(s) is(are) mailed.

Then, if the policyholder requests reinstatement of the policy within five months of termination and can demonstrate his or her condition would have qualified for LTC policy benefit eligibility on the termination date (i.e., that he or she was cognitively and/or functionally impaired in accordance with the definitions contained in the insured's policy) and pays all overdue premium, the policy is reinstated and treated as if it had never been out of force.

For purposes of this article, the reinstatement regulations of Florida and Washington will be analyzed and discussed. The reader may then consider the similarities and differences of these regulations to those of the other states.

Washington's reinstatement regulation states, "A long-term care insurance policy or certificate must include a provision for reinstatement of coverage in the event of lapse if the issuer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity ***before the grace period expired.*** Reinstatement must be available to the insured if requested ***within 5 months after lapse*** and may allow for the collection of past due premium if appropriate. The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate."

Florida's reinstatement regulation states, "If a policy is canceled due to non-payment of premium, the policyholder is entitled to have the policy reinstated if, ***within a period of not less than 5 months after***

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the date of cancellation, the policyholder or any secondary addressee designated…demonstrates that the failure to pay the premium when due was unintentional and due to the policyholder's cognitive impairment, loss of functional capacity ***or continuous confinement in a hospital, skilled nursing facility, or assisted living facility for a period in excess of 60 days."*** The Florida regulation also states, "Notice of possible lapse in coverage due to nonpayment of premium shall be given by ***United States Postal Service proof of mailing or certified or registered mail to the policyholder and secondary designee*** at the address shown in the policy or the last known address provided to the insurer. Notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing."

Disputes Arising from the Five-Month Reinstatement Request Time Period

An issue that has arisen recently surrounds the interpretation of the date on which the allowable five-month time frame to request reinstatement begins. The state of Washington suspended one insurer's license to sell LTC policies for six months in 2011 because it interpreted the five-month time frame as beginning on the date the (unpaid) premium was initially due, not the date on which the lapse transaction occurred, 65 days later.

To the extent that other jurisdictions follow Washington's lead, there are implications for insurers. Clearly, all insureds must be provided at least 7.13 months (equal to regulatory minimum of five months plus at least an additional 65 calendar days) after the last day coverage was paid for to request reinstatement. In addition, if for some reason an insurer delays terminating a policy beyond the required minimum 65 day time frame from the original premium due date, the five-month time clock only starts on this latter date. For instance, if a carrier has a system outage and does not lapse any policies for a day, a week, or some other time frame, this extra time the policy has remained in force does not count toward the five-month reinstatement request time period.

Disputes Arising from Demonstration of Cognitive or Functional Impairment

Another source of dispute in the cognitive and functional impairment reinstatement process is the requirement to prove that cognitive or functional impairment began before the grace period expired. Most states include language requiring that the evaluation standard of cognitive or functional impairment be no more stringent than that used to adjudicate claims under the policy. These standards usually involve review of medical records and the results of formal cognitive testing performed on or before the lapse transaction date.

However, insureds may not have formal cognitive testing documented in their medical records and so even those insureds who truly have Alzheimer's or another eligible cognitive impairment (as proven by cognitive testing performed at a later date) cannot clearly demonstrate such impairment in the medical records dated before the expiration of the policy's grace period. In these cases, reinstatement is not required by law. Alternatively, an individual may have had cognitive testing performed before the grace period ended, but the results of the testing do not indicate a ***severe*** cognitive impairment as required by the insured's LTC policy. While a modest cognitive impairment may have contributed in some way to the insured's alleged unintentional lapse of his or her policy, this level of impairment would not entitle the insured to have his or her policy reinstated.

Of course, state regulations are worded to permit insurers to utilize less stringent standards for evalu-

ation of impairment for purposes of reinstatement of coverage than for benefit eligibility determination for claims submitted on in-force policies, but it is unlikely that carriers would employ such a procedure in practice.

An interesting side note to this issue is the inclusion by the state of Florida of the phrase permitting reinstatement as long as the insured has been ***continuously confined*** in an Assisted Living Facility for at least 60 consecutive days. This is problematic for insurers because simply being confined in an assisted living facility does not mean the insured is eligible for LTC insurance benefits. In fact, the term assisted living facility applies to a broad range of entities; many such facilities may actually be independent senior living apartments and serve as the primary residence of insureds who are neither functionally nor cognitively impaired. The inclusion of this phrase in the Florida law significantly broadens the reinstatement right for coverage that was allegedly terminated unintentionally.

OTHER REINSTATEMENT REQUESTS

Many situations arise in everyday policy administration where a policy is unintentionally terminated and the customer wants to put the policy back in force when the termination is discovered.

Allegations of Premium Billing and Collection Processing Errors

A common complaint insurers hear is that the customer simply did not receive his or her billing notice or lapse warning or that a third party did not receive the lapse warning. It is unclear how often coverage is reinstated without investigation or management involvement when an insured maintains he simply did not receive his mail. Insurers would be wise to keep a record of all such reinstatement activity and may be surprised to find how often allegations of billing errors occur. To the extent that this activity is more frequent and exposes the insurer to more risk than it prefers, alternative management of the billing and collection process may be in order. For instance, an insurer who is reinstating a policyholder for a second or third time due to alleged lack of receipt of mail may wish to condition the reinstatement on future billing by automatic bank withdrawal.

Alternatively, an insurer may choose to investigate alleged billing errors in detail, rather than simply accepting the customer's word that an error occurred. If the insurer finds no evidence of any mishandling, it may deny automatic reinstatement but as a good faith policyholder service, may offer these individuals the opportunity to reinstate coverage by providing satisfactory evidence of good health. With mature blocks of business, it is unlikely that more than half of the applicants will be able to satisfy the underwriting criteria, but offering some means by which an individual may reinstate coverage may be viewed more favorably by state regulators or other outside third parties who may end up reviewing these situations than simply denying the request on the basis of not finding errors in the billing process.

As noted earlier, the Florida regulation requires that lapse warning notices to policyholders and third-party designees be mailed by U.S. Postal Service proof of mailing or certified or registered mail. Presumably, the reason for this requirement is to reduce or eliminate the number of disputes arising from alleged failure of the U.S. Postal Service to deliver required notices. However, the additional costs of mailing these notices by certified or registered mail are likely prohibitive for insurers with large blocks of business in Florida. While U.S. Postal Service proof of mailing is reasonably cost efficient, it does not provide evidence of ***receipt*** by the customer or third party, but rather simply provides evidence that the insurer ***mailed*** the notice(s). Carriers may wish to consider the possibility of mailing lapse warnings via certified or registered mail for older and/or longer duration policyholders and the less expensive U.S. Postal Service proof of mailing for the remaining policyholders.

In addition, to the extent that the root cause of alleged non-receipt of billing notices is due to the notices being inadvertently discarded as "junk" mail by the recipients, insurers may wish to review their billing packages for effectiveness. For instance, adding a bolded "Important Insurance Information Enclosed" message on the envelope may be an inexpensive yet effective way to reduce the possibility that these important lapse warning notices will be discarded without being opened.

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Premiums Arrive Late

A common problem that insurers face is whether to reinstate policies when premiums arrive shortly after the end of the grace period. Carriers may routinely provide an additional "internal grace period" of up to two days in the event that the 35th day following the mailing of a lapse warning falls on a Saturday, Sunday or holiday. But what happens if the 35th day after a lapse warning was mailed falls on a regular business day and the premium arrives the following day? When is a premium finally "too late" to allow the policy to be automatically reinstated? These are questions LTC carriers have to answer for themselves.

A key component to successful management of an LTC insurance operation is development and implementation of a comprehensive risk management strategy.

