SOCIETY OF ACTUARIES Long Term Care Insurance Section

Long-Term Care News

ISSUE 37 DECEMBER 2014

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Who Will Pay for Mom's or Dad's Nursing Home Bill? Filial Support Laws and Long-Term Care

Contributed by Julie Flaa, Director of LTC Product Development, Northwestern Mutual

Imagine this: One day you're sifting through your mail. In the pile of letters, bills and junk mail, you find a letter from a law firm informing you that you need to pay $50,000 to cover the cost of your father's recent nursing home stay, or the care facility will sue you.

While this may seem farfetched, depending on your parents' state of residence, this could be a possibility.

If your parents live in one of 29 states or Puerto Rico that has filial responsibility laws on the books, you could potentially be held legally responsible for their care under certain circumstances, such as when your parents are ailing and without sufficient financial resources to take care of themselves. Until recently, these statutes have been largely ignored. However, several recent court decisions indicate that there might be renewed interest in enforcing them.

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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

Another Strong Year

By Jim Berger

The role of the Long Term Care Section of the SOA is to promote research and education with respect to long-term care insurance. The section council has been focused on these goals in its monthly phone conference.

Members of the council organize sessions for several SOA meetings throughout the year as well as additional activities at the Intercompany Long Term Care Insurance conference. Sessions have been planned for the 2014 Health Meeting, the LIMRA/LOMA DI/LTCI conference, and the 2014 SOA Annual Meeting and Exhibit. Additionally, three webcasts were held in 2014 with a fourth scheduled by the end of the year.

Another facet of the education mandate is found in the newsletter. The articles are drawn not only from actuaries but from experts in fields such as claims, underwriting and marketing covering insurance-specific and non-insurance-specific topics. The newsletter's distribution goes to more than simply actuaries—it is a valued source of industry information. Thanks to Sheryl Babcock for editing this edition.

The research mandate has seen work related to volatility recently. A link to the technical paper "Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance" by Roger Loomis and his colleagues at Actuarial Resources Corp. can be found on the Long Term Care Section webpage. Its companion paper, "The Volatility in Long-Term Care Insurance" by Rachel Brewster and Sam Gutterman is descriptively focused. Also on the webpage is the Delphi study "Land This Plane" which searches for solutions to the LTC funding issue and was previously highlighted in this newsletter.

The section council has extended funding to other educational and research projects and is developing research proposals on brain exercises and their potential impact on LTCI claims, and current net premium levels compared to past levels (have we seen rates increase to a point of stability?). As LTCI is not just a U.S. issue, a dialogue between the SOA and the French Institut des Actuaires is occurring to learn what each country can teach the other about LTCI.

The council has entertained regulatory interactions on the topics of sex-distinct pricing and on the principles-based approach. And then there is the marketing of the section—sections are part of the glue that holds the SOA together.

To close, thanks goes out to three council members who have completed three years of service: Siva Desai, Missy Gordon, and Heather Majewski. And congratulations go to three new council members: Bob Yee, Juliet Spector, and Rebecca Tipton. The LTCI council is different from the typical section council in that it includes three non-actuaries with three-year terms: Sharon Reed, Joe Furlong, and Paul Gribbons. These three council members add valuable perspective to the work that is done. And to round out the roll-call, the other council members are Sheryl Babcock, Bob Hanes, Julie Flaa, Rachel Brewster, and Vince Bodnar. As the new council year begins at the annual meeting, the chairmanship moves to Bob Hanes with Vince Bodnar as the vice-chair. As a second-year chair, I remain on the council. Finally, appreciation goes to John Nigh, the SOA board partner, Mike Boot, the SOA staff partner, and Leslie Smith, the SOA section liaison. Thanks to all of these people and the service they give to the section. ■

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States Currently with Filial Responsibility Laws

Alaska	Kentucky	New Jersey	Tennessee
Arkansas	Louisiana	North Carolina	Utah
California	Maryland	North Dakota	Vermont
Connecticut	Massachusetts	Ohio	Virginia
Delaware	Mississippi	Oregon	West Virginia
Georgia	Montana	Pennsylvania	
Indiana	Nevada	Rhode Island	Puerto Rico
Iowa	New Hampshire	South Dakota	
See http://law.psu.edu/_file/Pearson/FilialResponsibilityStatutes.pdf for a recent list of filial support statutes.			

Filial support laws aren't new. In fact, they were initially derived from England's 16th century "Poor Laws." At one time, as many as 45 U.S. states had statutes obligating an adult child to care for his or her parents. Some states repealed their filial support laws after Medicaid took a greater role in providing relief to elderly patients without means. Other states did not, and a large number of filial support laws remain dormant on the books.

Now, with long-term care costs on the rise and funding sources under pressure, nursing homes and other health care providers may have increasing incentive to seek to use the courts to compel children to either help a parent financially or be at risk for covering the cost of his or her care.

In the last decade or so, a few court decisions in both South Dakota and Pennsylvania have opened the door to using filial support statutes to recover medical expenses. Underlying the earlier decisions was generally a finding of "unclean hands"—that the children had engaged in fraudulent conduct or had illegally transferred mom and dad's assets. Recently, however, there has been at least one court decision that found a child responsible for his mother's nursing home bill without any evidence of wrongdoing on the part of the child.

In 2012, the Pennsylvania Superior Court upheld a lower court ruling (Health Care & Retirement Corporation vs. Pittas[1]) that allowed a nursing home to obtain payment from the son of Maryann Pittas for her nearly $93,000 nursing home bill after she relocated to Greece with her bill unpaid. Maryann Pittas had applied for Medicaid but had left the country before there was a decision on her application. The nursing home then sued her adult son, John Pittas, for payment. This case was significant because, unlike the previous rulings in other jurisdictions, the court made no finding that John had engaged in any fraudulent transfers to divert or hide his mother's assets.

COULD YOU BE LEGALLY LIABLE FOR PAYING FOR YOUR PARENTS' CARE?

Filial support laws differ from state to state. Some states' statutes impose criminal penalties. Other states' statutes, such as the Pennsylvania statute in Pittas, impose financial responsibility. However, all state statutes require the court to find that the parent is indigent or unable to provide for his or her own support. Additionally, there are defenses to the filial support obligation, such as the child's financial inability to pay for such care or evidence of neglect or abuse by the parent prior to the child's emancipation.[2] For example, the Pennsylvania statute states "a child shall not be liable for the support of a parent who abandoned the child and persisted in the abandonment for a period of 10 years during the child's minority."[3]

PAY OR FACE POTENTIALLY SERIOUS REPERCUSSIONS

As mentioned above, some states' statutes impose criminal sanctions for failure to support one's parent. Massachusetts imposes a fine of not more than $200 or imprisonment for not more than one year or both[4], while in North Carolina, the person would be found guilty of a Class 2 misdemeanor on the first offense.[5] In those states where you could be held civilly responsible, a judgment against you could result in your wages being garnished or liens being placed against your property.

SO, WHERE ARE WE NOW?

No one knows whether these recent court cases will

encourage other states to enforce their filial support laws with greater vigor, but this is a development worth watching. However, as more of the Baby Boomer generation reaches their golden years, and as many nursing homes and local governments are faced with providing care to a growing number of indigent elderly patients, there's a possibility that other states will look more closely at their filial support statutes in an attempt to find another way to fund mom's or dad's nursing home bill.

The law surrounding filial responsibility is complicated. Seek the advice of your wealth management and legal advisors to help you understand the law in your state. Your wealth management advisor can help ensure your parent is provided for in the event he or she needs costly, long-term care. He or she can also review your retirement plan to provide suggestions and strategies for funding your own potential future long-term care needs.

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ENDNOTES

[1] *Health Care & Ret. Corp. of Am. v. Pittas, 2012 PA Super 96, 46 A.3d 719, 723 (Pa. Super. Ct. 2012), reargument denied (July 18, 2012), appeal denied, 63 A.3d 1248 (Pa. 2013)*
[2] *Va. Code Ann. §40-6-301*
[3] *23 Pa. Cons. Stat. Section 4603(a)(1)(ii)*
[4] *Mass. Gen Laws ch. 273Section 20*
[5] *N.C. Gen. Stat. Section 14-326.1*

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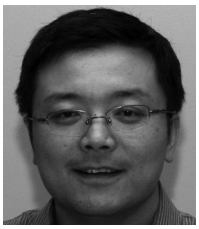
Interested in Being Interest-Sensitive?

By Hezhong (Mark) Ma



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Long-term care insurance (LTCI) is usually not thought of as an interest-sensitive product. Policyholder behavior, such as filing or terminating a claim or lapsing a policy, is not believed to tie to certain economic triggers. Additionally, cash flows from policies that provide either cash or indemnity benefits are not seen as varying by economic environment.