A separate emerging issue facing LTC insurers in the reinstatement management process relates to required health insurance policy reinstatement language that also appears in LTC policies. For example, the Florida health insurance reinstatement provision states, "Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. ***Later acceptance of the premium by the insurer,*** or by an agent authorized to accept payment without requiring an application for reinstatement, ***will reinstate this policy…"***

LTC insurers typically process premiums through a bank "lock box" process. Directly billed LTC insurance premiums are mailed to a post office box that essentially is a banking facility. As soon as the premium is received at the lock box, it is deposited into the insurer's bank account. The insurer's accounting team subsequently reconciles the premium receipts to its active policyholder list, and discovers that premiums have been received on a terminated policy. The insurer then refunds this premium to the lapsed policyholder by ***issuing a new check.***

Attorneys for terminated policyholders may suggest to their clients to mail premiums to the insurer and then file suit claiming that the insurer has "accepted" the premium because it deposited the money in its bank account without issuing a "conditional receipt" and therefore the policy has been reinstated, even if the insurer issued a refund check within a short period of time, such as a week or two weeks. To the extent successful, this path to reinstatement exposes the insurer to significant adverse selection and should be managed. Insurers may wish to research with their banking facility partner whether it is feasible to alter the process to eliminate certain checks from being directly deposited, and instead held in abeyance for up to 24 hours while being researched. Such checks could be directly returned un-cashed to the lapsed policyholders and the insurer would be less vulnerable to the argument that it had "accepted" the premium.

CONCLUSION

A key component to successful management of an LTC insurance operation is development and implementation of a comprehensive risk management strategy. Procedures to address the risks of the reinstatement process should be incorporated into such a comprehensive risk management plan. Carriers may wish to consider establishing a Senior Management Reinstatement Review Committee composed of underwriting, claims, actuarial, legal, compliance and policy administration personnel who would be charged with not only evaluating reinstatement requests but also with reviewing the various premium billing and collection processes used by the company to determine if there are ways to alter them to mitigate the reinstatement risk exposure (without exposing the carrier to other risks). Of course, as carriers begin to formulate risk management protocols to address reinstatement and other emerging LTC insurance business risks, it may be valuable to discuss the plans with internal or external risk management professionals and/or Sarbanes-Oxley compliance staff to gain additional perspectives and insights.

Note: *This is an abridged version of "Managing the Risks of the Long-Term Care Insurance Reinstatement Process." The article, in its entirety, is available online at* http://www.soa.org/ltc. ■

A Conversation on Reasonability

by Corin R. Chapman

Within the insurance industry, there are many standard risks to analyze, value and appropriately price for such as weather-related disasters, major epidemics, catastrophic earthquakes, substantial economic variations and regulatory changes. Wait, should regulatory changes really be grouped in with these critical occurrences? More than ever, implemented rules and regulations are having significant effects on the bottom line of insurance companies, particularly within the health insurance industry where new legislation seems to be created and debated almost daily. With the addition of many of these laws, a battle seems to be brewing pitting health insurance companies against regulators and vice versa. Given the understanding that actuaries from both sides have about the ultimate underlying effects of many of these regulations, it only makes sense that the burden must fall on our profession to step outside the political arena and have a conversation on reasonability. Only by working together can the relationship between those that issue insurance and those that regulate it be strengthened, therefore guaranteeing that a viable and fair market exists into the future for many of the health products marketed today, such as comprehensive medical, Medicare Supplement, and long- term care (LTC) insurance.

Each year, as medical premiums rise, sometimes by double-digit percent increases, consumers' trust towards insurance companies continues to decline. Critics cite specific examples of unscrupulous practices by a minority of insurance companies such as misleading sales practices, unfair rescissions or denial of coverage. These examples have occasionally been emphasized by the media and translated to all health insurance companies, often leading to increased pressure by the public to regulate health insurance companies. An obvious example of increased regulation is within the Affordable Care Act (ACA) in the form of a medical loss ratio requirement requiring all large group comprehensive health insurers to maintain a loss ratio of 85 percent and all small group and individual comprehensive health insurers to maintain a loss ratio of 80 percent. By limiting the allowable loss ratio, the government is attempting to essentially limit the profit a company can make, theoretically deterring any unfair practices.

Comprehensive medical insurers are not the only companies being targeted by recent regulation. Supplemental health insurance products, primarily

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excluded from ACA, have also been under increased scrutiny in recent years. In July, Representative Pete Stark from California and Senator John Kerry from Massachusetts introduced a bill to apply the ACA minimum loss ratio rules to Medicare Supplement. These rules would be in addition to the substantial guidance provided by the Medicare Supplement NAIC Model Regulation, current prior approval standards for rate increases in most states, and the fact that the Medicare Supplement market already has substantial price competition.

Additionally, through the current rate approval process, many insurance companies are being asked to set rate increases at levels that are below requested in order to maintain affordability of the product to the consumer. Reduced premium increases have the potential to put the product at a price level where it is no longer economical for insurers to remain in the Medicare Supplement market. For certain insurers, the introduction of the 80- to 85-percent minimum loss ratio would be the final deterrent from continuing to sell Medicare Supplement policies.

An additional product line where similar issues exist is within LTC insurance. LTC insurers have been a continuous focus of the media, the public, and regulators due to their product's inherent characteristics. LTC insurance premiums are paid over an extended time period, often greater than 20 years, in order to fund care that usually occurs towards the end of life. Therefore, any adverse action by the insurer, such as denial of benefits or an increase in premiums, has an increased likelihood of being experienced by an elderly individual with a fixed income. Premium increases may make the policies unaffordable for policyholders, causing them to lapse just when LTC services are becoming necessary.

In order to avoid consumers receiving unexpected rate increases, in 2000 the NAIC adopted the Long Term Care Insurance Model Regulation, which requires company actuaries to certify that rates are sufficient to pay future claims under moderately adverse experience. Additionally, the regulation requires that if companies do increase their rates, they need to meet an 85 percent minimum loss ratio on the increase from the original rate. Earlier this year, California presented and later tabled AB 999, which attempted to add an additional level of scrutiny by restricting rate increases to once every five years for pre-stabilization policies (sold prior to adoption of the NAIC LTC model regulations) and once every 10 years for post-stabilization policies.

From a consumer's point of view, increasing premiums on individuals, particularly the elderly who have already paid a substantial amount of premiums to an insurer, seems particularly onerous. Furthermore, for many regulators, the large rate increases being requested, some reaching 40 percent, seem to indicate irresponsibility on the part of the insurer. From the regulators' perspective, regulations are needed to ensure policies are priced correctly and to limit the insurers' ability to punish policyholders for their own pricing mistakes. Additionally from the regulators' perspective, it is necessary to have a given level of regulation to avoid insurers intentionally underpricing their products to build market share only to raise rates after policyholders have had the product for a substantial time period and no longer feel they can qualify for a new policy due to insurability standards. Therefore, many regulators feel limiting rate increases on LTC insurance policies is a clear and necessary step.

However, from an actuarial perspective, one cannot deny the need for rate increases for many insurers in order to maintain a sustainable product. The LTC insurance market remains relatively new and given the long tail on the claims curve, some insurers are only now starting to compile credible claims experience in which to compare previous estimates. Additionally, many of the assumptions that went into initial pricing, particularly those involving persistency, continue to evolve and differ substantially from expected. Initially, LTC insurance products were priced assuming a lapse rate similar to life insurance or Medicare Supplement products. However, lapse rates have decreased over time as the product and consumer behavior have evolved, leading to a substantial premium shortfall for many insurers. A perfect storm of lower than expected investments returns, changing mortality estimates and, in some cases, higher administrative expenses all have led to losses on insurers' blocks of business. Were these assumptions incorrect? Yes. Were they actuarially irresponsible? Probably not. When communicating needed rate increases, insurers point to the fairly immature market for LTC insurance and the fact that they need to continuously refine their assumptions to build and maintain a properly priced product.

However, from an actuarial perspective, one cannot deny the need for rate increases for many insurers in order to maintain a sustainable product.

As with many of the health products available today, many regulators are trying to protect their constituency, but is it destroying the possibility of having a viable market? Even at an increased premium, financial advisors agree that LTC insurance remains a valuable product for those who own it. With the baby boomer generation turning 65 and nearly two-thirds of people over age 65 estimated to need some sort of long-term care either at a facility or at home, it comes as no surprise that the lapse rate of LTC insurance is lower than anticipated. Even after rate increases, most providers fail to experience significant shock lapse. Further emphasizing the need for a viable LTC insurance market, increasing the number of individuals owning private LTC insurance will help reduce the mounting pressure on the Medicaid system caused by the usage of the home- and community-based care and institutional care benefit.

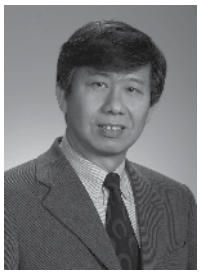
Despite the growing demand for LTC services, the number of insurers selling LTC insurance is decreasing. With the rising cost of LTC and the reluctance of regulators to approve needed rate increases, many insurers have chosen to discontinue sales and sometimes sell off their blocks of business. When determining applicable regulation, there must be more consideration of the effect the elimination of competition may have on the availability of the product. Regulators must consider if the coverage long-term care insurance provides is worth allowing insurers to institute unpopular and possibly financially harmful rate increases on in-force policies.

These issues are not unique to LTC insurance or even health insurance products. In general, insurers are often thought of as entities with unlimited capital, but as additional rules are implemented to govern profitability, the viability of many of these companies may become less stable. The balance between regulators protecting their constituency and allowing insurers to maintain a stable book of business is a struggle felt across the insurance industry with actuaries taking a front-and-center role on both sides. Actuaries have a unique opportunity to encourage more constructive conversations between all parties by educating both the regulators and insurers on all the potential ramifications of possible actions that either side may take. Additionally, as actuaries, we must continue to strive to create justifiable regulations and policies that work together to create a sustainable market.

Note: *This article first appeared in the December 2011/January 2012 issue of* The Actuary. *It is reprinted here with permission.* ■

Deconstructing Long-Term Care Insurance

by Robert Yee



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In spite of the growing need for long-term care financing, two observations about the current state of long-term care insurance market are inescapable. Recent sales are stagnant relative to the perceived demand. The number of insurance companies offering long-term care insurance is dwindling in both the individual and the group markets. These are clues that the current product offering is perhaps not working well for the consumers and the insurance companies. This article examines some of the shortcomings of today's product and suggests a different approach.

WHO WOULD WANT TO BUY THIS?

The vast majority of policies sold today have level premiums payable for life. However, history would suggest that premiums are likely to increase later when sufficient experience emerges. Many insurance companies with long-term care insurance business have implemented rate increases in at least one segment of their business.

Long-term care insurance premiums are determined from projections of future claims, voluntary lapses, mortality, investment returns and expenses. Because the business is highly persistent, small changes in the persistency and investment assumptions will have a large impact on the magnitude of the premiums that are necessary to fund future claims. Because the frequencies of claims are relatively low, credible claims experience develops slowly. Even though state insurance regulators cannot deny justifiable premium rate increases, they are reluctant to grant the amount of the increase as requested. Multiple rate filings are becoming a common practice. These factors all contribute to the uncertainty of both the timing and the size of the increases.

Almost all policies provide no cash value if the insured lapse or die.[1] While this feature helps to keep premiums low, it presents a problem for the insured when they are faced with a premium increase. Switching to another insurance company can be very costly because level premiums go up by the age at purchase. The insured will have to pay the higher new premium without receiving a residual value from the old policy. The older the policy, the more expensive it will be to replace.

On the benefit side, many insured may not claim for 20 or more years. Even though today's comprehensive policy covers a variety of care, the vast majority are still restrictive in that services will only be paid if they are specifically listed on the policy. However, long-term care services and supports are continuously evolving. Nursing home only policies purchased years ago have a declining utility today as home and community care are increasingly in vogue. The distinction between sub-acute and long-term care is blurring. Telecommunications technology is emerging to manage chronic diseases in the home setting. People's attitudes and preferences for care will likely change. There is a genuine concern that today's policy will not pay for prevailing services in the future. The alternate plan of care provision in most comprehensive policies offers no guarantee for relief since any "outside the box" benefit is at the discretion of the insurance company.

As a group, insurance companies' perseverance for their long-term care insurance business is questionable. Quite a number of them have left and, not surprisingly, rate increases soon followed. Hardly any insurance company that entered the market in recent years offered the traditional level premium policy.[2]

Given the uncertainty surrounding the premiums, the future relevancy of the benefits and the companies' commitment, a prudent buyer would hesitate.

WHO WOULD WANT TO SELL THIS?

Insurance companies are facing challenges on multiple fronts. In the early years, the long-term care insurance industry was plagued with mispricing from aggressive claims assumption and loose underwriting. The fairly large premium increases on older blocks of business failed to restore profits to the pricing expectation because of further

claims deterioration. Many seasoned companies in the industry have this baggage in their long-term care insurance business. Insurance companies have also erred in over-estimating the number of insured lapsing and dying. A small percentage decrease in the actual number of insured lapsing and dying will turn into a relatively large proportion of the insured claiming eventually.

Managing the investment risk is perhaps the greatest challenge for insurance companies. Investment income in long-term care insurance is a significant source of revenues. Moreover, there are very few investment instruments that can adequately provide the cash flow to match the long-term liability cash flow generated by long-term care insurance. During periods of low interest rates such as in recent years, this could be a serious concern for the in-force business. Cash flow generated from assets backing the reserves would be reinvested at rates below the original pricing interest rate assumption. Future profits would suffer.

For new business, companies would need to re-price with a lower interest rate assumption. A rough rule of thumb is that a one-half percent decrease in the pricing assumption translates into approximately a 15 percent increase in premiums. This puts considerable price pressure on sales. Because the rate filing approval process can take a year or longer, insurance companies are not capable of reacting quickly to drops in interest rates.

Sales production in general has declined in recent years. There is good evidence that the over 60 population may be saturated with offers of long-term care insurance. Younger individuals are less eager to purchase because long-term care is not an urgent concern. Without a strong marketing niche, consistent growth in this business may be a thing of the past for many insurance companies.

For insurance companies, the relief for unfavorable experience is premium rate increase. This relief is prospective only since losses from unfavorable experience are not recoupable according to insurance regulations. Because of the heightened sensitivity to rate increase filings, insurance regulators may only grant a portion of the amount of rate increases requested. Thus, for many insurance companies, the overall profit margins in their long-term care insurance line of business are significantly below what were expected.

Long-term care insurance policies issued after 2002 are generally governed by rate stability regulations. Under these regulations, the lifetime loss ratio formula can no longer reflect the actual investment results in the discounting. Because loss ratio is the measuring stick for rate increases, companies effectively assume all interest rate risks and are prevented from passing them along to the insured. Claims and persistency risks remain a shared burden for both the companies and the insured.

In recent years, the younger issue ages and the good persistency have extended the insurance companies' liabilities for a much longer period. In addition, future care delivery and societal changes will undoubtedly impact utilization of policy benefits. Perhaps it is becoming unreasonable to expect insurance companies to be able to predict all of the long-tailed risks accurately.

One recent development unrelated to long-term care is an additional concern. The United States is moving to a financial reporting system based on a market value valuation of liabilities. Changes in the valuation will be fully reflected on the bottom

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line at the time of change. Since a small change in assumption can produce a relatively large change in future liabilities, profit margins from long-term care insurance operation can be expected to be more volatile than they are today.

Confronted with low and uncertain future profits, lackluster sales growth and increasing difficulty in product risk management, it is not surprising that companies' commitment to this business is wavering.

To lessen the likelihood that the policy will be outdated, benefits are flexible to better suit the claimant's particular situation.

UNIVERSAL LONG-TERM CARE INSURANCE

An alternative to today's level premium policy is to apply the universal life insurance design to long-term care. Just as universal life unravels the internal mechanism of a whole life policy, universal long-term care insurance breaks the traditional long-term care policy down into its various components. In this design, the insured person periodically deposits its premiums to an account in the policy. Costs of long-term care insurance and expense charges are deducted monthly from the account. The expense charges would be consistent with actual expenses incurred by the insurance company. The company credits interest to the account. When the policy lapses, the account value, less any surrender charge, is paid to the insured person or a designated beneficiary in case of death. The account is evaluated periodically to ensure that the policy will not lapse due to zero account value.