Economic inflation, however, will generate claim inflation due to increases in the average amounts charged by care facilities. For most policyholders, the utilization rate (the ratio of benefit paid to the allowed benefit) of these benefits will generally start below 100 percent percent and rise later, due both to claim inflation and increased care needs. Holders of policies with reimbursement benefits would generally not use the maximum daily benefit at the early stage of care, either because they try to lengthen the policy's available coverage period or because the condition has not yet progressed to the point where the full benefit would be required.

In a hyperinflationary environment an LTCI claimant might start with a low utilization rate, but it will quickly reach the maximum daily benefit amount. Conversely, in a low-inflation environment, it will take longer for the utilization rate to rise from a low starting point to 100 percent. percent. Based on this premise, LTCI product profitability will depend on the rate of claim inflation as well as the discount rate provided in pricing guidelines.

COMPARING TWO POLICIES

The benefit inflation protection option (BIO) plays an important role in how the discount rate and claim inflation affect the product's loss ratio, all other things being equal. We used two virtually identical policies to illustrate how the dynamic relationship of the claim inflation rate, the discount rate and the BIO rate affects the lifetime loss ratio for each policy. Both policies were issued to females, age 62, and provided at issue a three-year benefit period and a $100 maximum daily benefit. The first policy had a 5 percent compound inflation protection feature and the second, no inflation protection. Proprietary morbidity, mortality and lapse assumptions are used.

Each policy anniversary, the first policy's maximum daily benefit rises by 5 percent due to BIO, and the second policy's remains the same. Additionally, each calendar year, the benefit amount charged by the care facility will rise due to claim inflation. The utilization rate, again, is the ratio of what is charged by the facility to the maximum daily benefit.

For this example, we are assuming a starting utilization rate of 60 percent, meaning that the claimant will receive a reimbursement of 60 percent of her policy's maximum daily benefit for each day spent receiving long-term care services. Each year the utilization rate could rise or fall, given the relative movements of claim inflation and benefit increases, subject to a 100 percent cap.

In the first year, the average per-day payment for a claim for both these policies is $60. Therefore, the utilization rate is 60. percent. If the claim inflation rate is 5 percent, then in the second policy year, the first policy's per-day reimbursement for the claim will rise to $63.

Therefore, for the policy without the BIO, the utilization rate in Year 2 is 63 percent ($63 / $100). However, for the policy with 5 percent compound BIO, the utilization rate in Year 2 remains 60 percent ($63 / $105). For this example, the premium amount is selected to produce a loss ratio of approximately 55 percent at an inflation rate of 5 percent and a discount rate of 5 percent.

For each policy, we projected the lifetime loss ratios over a range of claim inflation rates and discount rates, and plotted the results for each policy in Chart 1 and Chart 2.

Unsurprisingly, at any given claim inflation rate, lifetime loss ratios for both policies decrease monotonically when the discount rate rises. At any discount rate, the lifetime loss ratio rises with a higher claim inflation rate assumption. Profitability for both policies drops dramatically as long as the rate of claim inflation is no more than the BIO rate plus a "buffer zone" of approximately 2 percent. When the discount rate goes higher, the loss ratio reaches a plateau and rises more slowly. In other words, losses are capped once the utilization rate reaches 100 percent. The size of the buffer zone will depend on the amount of time it takes for a policy to climb from the initial utilization rate, 60 percent in this case, to the 100 percent cap. Note that for the policy without inflation protection, we extended the z axis range (measuring the claim inflation rate) to 0 percent - 10 percent, in order to show the pattern.

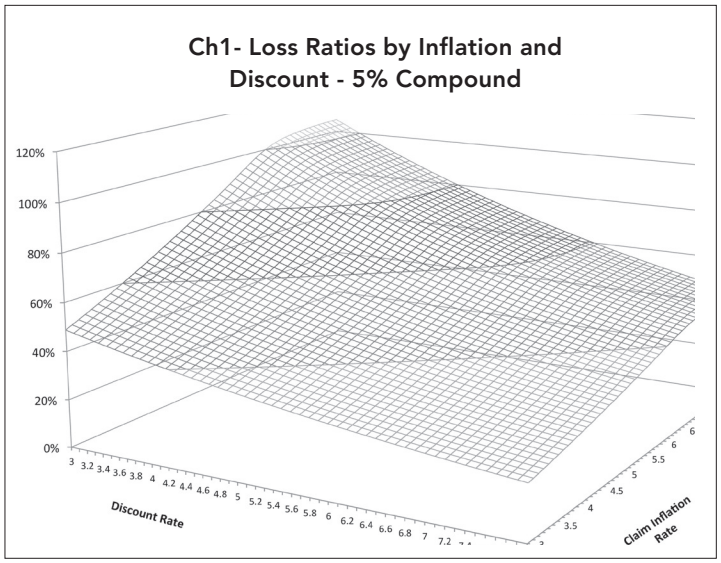
MARGIN BETWEEN DISCOUNT AND CLAIM INFLATION RATE

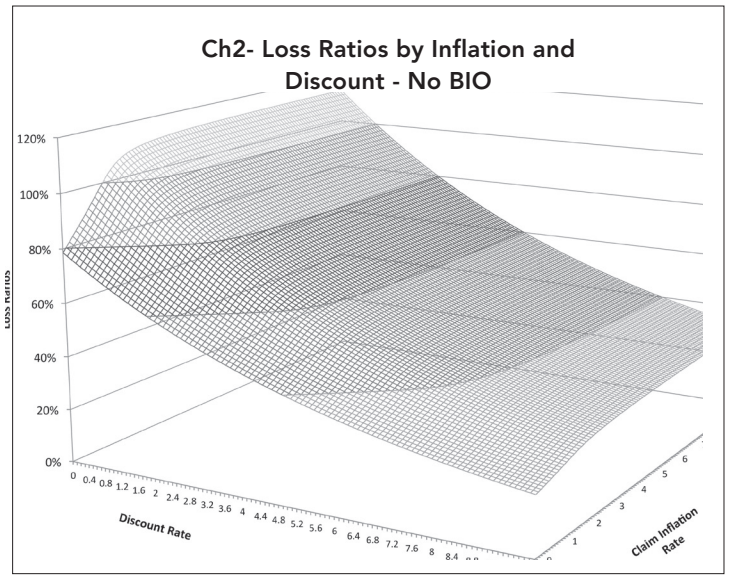
When examining loss ratios in terms of discount rates and claim inflation rates, it is tempting to think the loss ratios are somewhat constant as long as the difference between the discount rate and the claim inflation rate—that is, the "margin," remains constant. Let's examine this hypothesis by looking at Chart 1 and 2 from a different angle.

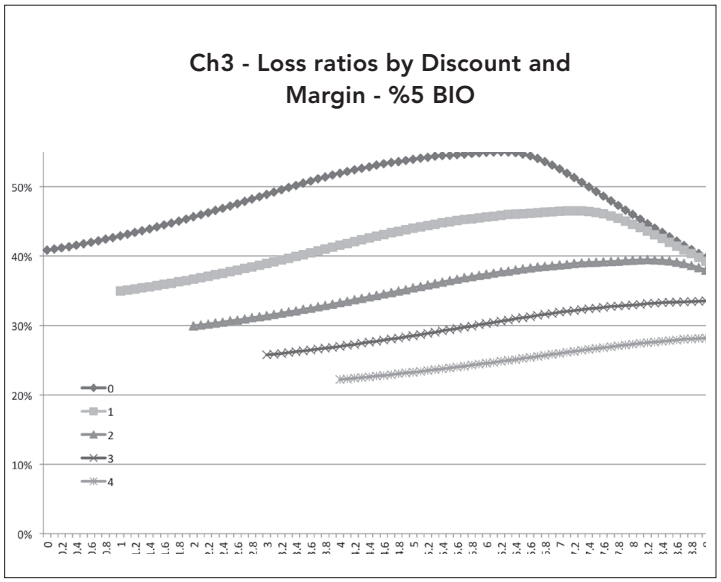
Charts 3 and 4 show loss ratios by discount rates, and the margins between the discount rate and the claim inflation rate.

If the margin dictates profitability, we should see level and parallel lines in the charts. But it does not appear to be the case. For the policy with the 5 percent BIO, the loss ratios shown in Chart 3 initially rise in a largely parallel fashion. When the discount rate goes above roughly 7 percent, the loss ratios start to converge and decrease. For the policy without the BIO, as shown in Chart 4, we observe the tail-end behavior earlier. The convergence and decrease started at low rates.