To lessen the likelihood that the policy will be outdated, benefits are flexible to better suit the claimant's particular situation. The claimant and an independent care counselor collectively control the nature and manner of the care assistance and support that are most suitable for the claimant. There are virtually no restrictions on how the claimant can spend the benefit dollars. This benefit approach is similar to the Medicaid Cash and Counseling demonstration programs.

When there is no claim, the account value makes the policy flexible to meet the changing needs of the insured. Flexibility also extends to premium

Universal Long-Term Care Insurance Illustration

Policy Year	*Attained Age*	*Monthly Benefits*	*Lifetime Maximum*	*Premium Deposit*	*Expense Charge*	*LTC Charge*	*Account Value*	*Level Premium*
1	50	$4,800	$180,000	$1,600	$760	$14	$867	$1,600
5	54	$5,402	$202,592	$2,020	$565	$49	$6,908	$1,600
10	59	$6,263	$234,859	$2,703	$330	$103	$20,564	$1,600
15	64	$7,260	$272,266	$3,617	$422	$226	$41,705	$1,600
20	69	$8,417	$315,631	$4,841	$544	$501	$73,191	$1,600
25	74	$9,757	$365,903	$5,131	$163	$985	$118,057	$1,600
30	79	$11,312	$424,182	$5,131	$163	$2,240	$170,085	$1,600
35	84	$13,113	$491,743	$5,131	$163	$5,484	$223,276	$1,600
40	89	$15,658	$587,167	$5,131	$163	$16,429	$261,032	$1,600

deposits and benefit changes. Premium deposits are discretionary as long as the insurance and expense charges are properly funded. Changes in benefits affect only the future insurance charges. There are other positive effects as well. The insured would have greater confidence over today's policy because the internal funding for the insurance costs is transparent. Future increase in long-term care insurance charges due to unfavorable experience should be less frequent and for a lower amount because only claims experience can trigger it. Moreover, the account value should be able to cushion the increase for the near term.

In exchange for greater product flexibility and stability, the insured retain the investment return risk. This can be viewed as an advantage if the policy is a variable form, similar to a variable annuity. In this form, there will be a choice of investment options for the policy account.

The advantage of universal long-term care to the insurance companies is obvious. They relinquish virtually all the interest rate, persistency and expense risks. Managing the product is greatly simplified since only the claim risk is transferred to the companies. Unfavorable claim experience can be offset by implementing an increase in the long-term care insurance charges. With proper timing of the increase, the impact of adverse experience to the reserve liabilities in the new financial reporting system should be minimal.

In exchange for lower risk, perhaps insurance companies can strengthen the product appeal to the insured. Insurance companies could establish a schedule of maximum long-term care insurance charges so that the insured's potential downside is capped.

Universal long-term care would need to overcome several obstacles before it can be marketed successfully. The availability of the account value makes the universal long-term care insurance policy inherently more expensive than a traditional level premium policy with the same benefits. This exacerbates the affordability issue for long-term care insurance. The premium flexibility in the design can temper the higher premiums somewhat. For example, an increasing premium schedule can offer starting premiums that are attractive.

Refer to the illustration on page 22 of a universal long-term care policy with the increasing premium schedule along with a traditional level premium policy. Note that the projected values in this illustration will most certainly be different than those in an actual policy illustration.

In this illustration, the starting premium deposit is the same as the level premium for a comparable traditional policy. The premium goes up 6 percent each year until age 70 where it then becomes level thereafter. The increasing premium schedule is consistent with the increasing benefits and with the general increase in ability to pay while the insured person is working. The schedule results in a substantial account value in later years to fund the rising long-term care insurance charges.

Another issue for universal long-term care is that the insured must pay attention and plan for additional premiums if necessary to continue the coverage. Insurance companies must inform the insured in a timely manner.

Still another challenge is market inertia. The market is usually slow to adopt new concepts. Universal long-term care is more complicated to explain than today's policy. Educating the agents and getting their buy-in will be formidable tasks.

Regulatory Matters

From a state regulatory perspective, insurance departments are already reviewing filings on annuity and long-term care hybrid policies. Universal long-term care insurance is such a policy with periodic premiums rather than a single premium. Regulations for policy illustrations can mimic that for universal life.

From a federal taxation perspective, the Pension Protection Act of 2006 bifurcates an annuity with long-term care benefit into two separate contracts. Universal long-term care insurance would most likely be treated favorably under this scheme.

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Two ideas have been advanced to make universal long-term care more attractive to the consumers. First, the premium deposits can be lowered by restricting the surrender provision. For example, full surrender is permitted prior to attained age 75. Thereafter, surrender can only be in the form of a life annuity. This provision would dramatically reduce the cost of paying the account value upon death.

Another idea is to make universal long-term care a part of 401(k) programs (or similarly tax-favored accounts). Conceptually, the policy account of a universal long-term care insurance policy operates as a subaccount in the 401(k) program. One can argue that 401(k) is the natural venue because long-term care financial protection is merely a component of retirement security. Funding for the universal long-term care within a 401(k) program is enticing since it would simply be an allocation of the existing assets in most cases rather than competing for discretionary spending dollars. This approach would require federal legislation and would be perceived as a very helpful gesture from the government to promote private long-term care insurance.

A tipping point may be fast approaching for the long-term care insurance industry. Insurance companies are questioning the role of long-term care insurance in their strategic plans. More of them may exit once the new accounting standards are adopted. Those remaining may not be eager to take on all the risks embedded in today's policy. Potential buyers are also disillusioned. The third stakeholder, namely, the policymakers, should be concerned about the future viability of the industry.

Universal long-term care is not a panacea for all the problems facing the industry. It can provide a reasonable option for the buyers and the insurance companies but it does little for the in force business. Nevertheless, among the efforts to revitalize the long-term care insurance market, it deserves a look.

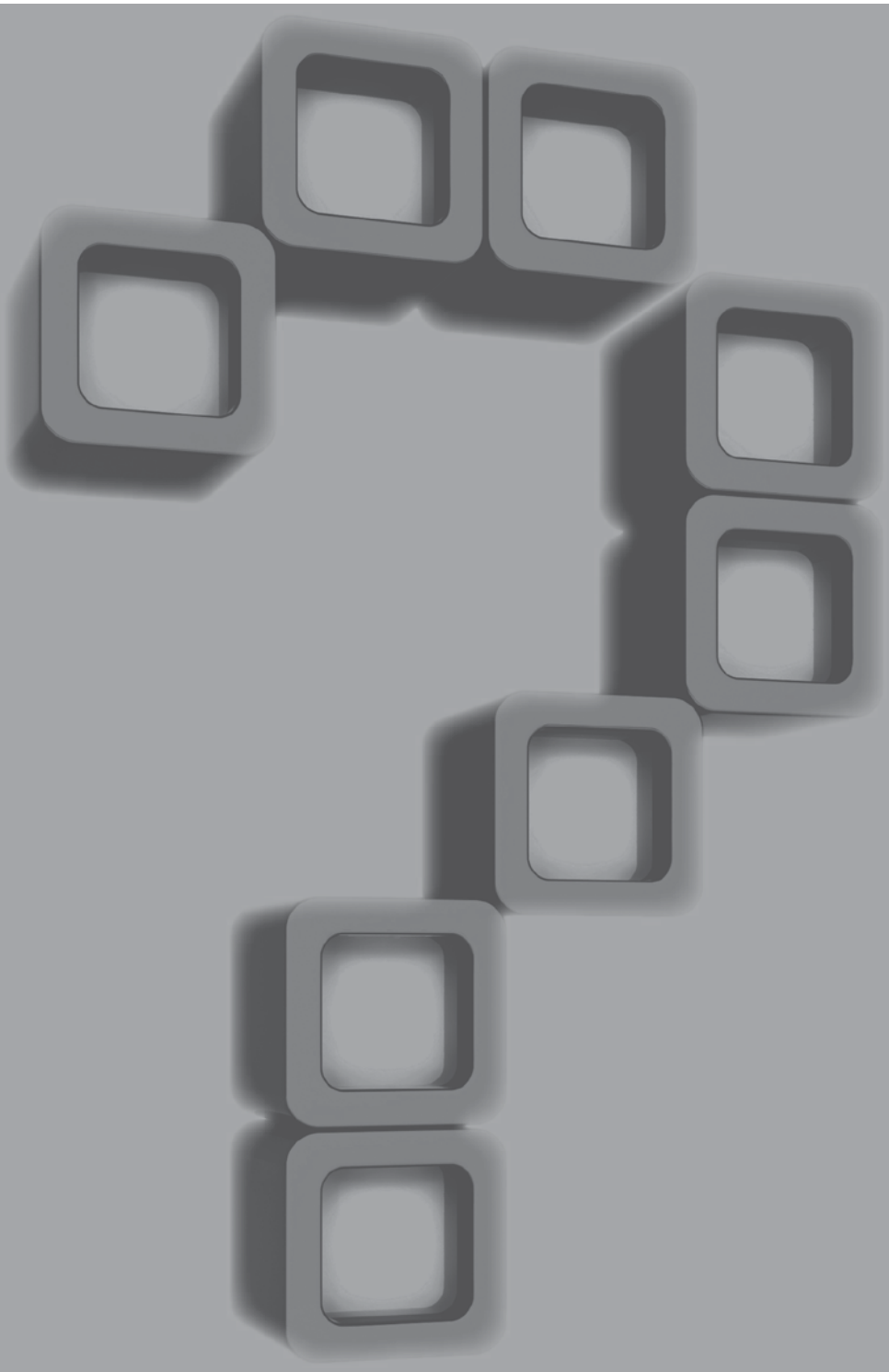
Note: *This is an abridged version of "Deconstructing Long-Term Care Insurance." The article, in its entirety, is available online at* http://www.soa.org/ltc. ■

END NOTES

1 Both the return of premium upon death and the non-forfeiture options in many of the policies provide some form of cash value but few buyers elected them.

2 Nearly all new entrants are life insurance and annuity companies. They are including long-term care benefit options in their single premium life insurance and annuity contracts—the so called hybrid policies. These policies require substantial premium (typically over $50,000 single premium), need for dual protection (long-term care and death), or both. They will probably have a difficult time penetrating the main segment of the long-term care insurance potential market—the working and the pre-retirement populations.

3 This illustration is for an individual issue age 50 in the Married–Standard risk class. The policy has a $160 initial daily benefit, a 5-year maximum benefit period, a 90-day elimination period and the benefits increases 3 percent compounded annually. Premium increases 6 percent annually to age 70 and level thereafter. Coverage ends at age 100. The policy has a 25 percent premium charge from year one through year five, 10 percent from year six through year 20 and 2 percent thereafter. In addition, there is a $200 initial charge and a $60 annual charge. The account value is accumulated at a 5 percent declared annual credited interest. The level premium is the average premium for a similar policy offered by a number of insurance companies.



Do you know which **organization** provides education to **millions** of **Americans**

First Principles LTC–Restoration of Benefits

by Robert W. Darnell

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Author's Note: *This article compares differences in long-term care insurance policies based on whether or not the restoration of benefits feature is included. A first-principles model was used for the mathematical determinations.*

Certain abbreviations are used: LTCI (long-term care insurance), NH (nursing home), ALF (assisted living facility), HC (home care), MDB (maximum daily benefit), MLB (maximum lifetime benefit), BP (benefit period), EP (elimination period), IP (inflation protection), ROB (restoration of benefits), and ALR (active life reserve, or contract reserve). The term 'care settings' refers to the three principle settings for those receiving benefits: NH, ALF and HC.

MODEL TYPES

The advantages of a first-principles model are becoming increasingly apparent and desired by LTCI carriers. Too often, people utilize the term "first principles" when they are simply referring to the derivation of claim costs by using claim-incidence (incidence) rates and claim-termination (termination) rates. A true first-principles model derives all values from calculations that use first principles. These basic principles are then used to develop pricing, valuation, and/or projection analyses for active lives and disabled lives.

For a first-principles model, incidence, utilization and termination assumptions are generated using measurements of company or industry experience. Monthly claims paid, claims incurred and claim reserves are calculated from the assumed incidence and termination rates. At the end of each month, the present value of future claim payments is calculated to tabulate the claim reserve. The reserve at the incurral date represents the incurred claim.

For a claim-cost model, incurred claims are calculated in advance of the analysis and entered as an assumption. An overall claim runoff pattern is also input, and all claim payments are assumed to runoff based on this schedule. Therefore, claim payments and claim reserves are a function of the input claim runoff. For the claim-cost model, all policies (active lives and disabled lives) incur claims which put the onus on the claim cost assumption to reach the appropriate claim levels.

Clearly, claim payments and reserves will generally be more precise using a first-principles model rather than a faster but less precise claim-cost model.

ROB: REMAINING BENEFITS

In general, the ROB feature will restore a policy's MLB, as if no claim occurred, under certain circumstances. The circumstances often include: benefits were not exhausted under the prior claim, and the insured proved that he could perform his benefit triggers for a specified period of time (commonly six months) following the conclusion of their most recent period of care.

For some policies, the maximum benefit cannot be defined. Examples include those policies with an unlimited BP and those with the ROB feature. Policies with a "fixed" BP and without ROB have a finite maximum benefit. If this latter policy includes some form of IP, the maximum benefit may be increased each year by the inflation protection amount, but the maximum benefit continues to be a fixed, although changing, amount.

When considering anti-selection, policyholders who are close to exhausting their benefits may end their period of care and return to an active status. To address this possibility, the following assumes that 50 percent of those about to exhaust their benefits return to an active status (the remaining 50 percent exhaust their benefits).

When a policy with ROB is priced, the incurred claim for each attained age is based on the entire benefit period. For a policy without ROB, prior paid claims must be considered because the policy will not pay more than the MLB. If pricing looks at each attained age, the paid claims for prior ages should be subtracted from the MLB, to obtain the MLB available for the current age. If pricing looks at cen-

tral ages, the paid claims for the central ages may be interpolated to obtain paid claims for all ages. Then the paid claims for prior attained ages may be added, and this total subtracted from the initial MLB to obtain the remaining MLB for current age.

NH-ONLY, ONE-YEAR BENEFIT PERIOD

As an example, consider a policy with a simple benefit structure: female, issue age 62, NH-only, MLB of $3,650, one unit with $10 of MDB, 0-day EP, no IP, and claims are paid at 100 percent utilization.

If a policy has ROB, each attained age is priced with an MLB of $3,650 ($10 per day for one year). The incidence and termination rates are used to calculate the paid claims for each month, at each attained age. Due to the ROB, the benefits are restored to their initial MLB after each claim and the insured has the availability of the full MLB at each attained age. Therefore, for each attained age, the full benefit period is used with the attained-age continuance rates to derive paid claims.

Calculating the (undiscounted) paid claims for each of the quinquennial ages, leads to a summary found in Figure 1 (see the 'With-ROB' column).

Figure 1. Paid claims by age at disablement: one-year NH-only benefits.

	ROB	
Age	With	Without
62	2.389	2.389
67	3.145	3.137
72	6.780	6.737
77	22.448	22.091
82	52.196	49.740
87	129.126	113.704
92	219.508	156.201
97	258.737	125.197
102	258.737	84.773
107	258.737	58.857
112	258.737	39.174
117	258.737	25.719

(Note: With the data set used, ages above 95 were combined to derive incidence and termination rates.)

We can linearly interpolate between central ages to determine the gross amount spent at interim ages. Using ages 62 and 67, the paid claims for age 66 are: $2.994. Paid claims for ages 62-66 are equal to: (2.389 + 2.994) ÷ 2 × 5 = 13.457. Paid claims for ages 118-120 are approximated using the paid claims for age 117. For ages 118 and 119, the incidence and continuance rates are the same as for age 117. Therefore, for a one-year benefit period, the paid claims for ages 118 and 119 are the same as for 117. For age 120, everyone has expired by the end of the year. We will approximate the paid claims as 50 percent of the paid claims for age 117.