Thinking no BIO as a special case of BIO, we can generalize the observations. When the discount rate is below a certain level, which in the test cases ap-







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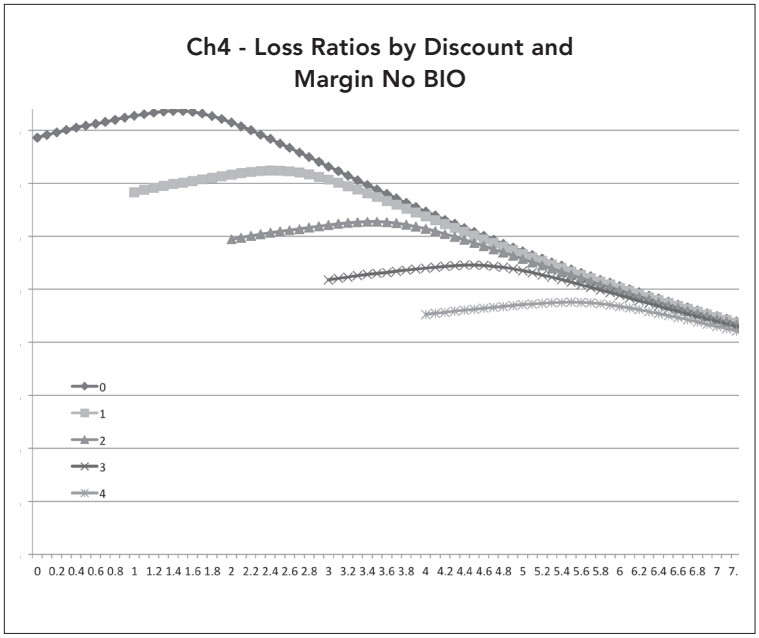

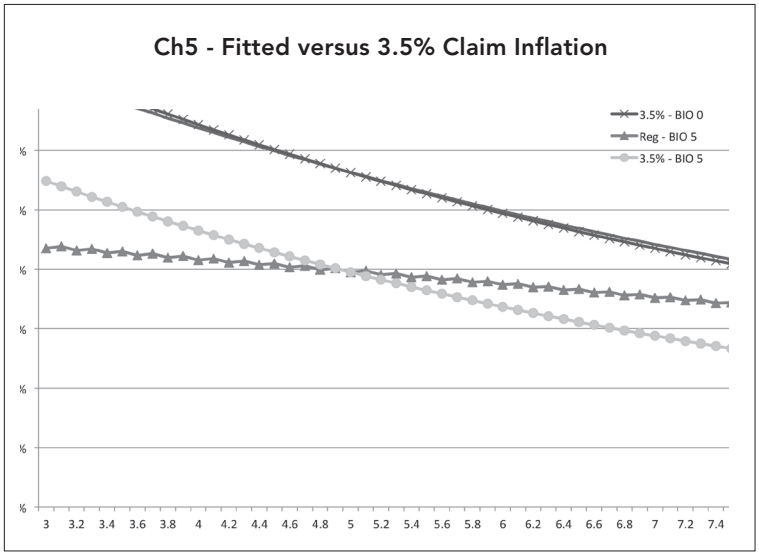

pears to be BIO rate plus approximately 2 percent to 3 percent, the loss ratio lines gradually rise. It suggests that the effect of the claim inflation outweighs the effect of discount rate on loss ratios. When the discount rate continues to rise, the loss ratio lines converge. In a high interest rate environment, the effect of the discount rate outweighs the effect of claim inflation on loss ratios. When the discount rate is very high, the utilization rate reaches the cap of 100 percent quickly, and the profitability is mostly driven by the discount rate. The loss ratios eventually decrease.

Therefore, the behavior of profitability depends on the level of BIO rate, discount and claim inflation rate. If the discount rate is significantly higher than BIO rate, profitability is more sensitive to the discount rate selected. In a low interest rate environment, where the discount rate is low comparing to BIO rate, the claim inflation rate metric will frequently dictate the profit outlook for the LTCI product. In today's prolonged low interest rate environment, companies should monitor their claim inflation experience closely. This is especially important for carriers with significant exposure to policies with a benefit inflation protection feature.

INTERACTION BETWEEN YIELD AND CLAIM INFLATION

The claim inflation rate and the discount rate are both driven by the same economic factors. In a hyperinflationary environment, a policy's yield rate and claim inflation rate will be high, and vice versa. For the sake of argument, let's say the claim inflation rate = 1 percent + (50 percent x yield). Given this relationship, for each yield rate plugged into this equation, we can calculate a fitted value for the claim inflation rate and therefore find a loss ratio based on the projections we produced. As a comparison, we also provide lines corresponding to a constant 3.5 percent claim inflation rate.

For LTCI products, as yield rises, the loss ratio declines, as seen in Chart 5. However, when we model the dynamic relationship between yield, claim inflation and the benefit inflation protection option, we see that the loss ratio lines become flatter. The interest-sensitive nature of LTCI can produce narrower variances of the results and deflate the exaggerated duration (slope), especially for policies with inflation protection. Cash flow testing results across different scenarios would show convergence, and risk profile metrics would improve as well.

Are you interested yet in calling LTCI interest-sensitive? ■

Short-Term Care as an Alternative to Long-Term Care

By Andrew Ryba

As insurance carriers and agents continue to explore the supplemental health product market, many have started to notice the potential that lies within short-term care insurance. It is a product that can help insureds finance the costs associated with certain short-term disabilities at a much lower annual premium than what traditional long-term care would cost them. And as the baby boomers continue to age and experience these types of disabilities, we expect to see increases in consumer demand. This article provides an overview of the short-term care market as it stands today and contrasts the product to traditional long-term care insurance plans.

Short-term care insurance is similar to long-term care insurance in that it helps cover the costs associated with confinement in a nursing home or an assisted living facility, and typically offers the option to include coverage for the costs of receiving home health care services. The policies are typically structured to pay daily benefit amounts directly to the insured once a covered event has occurred. The benefit triggers are also similar to those included in long-term care policies. The insured must have a medical professional certify that they need assistance with two of six activities of daily living (dressing, bathing, eating, toileting, transferring, and continence). However, with a short-term care policy, the disability does not need to be expected to last more than 90 days. Since the products include similar benefit triggers, some companies have found that it is possible to leverage the same people and processes that are used in the claim adjudication process to support both product lines.

As indicated by their names, the primary difference between short-term care insurance and long-term care insurance is the maximum length of time that the product will provide benefits. Long-term care policies available today will commonly offer protection for 10 years or longer, whereas short-term care policies can only offer coverage for a maximum of 360 days. This limited benefit period is the primary factor that subjects short-term care insurance to supplemental health plan rules as opposed to the more onerous long-term care insurance rules and regulations.

Because of the shorter benefit period, another key difference between short-term care and long-term care insurance is that short-term care can be offered on a simplified issue basis. Applicants can qualify for coverage by answering a set of health history questions and granting permission to the insurer to review their prescription drug usage history. In addition to these two basic risk selection tools, some carriers also perform a phone interview to verify the applicant's written answers. This more relaxed underwriting approach is appropriate due to the limited risk that the insurers are taking on with each issued policy and the smaller premium payment that is required from the insured. Unlike traditional long-term care insurance plans, the annual premiums are not large enough to support full medical underwriting expenses such as blood tests, the requisition of Attending Physician Statements and cognitive ability tests.

Today most short-term care plans offer a combination of benefit and elimination periods. The most common combination of benefit periods includes 90-day, 180/200-day and 360-day options. Consistent with the short-term coverage needs that the product is designed to cover, the elimination periods that are typically offered with these products are much shorter than on traditional long-term care plans, with 0-day and 20-day options being the most common. The following tables show the distribution of participating short-term care carriers that offer each option.

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Benefit Period	% of Carriers
30 Day	8.3%
60 Day	8.3%
90 Day	50.0%
150-200 Day	83.3%
210-270 Day	33.3%
360 Day	91.7%

Elimination Periods	% of Carriers
0 Day	66.7%
15 Day	16.7%
20 Day	75.0%
30 Day	33.3%
60 Day	8.3%
90 Day	8.3%
100 Day	8.3%

One area where short-term care and long-term care plans have similarities is in the level of innovation that is occurring within the products being offered. Just as carriers are coming up with new ways to differentiate their long-term care plans, short-term care carriers are also looking for ways to differentiate their products. Some carriers have considered the addition of product features such as "Pool of Dollar" concepts, more liberal benefit increase options and the use of alternative care plans.

As shown above, there are many differences between short-term care insurance and long-term care insurance. Short-term care insurance is designed to provide protection against the risk of a temporary debilitating medical condition at a lower premium rate than traditional long-term care insurance. Because of the limited risk exposure, the underwriting process can be streamlined to make efficient risk selection decisions. And as the target market continues to grow, it seems reasonable to expect that this will be a growing product line for many carriers. ■

Short-Term Planning for Long-Term Care: Non-Traditional Solutions for Funding Care

By Vincent L. Bodnar

What options exist for people who don't pass underwriting for long-term care (LTC) insurance?

What about people who did not buy insurance when they could, but later find themselves facing an expensive care episode?

Given that only 2 percent of all LTC services in the United States are funded by private LTC insurance, and not everyone else goes on Medicaid, people are doing something else that is working, right?

I've spent the last year or so in discussions with insurance agents, financial planners, elder law attorneys, nursing home and assisted living executives, government policymakers, academics and insurance company executives on multiple continents piecing together answers to these questions. Much of this was motivated by my passion for much needed innovation in a long-term care insurance market, thinking that the answers might just lead to some new product concepts.

I'd like to share just a portion of what I've learned so far in this short article, which is based on a presentation I gave at a recent conference.

SUBSTANDARD LONG-TERM CARE PRODUCTS

The answer to the first question, "What options exist for people who don't pass underwriting for long-term care insurance?" is, at least currently, "not much." Today, people in this situation can't purchase traditional LTC products and must deal with financing their care if and when they are faced with a care episode.

Some life insurance products are sold in the workplace on a guaranteed simple issue basis, and LTC riders on such products are becoming more common. However, the availability of such an option is still limited and generally they have small face amounts, which means small LTC benefits.

Not long ago however, stand-alone substandard LTC products were available to persons that could not meet stringent underwriting criteria. These products disappeared at just about the same time that new sales in the traditional LTC market collapsed in the mid-2000s. The timing may be right for a come-back. I'll expand on my thoughts about this later. First, let's take a look at some key features of these products.

In spite of what you might think when you first encounter the concept of substandard products, these products are designed in such a way that many risks are more mitigated than their more selective counterparts. For example, many include the following risk limitations:

- Short benefit periods: 12 to 36 months
- Long elimination periods: 120 to 180 days
- Low daily benefit maximums: $70 to $120
- Covered services are limited to nursing home care
- No waiver of premium
- No restoration of benefits
- Low first year and no renewal commissions

These limitations reduce risk exposure in areas that have lead to unforeseen losses with other traditional LTC products.

Pricing of these products should take a release from risk posture, meaning that conservative pricing and reserving should be deployed, allowing bigger profits to emerge in the future if results occur as expected. Industry data that I have studied shows that incidence rates are, as one might expect, higher than those of traditional products in early durations. However, over time, these incidence rates do converge to ultimate incidence rates that are similar to those of traditional products. In a release from risk approach, an actuary could price a substandard product assuming that the early duration incidence differences are permanent.

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Policy termination assumptions can be another source of conservatism. Deployment of traditional product termination rates should be conservative, as substandard products should have higher mortality rates and terminations due to benefit exhaustions (resulting from shorter benefit periods and lack of restoration provisions). The actuary can also take into consideration the lack of minimum loss ratio requirements and the lack of competition in determining the level conservatism that is appropriate for such a product.

As for ongoing risk management, the actuary should consider that the critical experience occurs in the earlier durations, particularly just after the non-contestable period of the product. From there, the actuary should monitor incidence rates to confirm that they begin to grade down to ultimate levels. First principles monitoring is simpler than for traditional products due to the lack of certain product complexities (one level of care covered, and no restoration of benefits). Also, a shorter tail on claims results in earlier knowledge of claim sizes.

The potential market for such a product is large. Even in its shell of its former self, the traditional market still issues about 200,000 policies per year. According to some leading producers, about 15 to 25 percent of all applications submitted are declined coverage due to today's strict underwriting standards, and another 10 to 15 percent of applications are never submitted. This translates to a potential market of 65,000 to 135,000 of new substandard applications annually. Distribution could be greatly streamlined through automatic referral agreements with carriers that issue standard products.

POINT OF CARE ANNUITIES

Now for my second question: "What about people who did not buy insurance when they could, but later find themselves facing an expensive care episode?"

I researched the financial situation the average person over age 80 finds himself in. His net worth is $275,000, of which $135,000 is home equity. His average annual income is $22,000. Currently, the average annual cost of a nursing home stay is $81,000, which results in an average income shortfall of about $60,000. The fear of outliving assets becomes very real at this point, as it will take only four years for this to happen for the average person. This fear is often shared with the adult children of the person needing care, who commonly make or heavily influence the tough financial decisions in these cases. Many people panic and initiate Medicaid planning.

In this average situation, the incidence risk has been decoupled from the longevity risk. The person is now faced with a care episode. The time for insuring against the chance of that occurring has now passed. If we look closely however, the person has the means to pay for an average stay in a nursing home (just under two years), but surely cannot afford to pay for a stay that lasts more than four years, which is a real risk. So, we are left with a need to protect against the longevity risk. This is nothing new. Isn't this what immediate annuities are for?

Traditional immediate annuities are priced assuming that the annuitant is anti-selecting. That is, that the person is very healthy and is expecting to live longer than others the same age. For example, let's assume that the premium for a healthy person buying an annuity at age 82 is 10 times the annual payment he will receive. So, a $120,000 single premium will purchase an annual income stream of $12,000. However, someone beginning a nursing home stay typically has health conditions that will shorten his life expectancy to, let's assume 20 months. This makes the purchase of a traditional immediate annuity to protect against longevity uneconomical.

Enter the underwritten annuity. Particularly, one aimed at people entering a nursing home. Here, underwriting is counter to what we think of in life and health insurance. The more conditions a person has that shortens life expectancy, the more leverage that person has. An underwriter could discern, based on health conditions, that a particular person is expected to live 20 months. Allowing for profit margin, the insurer might assume a two year life expectancy for pricing purposes. In this case, the $120,000 could purchase an annual income stream of $60,000 for the life of the annuitant. That is enough to fill the average income gap during a nursing home stay while the annuitant lives. This could be purchased from just a portion of the average person's net worth at age 80+. This would eliminate the fear of outliv-

ing assets and the panic that leads to the initiation of Medicaid planning.

Does such a product exist? Yes. As of the date of this article, there is at least one on the street in the United States. We can see proven success elsewhere. This is the predominant form of LTC insurance in the United Kingdom, where the traditional product as we know it in the United States is not sold. Is there a market for it here? I think so. The target market comprises people that are entering or are currently in care episodes with income shortfalls, but enough net worth to fund that income shortfall for an average remaining impaired life expectancy. You might be surprised to learn that this is the case for about half of the U.S. population over age 80.

OTHER OPTIONS

Other point-of-need funding solutions have emerged for those that did not previously purchase LTC insurance. I've learned that there is a budding financial advisory space that focuses on these cases and that is not pushing a Medicaid solution.

The approach taken is to first determine if there is an income shortage and, if so, to quantify it. Then, steps are taken to convert net worth into income streams that help to fill that gap. The most common ways of doing that are:

- Home equity can create income via reverse mortgages.
- A life insurance death benefit can be assigned in exchange for a lifetime income payment (life settlements).
- A series of loans against a life insurance policy can be taken, but only while principle lasts.

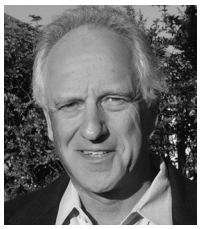
At least one "financial concierge" company has emerged on this scene. This company receives referrals from nursing home and assisted living facility admissions offices. It acts as an advocate for new entrants in finding ways to finance care. It can provide bridge loans as solutions are put in place, which can take months in many cases. They also receive real estate brokerage or referral fees in cases where a home is sold and referral fees for other transition services (such as moving and storage services). Is it possible that we are seeing the beginning of a new distribution point for financial products at this critical point in people's lives?

CONCLUSIONS

As stated earlier, this is just a portion of what I've learned about this topic so far, and I continue to learn more as I research the answers to the questions at the beginning of this article both in the United States and around the world. I hope that what I have shared here has provided some useful information to the reader and to our industry. ■

Joint SOA/IA Long-Term Care Workshops

By Etienne Dupourqué



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

Long-term care insurance (LTCI) markets in France and United States are both very important and very different. Recently, companies in the United States have been leaving the market, while companies operating in the French LTCI market are staying put. Several actuaries from the French Institut des Actuaires (IA) and the Society of Actuaries (SOA) have come together to examine each countries' long-term care services and supports systems. The purpose of these common workshops is to cross leverage the knowledge of the LTCI market and actuarial techniques by sharing best practices, thoughts, and innovation. Both the SOA and IA issued announcements about the project, and several actuaries showed interest, along with individuals outside of the actuarial profession. Currently the workshops have seven SOA participants and 20 IA participants.

As luck would have it, David Schraub, a member of the Institut des Actuaires and a fellow of the Society of Actuaries, is also the risk management SOA staff fellow, and is acquainted with several of the French participants. David, while not a participant, has been attending the calls and is instrumental in its smooth progress. Thanks also to Leslie Smith, SOA section specialist, who has helped organize the communication between the two countries.