Total paid claims are estimated as $8,770.98.

(2.389 + 2.389 + (3.145 – 2.389) * 4 ÷ 5) ÷ 2 × 5 + (3.145 + 3.145 + (6.780 – 3.145) * 4 ÷ 5) ÷ 2 × 5 + … + 258.737 × 5 + 258.737 × 3.5 = $8,770.984.

If a policy **does not have** the ROB feature, we must keep track of the paid claims at all attained ages to ascertain that total benefits do not exceed $3,650. At age 62, the issue age, we have the full MLB of $3,650 available. We calculate, again, paid claims equal to $2.389.

To calculate the paid claims at the next central age, 67, the remaining MLB must first be determined. With ROB, the remaining amount is always $3,650; however, without ROB, the amount decreases because the total gross paid claim amount will not exceed $3,650. Using the paid claims at age 62, we can derive the paid claims at each of attained ages 63, 64, 65 and 66. We could go through a fair amount of work to determine the amount spent at ages 63-66, or, we can conservatively estimate the paid claims as: 2.389 × 5 = $11.944. The MLB available at age 67 is: 3650.00 – 11.944 = $3,638.056. To determine paid claims, use continuance rates until the remaining maximum of $3,638.056 has been spent. For age 67, we find the amount of paid claims is $3.137 (approximately one cent less than the version with ROB).

To determine the remaining MLB amount available at central age 72, we utilize the paid claims at age 62 of 2.389, and 3.137 at age 67. By interpolation, the paid claims at age 66 is $2.988. The cumulative amount paid out at all ages prior to age 72 is: (2.389 + 2.988) ÷ 2 × 5 (for ages 62-66) + 3.137 × 5 (for ages 67-71) = 13.441 + 15.687 = $29.129. To calculate the claims paid at age 72, run the continuance rates until the maximum remaining benefit, 3,650 – 29.129 = $3,620.871, is reached. From this we determine that the amount of paid claims at age 72 = $6.737.

CONTINUED ON **PAGE 28**

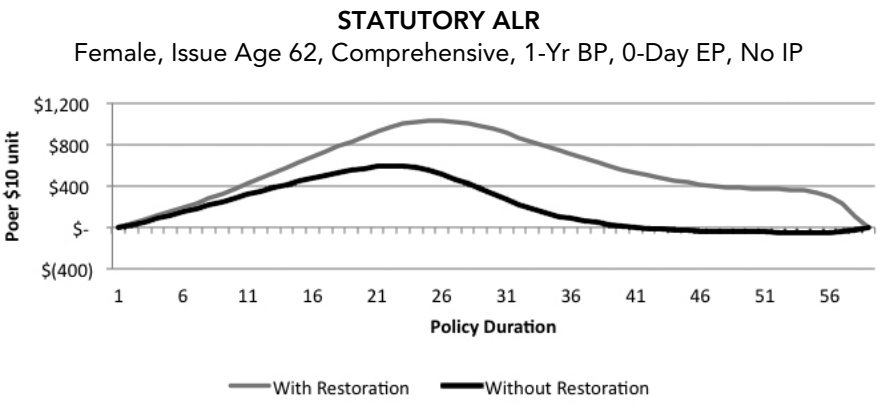
In a similar manner, for the remaining central ages, we can calculate the available MLB and use the continuance rates to calculate the paid claims. Paid claims for the central ages are shown in the 'Without-ROB' column of Figure 1 on page 27.

As illustrated, we can approximate the cumulative paid claims: $3,446.67.

Figure 2. Paid claims by age at disablement, one-year comprehensive benefits.

	ROB					
	With			Without		
Age	NH	ALF	HC	NH	ALF	HC
62	2.10	1.21	3.58	2.10	1.21	3.58
67	2.77	1.60	5.95	2.75	1.58	5.92
72	5.96	3.46	11.95	5.84	3.39	11.78
77	19.68	11.52	20.00	18.70	11.00	19.37
82	45.74	26.66	32.83	40.35	23.82	30.29
87	112.93	66.19	56.24	83.73	50.67	46.10
92	192.08	112.62	70.36	88.81	55.36	40.18
97	226.58	133.24	71.67	44.27	28.13	20.11
102	226.58	133.24	71.67	23.85	15.34	11.94
107	226.58	133.24	71.67	9.30	6.17	5.23
112	226.58	133.24	71.67	5.71	3.79	3.21
117	226.58	133.24	71.67	1.71	1.13	0.96
Total	**$7,679.92**	**$4,511.36**	**$2,825.00**	**$1,632.83**	**$1,005.17**	**$986.70**

Figure 3. Statutory ALR, one-year comprehensive benefits.



With the policy assumptions used here, the policyholder does not use all of his/her benefits. Using more lenient assumptions (i.e., higher claims), the policyholder may run out of benefits prior to attaining age 120, the omega age of the 1994 GAM.

The policy with ROB is expected to have paid claims that are considerably larger than the policy without ROB ($8,770.98 versus $3,446.67).

COMPREHENSIVE, ONE-YEAR BENEFIT PERIOD

For the next example, consider replacing the NH benefit with comprehensive benefits (NH, ALF and HC) – still with a single benefit pool. The underlying mathematics are more complicated: three care settings, incidence and termination rates for each, and transfers between the care settings are all considered. Utilization used is 100 percent for the NH benefit, 75 percent for the ALF benefit and 50 percent for the HC benefit.

Differences between one benefit pool and three benefit pools should be pointed out. Most policies have one MLB for the entire policy, while some policies have separate MLBs for each care setting, or perhaps one MLB for facility coverage (NH and ALF) and one MLB for HC. For multiple MLBs, anti-selective transfers should be considered as one of the MLBs is depleted, while another pool has remaining benefit capacity. Multiple-pool policies force the consideration of these last-minute transfers whether the policy has ROB or not.

Figure 2 illustrates the paid claims by age at disablement for policies with and without ROB.

The policy with ROB has approximate paid claims of: 7,679.92 + 4,511.36 + 2,825.00 = $15,016.28 The policy without ROB has approximate paid claims of: 1632.33 + 1,006.15 + 986.70 = $3,625.19. Figure 3 compares the statutory ALR for these two policies.

Note that the benefit without ROB produces negative reserves in the later durations. As the MLB is reduced, due to past paid claims, the higher attained ages generate incurred claims that are less than the net premium, causing the negative reserves.

LONGER BENEFIT PERIODS

When benefit periods of two years, four years, six years and lifetime, we find the following paid claims as shown in Figure 4.

COMPREHENSIVE, FOUR-YEAR BENEFIT PERIOD, 5 PERCENT COMPOUND IP

If we again look at the policy with a four-year benefit period and comprehensive benefit period, and add 5 percent compound IP, we can calculate the statutory ALR. The results can be found in Figure 5.

In Figure 5, the graph for with-ROB includes an increase beginning around duration 46. This anomaly is caused by the mortality rates for these attained ages. The mortality rate, in general, increases with attained age. However, the 1994 GAM mortality rates for ages 112 through 119 are forced to 0.5.

PRICING ROB

The price of the ROB feature varies with the variables that change the cost of benefits. The primary variables include gender, marital status, issue age and the benefit period. The price also varies with the number of benefit pools and level of underwriting.

As a comparison, the Figure 6 illustrates the cost for insureds who are initially married but their spouse did not apply, and 5 percent compound inflation protection.

To calculate these premium percentages for the ROB, a level annual premium was calculated for the base policy without ROB. A hurdle rate of 15 percent was used.

SUMMARY

With a claim-cost model, many policies without ROB have incurred claims calculated as if the policy includes the ROB feature. In this case, a policy without ROB may be thought to have the same claim incurrals as a policy with ROB. This problem may be further exacerbated by analysis of experience data. If utilization is higher than expected, it may be thought that the upper curve (see, for example, Figure 3 or Figure 5) is even higher than it is, and the entire curve may be raised. In reality, most policies are on the lower curve because they do not have ROB. If utilization is higher during the early policy years, the curve will be higher for these durations, but, because policy benefits are limited, the curve will be lowered for the later durations as benefits begin to run out. In addition to the curve being lower at the later durations, the curve may reach zero sooner, and the curve is shortened, as policies expire.