Néfissa Sator represents the participation of the IA along with Sophie Michon and Jean-Pierre Decourcelle, who are in Paris, coordinating the project in France.

The workshop, chaired by Etienne Dupourqué, held its first joint conference call on September 23. The seven SOA actuaries and 15 IA actuaries introduced themselves and organized an approach to the workshop calls. The second joint conference call occurred on October 6, with Malcolm Cheung, Al Schmitz, Robert Eaton, and Andrew Dalton presenting the U.S. market perspective. While there are language and technical terminology hurdles to overcome, the presentations were met with great interest and were an outstanding introduction to U.S. LTCI for the French audience. The next planned call will cover the French LTCI Market. Following calls will be held biweekly and are expected to last 90 minutes. A report from the workshops is targeted for March 2015 and may be presented at the Intercompany Long Term Care Insurance conference.

It is a great pleasure to introduce some of the participants of the newly started joint Society of Actuaries and Institut des Actuaires Long-Term Care Workshops:

AL SCHMITZ

Al is a consulting actuary with Milliman, Inc., and has worked with most of the major LTC insurance carriers in the United States on product development, financial projections, appraisals, compliance issues and experience analysis.

ANDREW DALTON

Andrew is a principal and consulting actuary with Milliman, Inc., located in the Wayne, Penn. office. Andrew consults primarily to life and health insurance companies, and has extensive experience in long-term care insurance.

ANNE SERRA

Anne is special advisor to the CEO and secretary of the Board of Caisse Centrale de Réassurance (CCR). Prior to joining CCR in May 2012, Anne worked at the Autorité de contrôle prudentiel et de résolution (the French bank and insurance supervisory authority) where she was responsible for a team of insurance supervisors.

BRIDGET BROWNE

Bridget is a senior lecturer in actuarial studies at the Australian National University in Canberra. She joined ANU in 2011 after serving as Life Chief Pricing Actuary at Partner Reinsurance where she was responsible for all aspects of pricing of Partner Re's Life portfolio worldwide, including long-term care insurance in several markets.

DAVID DUBOIS

David is director of development within the French subsidiary of RGA.

ETIENNE DUPOURQUÉ

Etienne is a consultant in Vermont specializing in long-term care. Most recently he worked with state regulators through the U.S. long-term care insurance rate increase activities.

FRANÇOIS LUSSON

During his twenty-two years of experience in actuarial consulting and social protection, François specialized in projects relating to long-term care, life, annuity, retirement, and the financial development of social protection programs.

GÉRALDINE JUILLARD

Géraldine works at La Banque Postale Prévoyance (LBPP), which offers death, disability and long-term care insurance. Primary duties include pricing new products, updating existing products, proposing underwriting guidelines, writing actuarial specifications for the information systems development and risk monitoring (mortality, long-term care incidence).

JACQUELINE TABOULET

Jacqueline is an actuary with Mutuelle générale de l'Éducation nationale (MGEN) where she works on long-term care products and Solvency 2.

JEAN-PIERRE DECOURCELLE

Jean-Pierre is the chief actuary of the Groupe Prévoir, where he supervises a team of actuaries, oversees the development of new products, coordinates the technical inventory, and manages the experience analysis of claims and profitability.

MALCOLM CHEUNG

Malcolm is vice president of LTC for the Prudential Insurance Company of America in Roseland, N.J. With Prudential's recent strategic decision to discontinue long-term care sales, he oversees the experience analysis and re-pricing efforts associated with the management of the closed block.

NÉFISSA SATOR

Néfissa is responsible for the Northern American business activities of the group Forsides Actuary, a major European actuarial and risk management consulting firm.

ROBERT EATON

Robert is a consulting actuary with Milliman in Tampa, Fla. Robert works primarily with long-term care and life insurance companies, with a focus on the worksite space, or group insurance.

VINCENT BODNAR

Vince is a director at Towers Watson and is recognized as one of the leading long-term care insurance experts in the United States.

VINCENT LEPEZ

Vincent is chief pricing actuary and head of research & development at SCOR Global Life.

YVES LEDERER

Yves is head of product development, marketing, and management for ACMN (Assurances du Crédit Mutuel Nord) VIE, the life insurance company subsidiary of Credit Mutuel Nord Europe.

JOSHUA J WEBER

Joshua is an AVP & actuary with Genworth Financial, located in the Richmond, Va. office. ■

LIVING *to* 100

SOCIETY OF ACTUARIES
INTERNATIONAL SYMPOSIUM

2014 Living to 100 Symposium Monograph

Presentations from the 2014 Living to 100 Symposium are now in an online monograph at ***livingto100.soa.org***. The symposium brought together thought leaders to discuss the latest theories, research and implications on longevity and quality of life. Topics discussed included:

- The evolution of retirement;
- Work flexibility for a graying workforce;
- Business implications of living longer;
- Lifestyle and longevity; and
- Mortality trends and projection methods of older age.

The Living to 100 Symposium featured actuaries, demographers, physicians, academics, gerontologists, economists, financial planners, researchers and other professionals. This monograph will help to continue the conversation about how to address living longer, the impact to social support systems and the needs of advanced-age populations.

The Link Between Retirement and Long-Term Care: Differing Perspectives on Long-Term Care

News from the Sessions on Long-Term Care and Retirement Security held at the 2014 SOA Annual Meeting & Exhibit

by John Cutler

The Society of Actuaries Committee on Post-Retirement Needs and Risks, working closely with the SOA Long Term Care Section, issued a call for papers last year: "Managing the Impact of Long-Term Care Needs and Expense on Retirement Security: A Holistic and Multi-Generational View." These papers that were chosen were highlighted at the 2014 Society of Actuaries Annual Meeting. The materials for those sessions can be found at *https://www.soa.org/Professional-Development/Event-Calendar/2014/annual-meeting/Agenda-Day-4-and-Presentations.aspx.* Session recordings will also be available (no charge for SOA members) at the same link.

The goal of the discussion was to explore several aspects of the relationship between retirement security and long-term care, as well as offer ideas about improving long-term care financing and management. They have also been gathered and published in a monograph at *http://www.soa.org/Library/Monographs/Retirement-Systems/managing-impact-ltc/2014/mono-2014-managing-ltc.aspx*.

These papers add to the section's and others' ongoing discussions about the future of the long-term care system including the "Land This Plane" project. Some of the items of greatest focus are integration with retirement security, impact on the caregiver and family, and integration with housing.

This article previews some of the papers and issues covered in the monograph:

- The Impact of Long-Term Care Costs on Retirement Wealth Needs by Vickie Bajtelsmit and Anna Rappaport
- How American Society will Address LTC Risk, Financing and Retirement by John Cutler
- Financing Future LTSS and Long Life through more Flexible 401(k)s and IRAs by Karl Polzer
- Improving Retirement by Integrating Family, Friends, Housing and Support: Lessons Learned from Personal Experience by Anna Rappaport
- An Affordable Long-Term Care Solution through Risk Sharing by Kailan Shang, Hua Su, and Maggie Lin
- How Adequate is Long Term Care Protection in Developed Countries? by Doug Andrews
- Home Equity and At-Need Annuities-A Dynamic Long-Term Care Funding Duo by Steve Cooperstein
- The American Long Term Care Insurance Program (ALTCIP) by Paul Forte
- An Overview of the US LTC Insurance Market (Past and Present): The Economic Need for LTC Insurance, the History of LTC Regulation & Taxation, & the Development of LTC Product Design Features by Rachel Narva, Larry Rubin, et al.
- Home Equity: A Strategic Resource for Long-Term Services and Supports by Barb Stucki
- The 65+ Age Wave and the Caregiving Conundrum: The Often Forgotten Piece of the Long-Term Care Puzzle by Sandra Timmermann
- Long-Term Care Benefits May Reduce End-of-Life Medical Care Costs by Stephen K. Holland, Sharrilyn R. Evered, and Bruce A. Center.

Of note, the first five papers were awarded prizes by the Society of Actuaries Committee on Post-Retirement Needs and Risks.

WHERE WE ARE NOW

Long-term care (LTC) expenses can be devastating to the retirement income and lifetime financial security plans of households as well as their family caregivers. Households manage this risk with a variety of approaches but few have a formal plan or insurance; their primary plan is to rely on family and friends for care, and their last resort protection is usually Medicaid. This lack of protection has put middle

CONTINUED ON **PAGE 18**

John Cutler currently works both on long-term care insurance and related issues at the US Office of Personnel Management (OPM) as well as in the new health care reform office of National Healthcare Operations within OPM.

class households at risk and has severely exacerbated household and societal challenges to a financially secure retirement.

In spite of these risks, only about 10 percent of the population own private long-term care insurance (though more at ages over 65). Plus, many consider the market to be one in a state of disarray, with many companies having exited the market and many more imposing rate increases as experience has differed from pricing assumptions. Medicaid is the largest funder of formal programs, and these programs are under great financial pressure. Medicare funds a small amount of long-term care via its coverage of post-acute care (but much less than many people believe) and is also under financial pressure.

While some may see a struggling market, many alternative products have emerged and provide a clear sign of a maturing private insurance market. Families are increasingly making use of alternative products such as short-term care insurance and combination products. These combination products, which include both life and annuity products with either a long-term care or a chronic illness riders, have seen double digit growth in each of the last five years while individual long-term care products have seen declines.

Many Americans are involved in caregiving for parents and other older family members. The individual, business and societal costs of the care they provide usually are not factored in when the costs of the long-term care system are discussed. These costs can be very substantial and are generally not recognized in the long-term care discussion.

There is also a big move to try to keep more people in their homes longer, as most people would prefer. The societal resources to support it are often not available. The challenges related to aging in place and the strains it places are likely to grow as the population ages, and as there is greater emphasis on enabling people to remain in their homes. These issues are discussed by Sandra Timmermann in her paper, "The 65+ Age Wave and the Caregiving Conundrum: The Often Forgotten Piece of the Long-Term Care Puzzle."

GENERAL OPTIONS FOR PRIVATELY FINANCING LONG-TERM SERVICES AND SUPPORTS

Individuals have a number of options for financing long-term care. In their paper "The Impact of Long-Term Care on Retirement Wealth Needs" Vickie Bajtelsmit and Anna Rappaport offer a comparison of four methods of financing. The paper also provides results of modeling that show the impact of shocks and how they can devastate retirement security. The table found at the end of this article is from this excellent work.

HOW INSURANCE FITS IN

Insurance is suggested as an important method of private financing, but at present only about 10 percent of the U.S. population have long-term care insurance. Several of the papers provide ideas for improving insurance solutions. Paul Forte suggests a new approach to insurance using an exchange; his approach is designed to fit the needs of middle income Americans, a market often underserved. He argues for federal structure and a new design for this system. Richard Narva and his co-authors offer a regulatory and market overview of the existing traditional private insurance system. They contend that the traditional product as currently designed does not meet the needs of consumers well. They provide their views of changes to the existing product. Kallan Shang and colleagues offer a different view of product design focused heavily on sharing of risk—particularly investment risk. Some of these ideas will greatly expand the number of people with insurance and others will not. We hope that these ideas will generate more dialogue on the design of the marketplace and insurance products, leading to better solutions. Dr. Stephen Holland and his colleagues look at how the use of long-term care insurance benefits relate to health care and how they reduce medical spending, particularly at the end of life.

Karl Polzer offers us ideas for the integration of 401(k) plans and paying for long-term care. His policy recommendations provide for restructuring the 401(k) and IRA rules to allow 25 percent of account balances to be set aside for long-term care, with favorable tax treatment, and distribution requirements that fit with long-term care needs. The funds in the special account can be used to pay insurance premiums or to pay for long-term care expenses directly. The Polzer proposal can be combined with any of the financing methods shown in the columns in the chart on page 21. We hope that actuaries will consider this proposal and use it to start a conversation about how to integrate retirement and long-term care financing.

John Cutler's paper looks even more broadly. What happens if these private and social insurance programs remain essentially unchanged? Where will individuals and society be in the near future? Among some surprising suggestions is that more is going on than we think; that we might actually be

seeing long-term care changes underway but too incremental (and fragmented) to be obvious.

Two papers look at case study examples with regard to long-term care and housing choices. The paper by Steve Cooperstein looks at a specific situation and how a combination of an annuity, housing values, and long-term care insurance were melded to help finance the care. It provides an innovative success story. Sandra Timmermann also looks at the family and the role of the caregiver, as well as the impact on employers and their role in supporting family caregiving. The paper by Anna Rappaport looks at several case studies and the choice of housing options, and provides insights into some of the challenges individuals have experienced and the solutions they have used. It provides insights into evaluating a range of housing choices, and discusses special issues where there is a large up-front payment. It discusses some of the pros and cons of Continuing Care Retirement Communities. Barb Stucki explores how to better use home equity as a means of financing long-term care and she offers some innovative ideas.

SUMMARY

These papers cover a variety of topics and should be helpful in thinking both about what individuals need to do today and about the structure of the long-term care system. The papers will be of interest to a range of audiences including individuals, advisors, financial service companies, and policymakers. In addition, the Society of Actuaries and American Academy of Actuaries will host a round table session, including a discussion of several of these papers, at the National Academy of Social Insurance January program on Medicare and Medicaid. As January will also see the swearing in of a new Congress and we move to thinking of the 2016 elections, the interest in approaching solutions to our long-term care financing problems will be foremost on our mind. These papers in a small way kick that effort off. ■

COMPARISON OF PRIVATE FINANCING OPTIONS

	Insurance	Savings	CCRC[a] with a life care contract	Housing Equity
Prevalence	Less than 10 percent of care is paid for by private long-term care insurance.	About 15 percent of long-term care is paid for out of pocket. On average, older households have insufficient funds to cover the cost.	Low; limited to higher wealth households.	Low prevelence of reverse mortgages to pay for LTC.
When to do it	While still healthy enough to quailify for lower rates.	Throughout life.	Payment at time of entry and ongoing payments thereafter.	When funds are needed.
Constraints	Limited access after health deteriorates. LTC insurace may not cover all costs.	Requires long period of saving to accumulate sufficient savings.	Limited access after health deteriorates.	Insufficient home equity to finance care; illiquidity may make selling difficult.
Match of solution to care needs	Depends on contract terms, e.g., qualification for benefits, type of care covered, waiting periods, maximums.	Does not provide or finance care directly; difficult to estimate needs; savings may be insufficient; flexibility to use funds as needed.	Depends on contract terms and care available at CCRC chosen.	Does not provide or finance care directly; no guarantee that home equity will be sufficient to meet needs.
Risks	Insurance premiums may increase over time; expenses may exceed policy maximums if care required for extended periods.	Investment risk; potential for shortfall; difficulty of managing assets; savings may be depleted prior to needing care.	Monthly costs are likely to increase; CCRC could change management or go bankrupt; don't know if all needs will be covered.	Housing equity may be inadequate to meet needs, housing market risk, interest rate environment impact on reverse mortgage payouts.
Which household type should use this methond of financing?	Middle and upper middle income because they can afford premiums.	Higher income and net worth households; need to start early and be willing to take investment risk.	Higher net worth only because of the cost of buy in and regular payments.	Any households that own their home; lower risk for singles.
If no LTC costs incurred, what cost has been incurred?	Insurance premiums from date of purchase to death.	Nothing. All savings can be accessed for other purposes.	CCRC buy-in price, higher monthly living cost to cover premium for long-term care.	Nothing. Housing equity is still available to use for other purposes
Issues for surviving spouse	Reduces risk of asset depletion; insurance can be cheaper if bought for both spouses.	Healthy spouse may incur personal and financial costs to delay accessing paid care; survivor may have insufficient assets to meet own needs.	Security of being in the CCRC and of receiving care if needed; monthly charges higher than alternative housing; high cost for relocation if it becomes necessary.	Healthy spouse may incur personal and financial costs to delay accessing paid care; survivor may have insufficient assets to meet own needs.
Tax issues	Some long-term care insurance has tax advantages.	Most retirement saving is tax-deferred; wealth will be taxed on withdrawal.	Part of the buy-in price and monthly cost are deductible as insurance.	Gain on the sale of the house usually tax free.

a Continuing Care Retirement Community

(Source: The Impact of Long-Term Care Costs on Retirement Wealth Needs, by Vickie Bajtelsmit and Anna Rappaport, 2014)

$100 Billion and Growing: Long-Term Care Reserves in 2013

By Tom Penn-David

Editor's Note: An original version of this article appeared in the Milliman Disability Newsletter.