Figure 4. Paid Claims, female, comprehensive benefits.

ROB Option	Benefit Period			
	2-Year	4-Year	6-Year	Lifetime
With	$26,418.30	$37,988.17	$44,849.90	$61,907.50
Without	7,243.37	14,471.48	21,652.09	61,907.50

Figure 5. Statutory ALR, four-year comprehensive benefits, 5 percent compound IP.

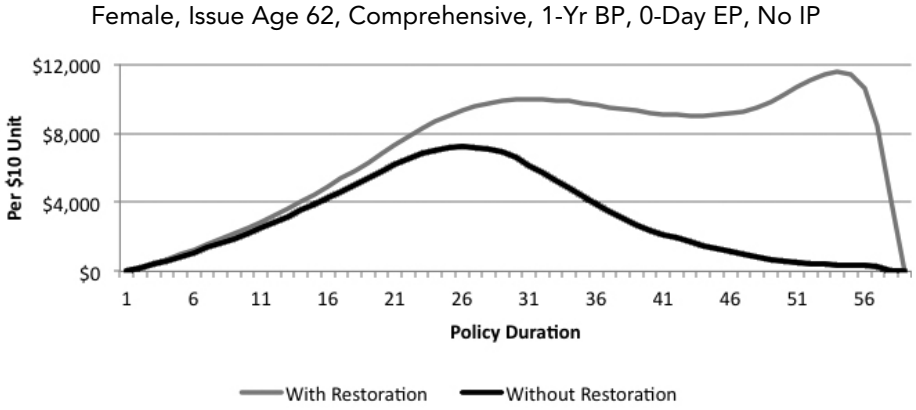


Figure 6. ROB pricing for a single-pool policy.

Benefit Period	Price of ROB as a Percent of Underlying Policy			
	Male		Female	
	Age 22	Age 87	Age 22	Age 87
1-Year	8.9%	14.3%	28.9%	39.7%
2-Year	4.2	6.4	21.8	29.1
4-Year	0.7	1.2	9.5	12.4
6-Year	0.1	0.2	3.5	4.7

CONTINUED ON **PAGE 30**

The effect of the ROB can be quite significant for pricing, valuation and projections. The premium for the ROB can also be substantial, especially for females and at the lower MLBs. The move to a first-principles model should reflect this benefit and its importance.

Note: *This is an abridged version of "First Principles LTC – Restoration of Benefits." The article, in its entirety, is available online at* http://www.soa.org/ltc. ■

Four Questions

"A moment's insight is sometimes worth a life's experience."

With this quote from Oliver Wendell Holmes, Sr. in mind, we pose a series of identical questions to diverse long-term care insurance industry leaders asking them to share thoughts that we hope will yield meaningful and interesting insights for all. We thank Terry Truesdell and John Cutler for taking the time to respond to our questions.

Q: LOOKING BACK, WHAT ONE CHANGE DO YOU BELIEVE WOULD HAVE ENABLED ADDITIONAL CONSUMERS TO BE PROTECTED FROM THE IMPACT OF LONG-TERM CARE EXPENSES?

Truesdell: First off, I recognize that hindsight is always 20/20. I think that if we had established a different standard for the "right" long-term care policy benefit design, we would be far better off as an industry. What I mean by this is that rather than set the bar at you-must-sell compound 5 percent, lifetime maximum which has proven to be very costly for both insurers and consumers, we should have been looking at other types of options that solve the problem differently—more buy as-you-go rather than funding these rich benefits over the life of the policy.

Cutler: If one could go back when programs like Social Security and Medicare were created and incorporate long-term care (LTC) into them instead of Medicaid.

Q: AND LOOKING AHEAD?

Truesdell: I think we have to align with the government to help them understand the benefits of creating a favorable buying environment through tax incentives. Obviously, an above-the-line tax deduction would be great but understanding it may not be possible to achieve that. There are other ideas that would make buying more attractive such as using 401K/403B/IRA dollars on a penalty-free basis for LTCI premiums. State governments in particular should be convinced that long-term care insurance can play a role in ameliorating their Medicaid budget issues.

Cutler: Looking forward, probably the best change would be something like incorporating a social program that backstops risk (for both the individual and the private market) but allows or motivates people to move money into a private insurance program to better protect themselves than can be afforded by the government alone.

Q: WHAT JOB WERE YOU DOING PRIOR TO STARTING YOUR WORK IN LTC? OR, IF YOU HAD TO PICK ANOTHER JOB/CAREER, WHAT WOULD YOU BE DOING?

Truesdell: I love the LTC job, industry and people so I can't think of anything I would rather do than be in long-term care. I have spent most of my career in the insurance business. I had worked in retail prior to insurance but I truly love this field of work.

Cutler: Probably banging my head against the wall just as I am now but at some cool think tank kind of place where it is OK to wear tweed jackets and smoke a pipe.

Q: WHAT KEEPS YOU UP AT NIGHT WHEN THINKING ABOUT YOUR SPECIFIC LTC FOCUS AREA?

Truesdell: It has come to me over time that you really can't change anything in the middle of the night—that real change is a day job. I try not to let things bother me at night. It's not that there aren't huge issues out there, but I focus on what I can control and the change that I can implement.

Cutler: That's a tough one since I can sleep through probably just about anything. I guess what BOTHERS me most is that we never seem to get long-term care past being No. 4 or No. 5 on whatever list people keep of the three most important things they have to do (both as individuals and as policymakers). There are always needs and concerns ahead of long-term care. ■

Terry Truesdell is president/CEO of National LTC Network, Inc. He can be reached at *terrytruesdell@nltcn.com*.

John Cutler is the team leader for the new multi-state health care plans at the U.S. Office of Personnel Management (OPM). Prior to that, he worked on the Federal Long Term Care Insurance Program as well as the early efforts around long term care awareness. He can be reached at *john.cutler@opm.gov*.

ILTCI Recap: A Blueprint for the Future

Vegas provided the setting for the 12th Annual Intercompany Long Term Care Insurance Conference in March, and attendance was up with more than 750 people. This year's conference proved to be one of the best yet. The theme "Blueprint for the Future" did not disappoint and set the stage for exciting and informative forward-looking sessions, providing perceptive learning, and impromptu networking. The ILTCI Conference Association would like to thank those who devoted their time, skill and expertise over the past year, as well as the corporate sponsors and co-sponsors, and exhibitors who help make the conference possible.

There were several pre-conference workshops and meetings: a two-day CLTC Master Class, and meetings for the SOA LTCI Section Council, LTCI Think Tank, and the ILTCI Technology/Business Group. A CE-earning session, 'Funding Longevity Using Reverse Mortgages," also was held.

The conference opened with its traditional Exhibit Hall Reception where attendees were able to visit with friends and peers as well as catch up on what our exhibitors had to offer. Supported by our industry sponsors and exhibitors, the conference meals and various exhibit hall receptions gave attendees unparalleled opportunities for networking with their customers, clients and peers.

The conference opened with its traditional Exhibit Hall Reception where attendees were able to visit with friends and peers as well as catch up on what our exhibitors had to offer.

ILTCI was fortunate to have Scott Kipper give the welcoming address. As commissioner of the Nevada Division of Insurance, his message engaged the audience on the panache of Nevada, and his view of the current and future state of the LTCI industry. Jay Bushey, chair of the SOA LTCI Section Council, provided an overview of the section's accomplishments over the past year and the council's current activities and goals for 2012.

Introduced by Greg Maciag, president and CEO of ACORD, David A. Smith, our keynote speaker offered a global view of the forces that will affect the LTCI industry in the coming years. An internationally recognized futurologist and president and CEO of Global Future Forecasting, David provided topical insight on what the future could mean to long-term care insurers. His presentation covered global trends in economics, population and care giving, as well as new insurance products, new care products and technology.