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INTRODUCTION

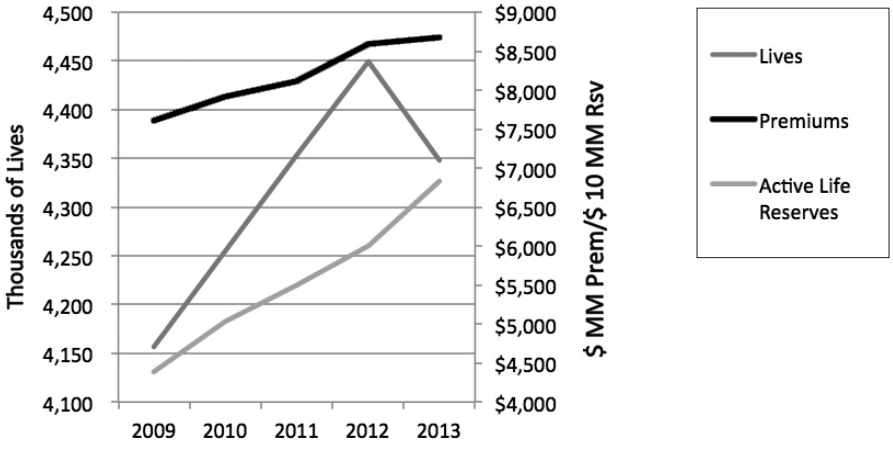
The recent long-term care (LTC) reinsurance transaction between CNO and Beechwood Re may signal the start of a broader market for buyers and sellers of long-term care blocks. One of the major themes of the LTC market over the last 15 years has been the significant number of departures of life insurers (and a few casualty insurers) from this product line while the previous 20 years had shown a large number of entrants to the market. In this article, we provide an overview of market development over the last five years and take a look at the current disposition of LTC reserve blocks between active and inactive insurers. Note that for the sake of simplicity, we have limited our analysis to blue book life insurers only. There are only two meaningful yellow book LTC insurers and total LTC premiums for orange book insurers are minimal.

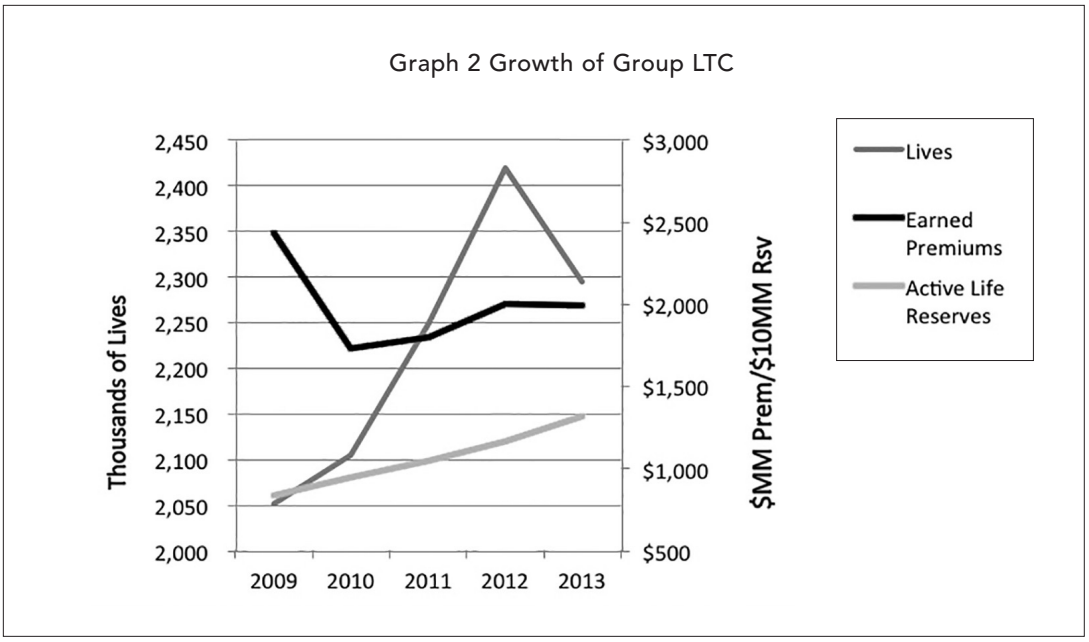
INDUSTRY DEVELOPMENT: LIVES, PREMIUM AND ALR'S – 2009 THRU 2013

LTC industry statistics

2012 marked the recent high water mark in the number of individual insureds covered by LTC insurers (based on the A&H Experience Exhibit). This probably speaks volumes about the health of the LTC market. However, while growth in covered lives reversed itself in 2013, growth in premium earned per life and more rapid growth in ALR per life has continued. The graphs below show growth trends for individual and group LTC separately. It is not surprising that both earned premiums (and premium per life) and ALR have been rising considerably faster than covered lives for individual LTC. Note that earned premium and lives come from the A&H Experience Exhibit while ALR's come from the LTC Experience Report.

Graph 1 Growth of Individual LTC





Development of group lives, earned premium and ALR's has been somewhat more inconsistent as might be expected but does show the same peak in covered lives in 2012. Graph 2 shows the development of group LTC.

Estimates for total LTC reserves

The LTC Experience Report provides a reasonable basis to estimate total ALRs for all LTC insurers. DLRs, on the other hand, are not as clearly separated out. To estimate DLRs, we have analyzed Exhibit 6 Guaranteed Renewable DLRs reported for each insurer with sizable ALRs. GR DLRs as a percent of total GR reserves vary from 20 percent for the two largest LTC insurers up to 34 percent for Senior Health and as low as 9 percent for Met, Pru and NML. Met and Pru presumably include a lot of non-LTC short-tail business in their GR blocks. NML suggests a different dynamic. Across the top 25 GR insurers (excluding AFLAC), DLRs aver-

TABLE 1 ESTIMATED TOTAL LTCI RESERVES

Year -->	2009	2010	2011	2012	2013
Reported Individual LTC Policy Reserves	43,889	50,366	54,986	60,042	68,274
Estimated Individual LTC Claim Reserves	9,634	11,056	12,070	13,180	14,987
Reported Group LTC Policy Reserves	8,374	9,506	10,525	11,690	13,193
Estimated Group LTC Claim Reserves	630	715	792	880	993
Reported Life/LTC combo Reserves	648	1,505	6,238	7,647	9,053
Estimated Total LTC Reserves	63,175	73,148	84,611	93,438	106,499

CONTINUED ON **PAGE 22**

age 18 percent of total GR reserves. Based on this analysis, our estimates by year for ALRs and DLRs for all LTC insurers are shown in Table 1 (reserves in $millions).

Notes on reporting anomalies

Note that we are relying on information reported in the LTC Experience Report Form 2. As we reviewed this information, we concluded that it provides a reasonable overview of industry totals and that there are apparently some significant market participants who either have not filed this report or have reported zero amounts.

DEVELOPMENT OF LTC COMBOS – 2011 THRU 2013

Another important side of the LTC story has been the rise of life/LTC combination products. LTC Experience Reporting Form 4 provides some window into the rapid growth of this market. As with the stand-alone market, there are significant reporting anomalies. Notably, chronic illness products are not reported and it appears that at least some notable insurers in the LTC combo market have not reported on their business. However, Graph 3 provides a picture of the rapid growth in lives and reserves for this market segment in the last three years (data from earlier years is inconsistent).

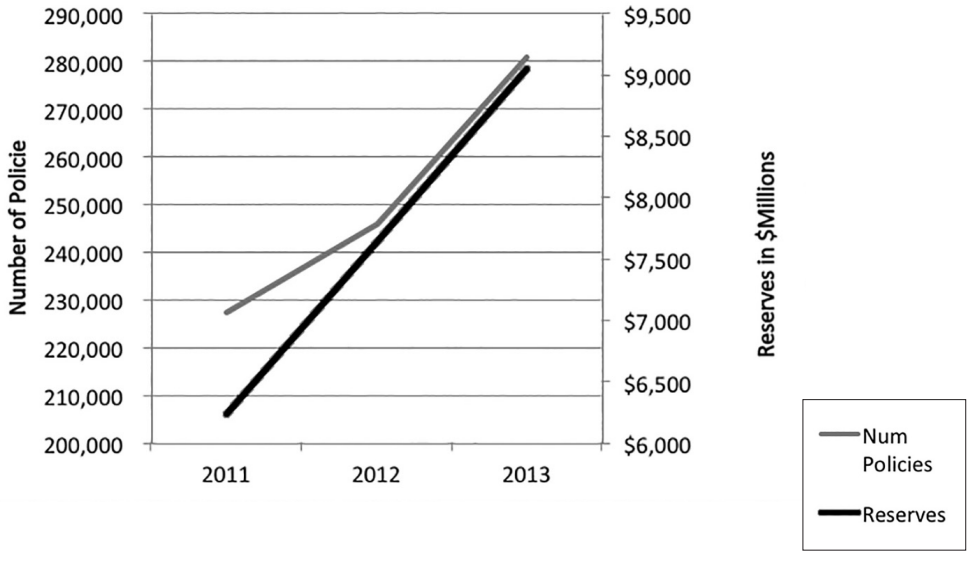
DISPOSITION OF ALRS BY ACTIVE VS. INACTIVE INSURERS

It is very easy to list off the top of one's head 10, 20, or more insurers who have been large players in the LTC market within the last 15 years and have stopped selling LTC—either group or individual or both. There are at least two ways to identify companies who have exited the market. One is the database maintained by the California Department of insurance. The other way is to identify insurers who have shown a decrease in the number of lives covered over the last few years. As we have performed this analysis and classified each insurer (125 reported either individual or group earned premium in the A&H Experience Exhibit), we noted a number of insurers with apparent anomalies—e.g., insurers who we believe are inactive but saw meaningful growth in covered lives or vice versa. However, Table 2 shows our best estimate of earned premiums and ALRs for each insurer that we could reasonably classify. Note that our counts are based on legal reporting entities so any given insurer (e.g., Genworth or Hancock) may be represented by more than one entity.