The second general session, "Healthcare Reform and the Future of Long Term Care," was led by Gary Jacobs from Universal American. The session included views from the private insurance industry, the provider community and from the employer's perspective. Mark Parkinson, the former Kansas Governor and current president and CEO of the American Health Care Association and the National Center for Assisted Living, and Jeff Ellis, vice president and CFO of Benefits with MGM Resorts International, presented. The three addressed varying perspectives on the link between health care and long-term care. Lastly, a post-conference "SOA Actuarial Professionalism" workshop included discussions on the Actuarial Standards of Practice for LTC actuaries, the Actuarial Board for Counseling and Discipline (ABCD) and the new joint discipline structure.

The 48 educational sessions, from our six tracks, are summarized below: Actuarial and Management; Claims and Underwriting; Operations and Technology; Policy, Providers and Compliance; Sales and Marketing; and General Topics.

The Policy, Providers and Compliance Track offered up-to-the-minute content, colored by the rapidly changing landscape for health care and long-term care issues as well as the ever-present changes in the LTCI regulatory environment. Attendees were informed and challenged by the ever-changing regulatory environment in the litigation and regulatory change sessions. The "Interstate Compact" session provided attendees with insight on product filing requirements and carrier experience. Sessions included the ever-popular "Washington Watch" which critically examined goings-on in Washington and the implications for our industry. The session was informative, witty and provided insightful commentary on key policy drivers for our indus-

try. Another session focused on the development of long-term care services and supports by presenting findings of a comprehensive study that essentially provides a scorecard for how states are doing with respect to four specific dimensions of LTSS system performance. The conference also focused on end-of-life care issues with implications for long-term care insurance. Recognizing the importance of reducing the burden on informal caregivers, another session examined two model programs designed to support and enable informal caregivers, in particular those dealing with a loved one with Alzheimer's Disease.

The Actuarial and Management Track devoted much of its time and attention to providing ideas and practices that would help individuals and companies plan for a better future. The sessions started with an interesting exchange of creative ideas to help build a best practices dashboard for monitoring and managing one's block of business. One couldn't help but to leave this session with some new ideas to improve or initiate his or her own dashboard. There were two sessions this year that were designed to challenge actuaries into thinking about how they can use Monte Carlo Simulation models to improve their skills and knowledge. One of these sessions focused on how to quantify the risks inherent in long-term care insurance (LTCI) and demonstrated how these models can help an actuary define moderately adverse experience. The Group LTC market was also represented at the conference with a discussion of what the future holds, including ideas for products that may be best suited for this market. A panel of experts discussed what influences companies to get in and get out of LTCI. This session included informative views from rating agencies and reinsurers. Recognizing that sales of combo products are on the rise, a good overview of this market was provided along with the results of the recently completed SOA-sponsored research of the pricing synergies of combination plans. Another session had an interactive discussion on this year's revisions that were made to the Academy Practice Note on rate stability and controversial issues that surround the NAIC LTCI Model Regulation. Now

that CLASS is no longer an option, a panel shared thoughts on what is next. This discussion was interesting and included ideas on how the long-term care (LTC) financing needs of the working disabled and the middle class can be met. Statistics can be useful but at times misunderstood. This was the theme at the final session which helped to set the record straight and provided some relevant and actuarially sound statistics for all to use.

For 2012, the Claims and Underwriting Track focused on the conference theme of "Blue Print for the Future" by producing several sessions on how technology will change the landscape for claims and underwriting practices across the industry. With a focus on the future, sessions reviewed how independent review organizations and private caregivers are changing the way claims are processed. The future of genetic testing and new developments related to cognitive impairment were reviewed for their future impacts on risk evaluation strategies. A roundtable discussion, focused on claims process trends, allowed industry experts to share experiences and solutions for tomorrow. For the third year, claims and underwriting experts discussed what they can learn from each other in their ever

CONTINUED ON **PAGE 34**

Two sessions targeted marketing, both from the point of view of distribution and from the point of view of the home office.

changing environments. An interactive session with a diverse panel that included a private caregiver, an agent/broker and a health care provider elevated ideas to help shape future claim processes. Overall, there was a clear focus on the future of claims and underwriting practices and how these will change to meet future needs over time.

The Sales and Marketing Track presented eight sessions at the ILTCI Conference in Las Vegas March 20 and 21. A highlight was the session, "How to Become a Billion Dollar Industry Again," featuring Marianne Harrison, president Long Term Care for John Hancock; and Buck Stinson, president, Insurance Products, Genworth Financial. They and two distributors forthrightly answered the questions from an involved audience.

Two sessions targeted marketing, both from the point of view of distribution and from the point of view of the home office. Other sessions highlighted recruiting techniques, how to associate with associations, non-traditional long-term care products, and effective selling with or without the use of technology. Finally, the "Sales Ideas That Work" session featured a "Cruise to Success" theme, complete with cruise liner props. This interactive forum highlighted seven topics where participants shared innovative ways to increase sales.

The General Topics Track was new in 2012 and presented a wide array of sessions of interest to conference attendees without being specifically tied to a certain area of practice. "Approaches to Address Middle Market LTC Needs" focused on the solutions that currently exist for the middle market, reviewing affordable examples of those solutions, and examined the reasons consumers do not purchase coverage. In "Clash of the Titans," Harley Gordon and Steve Moses engaged in a lively debate about the most important challenges facing the private LTCI industry. "International Perspectives" helped attendees understand how other countries are dealing with LTC financing issues. "Outsiders' View" investigated how those outside the industry view the LTCI industry. "Regulation and Innovation" provided an update from the Society of Actuaries' LTC Refinement Work Group. Attendees were able to speak directly with state insurance department representatives on current issues affecting LTCI at "Regulators for Regulators." "Reverse Mortgages?" provided an overview of the reverse mortgage market and its relationship to LTCI. Finally, "Smart Homes, Robotics, and Changing Care" presented the cutting edge in how technology is shaping care today.

Staying true to this year's goal of crafting a blueprint for the future of LTCI, the 2012 ILTCI Operations and Technology Track provided attendees with information, tools and case studies, to effectively handle challenges, more readily recognize opportunities, and realize quick wins and long-term successes. While there is often a focus on marketing and new business, the operating side of the company must be efficient in reporting, processing and providing excellent customer experiences. Industry experts developed and led noteworthy, engaging discussions to address the realities of operating in the industry's current climate, and considered all aspects of organizational operations. One session highlighted how smart LTCI marketers are regarding combining prospects' buying habits, social media and high-touch customer service successfully. This transforms data into information, and information into actionable intelligence that turn prospects into customers. It also provided meaningful ways to deliver a superior customer experience, something that's challenged the LTCI industry for years. Another session highlighted improved cus-

tomer value by focusing on call center metrics as a way to mitigate complaints, resolve issues on one call, and improve performance through reporting, survey analysis and listening to the voice of the customer. And others specifically talked to adopting and applying technology in manageable, meaningful ways. All in all, the sessions allowed for a comprehensive discussion on the people, processes and systems that support LTCI operations.

The 12th annual conference will be hard to beat, but work has begun to set the wheels in motion to reach that goal with next year's conference. Mark your calendars now for the Thirteenth Annual ILTCI Conference, to be held March 3-6, 2013, at the Hilton Anatole in Dallas, Texas. Thanks again to all who have made this year's conference a success.

Note: The introduction for this article was provided by Kathy Hamby and David Kerr, chair and co-chair of the 2012 Conference, respectively. Track chairs provided the reports on the respective tracks: Steve Schoonveld and Keith Burns, Actuarial and Management; Jacqui Bencomo Carreno, Grace Nogueira, and David Swaim, Claims and Underwriting; Brian Vestergard, Rod Perkins and Dave Benz, General Issues; Susan Nelson and Sharon Reed, Operations and Technology; Beth Lovaas, Eileen Tell and John Cutler, Policy and Providers and Compliance; and Louis Brownstone, Gloria Slaughter, Laura Wooster and Steve Cain, Sales and Marketing. ■

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