REINSURANCE BLOCKS

Six traditional reinsurers have been active in the LTC reinsurance market at some point. They are

Graph 3 Growth of LTC Combos



ERC, Gen Re, Hannover, Munich Re, RGA and Swiss Re. In total, their LTC reserves represent around 9 percent of the total reserves that we estimate for the entire LTC market. Table 3 shows LTC treaties, premiums and reserves reported in Schedule S in 2013 for each of these reinsurers.

Note once again that there are some reporting anomalies and we have used estimates. Four of the six reinsurers use the NAIC reinsurance type "LTC/I" to describe LTC treaties while two do not use that type. Note that we found no "LTC/G" treaties among this group of reinsurers. It is also notable that it currently appears that only one of the six is still active in the LTC reinsurance market.

CONCLUSIONS

Viewed from a broad industry perspective, the LTC insurance product has had mixed measures of success and challenge over the last 15 to 20 years. However, viewed from the narrow perspective of a potential reinsurer or purchaser of LTC reserves, the size of a potential market is very substantial. Realistically, until new money earned rates are significantly higher, the number of economically feasible transactions will be quite limited. However, there certainly is enough potential business out there to warrant continued attention. ■

TABLE 2 ACTIVE VERSUS CLOSED LTCI BLOCKS

Status	Individual			Group		
	#	2013 Earned Premium ($000's)	2013 ALRs ($000's)	#	2013 Earned Premium ($000's)	2013 ALRs ($000's)
Active	24	5,830,838	34,746,332	5	1,124,170	4,221,399
Inactive	66	2,816,032	33,370,880	21	874,072	8,080,776
Never Material	35	31,309	107,391	99	954	3,659

TABLE 3 REINSURED LTCI

Reinsurer	Treaties	Premiums	Reserves
ERC	14	$ 382,460,733	$ 6,581,009,136
Gen Re	29	$ 72,927,491	$ 661,851,336
Hannover	7	$ 22,550,083	$ 216,095,843
Munich	21	$ 217,875,156	$ 1,134,349,790
RGA	17	$ 377,577,019	$ 431,621,557
Swiss	10	$ 7,946,810	$ 81,378,236
Totals	98	$ 1,081,337,292	$ 9,106,305,898

Handling Long-Term Care Insurance Claims: Provider and Policyholder Eligibility Issues

By Jan M. Michaels and Stephen A. Skardon

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INTRODUCTION

Long-term care insurance claim handling practices have received increasing attention as a result of class action lawsuits and recent policyholder verdicts. As a result, at least some long-term care insurers have begun reviewing and improving their claims handling. These efforts are likely to improve the policyholder's claim handling experience and, hopefully, will reduce litigation.

However, there is always room for improvement. This article focuses on issues that arise when determining policyholder eligibility and provider eligibility under tax-qualified long-term care insurance policies and provides some suggestions and observations that should further improve claim handling and reduce litigation.

POLICYHOLDER ELIGIBILITY – IS THE POLICYHOLDER CHRONICALLY ILL?

The "Chronically Ill" Certification

The first step in analyzing a claim under a tax-qualified policy is to determine whether the policyholder is Chronically Ill. This should be a relatively straightforward analysis, since it requires nothing more than confirming that a Licensed Health Care Practitioner (LHCP) has certified that the policyholder is either "unable to perform (without substantial assistance from another individual) at least [two] Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity," or "requir[es] substantial supervision to protect … [the policyholder] from threats to health and safety due to Severe Cognitive Impairment."[1] As long as the LHCP provided the certification within the 12 months preceding the claim, and there are no indicia of fraud, the policyholder is Chronically Ill and eligible for policy benefits.

While this concept is relatively simple, claims analysts might unnecessarily (and improperly) complicate the task by looking to facts beyond the LHCP's certification to determine if a policyholder is, in the analyst's view, Chronically Ill. For instance, analysts may make Chronically Ill determinations by comparing the LHCP's certification with the services that the policyholder receives. If the LHCP's certification shows that a policyholder requires substantial assistance with three activities of daily living (ADLs) for a period of at least 90 days, but the care records show that the policyholder is receiving substantial assistance with only one ADL, then the analyst might decide to challenge the Chronically Ill certification. This approach is improper and is likely to antagonize policyholders and their families.

In other instances, long-term care insurers have discounted Chronically Ill certifications because they questioned the LHCP's objectivity. While physicians and other care professionals certainly are advocates for their patients and clients, insurers should not discount or ignore a LHCP's Chronically Ill certification based on a perceived lack of objectivity. Tax-qualified long-term care policies do not provide for this type of judgment call. If the policyholder's medical and care records call the Chronically Ill certification into question, the insurer may have a basis for seeking additional information or challenging the certification. However, the certification should not simply be discounted.

Claims analysts must remember that LHCPs are the only persons that can certify policyholders as Chronically Ill under a tax-qualified policy. If a LHCP makes that certification, and there is no indication that it is fraudulent or inaccurate, then the insurer must accept the certification and conclude that the policyholder is Chronically Ill and eligible to receive benefits. Moreover, if the analyst has reason to believe that the certification is inaccurate, a full investigation should be undertaken, including communicating directly with the LHCP and the policyholder, and employing other tools that the policy language may provide (such as an independent medical examination). The analyst

should not deny coverage based on suspicion that the policyholder may not be Chronically Ill alone, if an LHCP has provided a facially valid Chronically Ill certification.

What ADLs Are Relevant and When

When assessing a policyholder's eligibility, analysts must know both what ADLs are relevant to the claim and when they are relevant. Analysts who do not understand these issues may recommend approving uncovered claims and denying covered claims.

ADLs are often described as the "basic tasks of everyday life." However, for purposes of tax-qualified long-term care insurance, the federal government has limited them to eating, toileting, transferring, bathing, dressing and continence.[2] These six ADLs are the only ones that matter for tax-qualified long-term care insurance claims, and are the only ones that should be considered when assessing policyholder eligibility.

These six ADLs are identified (and usually defined) in tax-qualified long-term care policies. Accordingly, determining what ADLs are relevant should be relatively straightforward. Unfortunately, in the real world the ADL issue can be confusing. Several factors account for this. One important factor is that health care practitioners commonly define ADLs to include more than the six ADLs that are relevant to tax-qualified policies. Another is that long term care claim forms, which often are multi-purpose forms that are used in connection with claims under both tax-qualified and other types of long-term care policies, may identify more than the six ADLs.

Licensed or certified health care professionals like nurses and social workers commonly manage and staff long-term care insurance claims handling operations. Many of these professionals practiced in their respective fields before working for insurers and third-party administrators. Health care practitioners often think of activities that are known as "instrumental activities of daily living" (IADLs) as ADLs. IADLs are activities that reflect the ability to live independently, such as managing medications and personal finances, housekeeping, meal preparation, using transportation, operating a telephone and shopping. The federal government has not seen fit to include IADLs in determining eligibility for tax-qualified long term care insurance. Accordingly, conflating ADLs and IADLs can lead to improper eligibility determinations. For instance, a treating physician may certify a policyholder as Chronically Ill because he or she requires substantial assistance with toileting and medication management for a period of at least 90 days. Such a policyholder would not be Chronically Ill under a tax-qualified long term care policy because only toileting qualifies as an ADL for eligibility purposes. Nevertheless, claims analysts with prior health care experience may be inclined to rely on their past professional understanding of ADLs, rather than the policy requirements, and to accept otherwise invalid Chronically Ill certifications. Unless these errors are caught during a claim review, the insurer will end up paying for non-covered claims.

The failure to understand when ADLs are relevant to eligibility also can lead to the denial of covered claims. Simply put, ADLs are irrelevant to determining the eligibility of policyholders suffering from a Severe Cognitive Impairment. Both the Chronically Ill definition, and the Internal Revenue Service's interim guidance on tax-qualified long term care policies, make this clear.[3] This makes sense from a practical standpoint. Not to state the obvious, but Severe Cognitive Impairment entails cognitive limitations, not physical limitations (although a person may qualify under both parts of the Chronically Ill definition). Accordingly, for policyholder eligibility purposes, the focus with respect to Severe Cognitive Impairment is on whether the policyholder requires substantial supervision to protect against threats to health and safety. A person suffering from dementia may be physically capable of performing all six ADLs, but may forget to perform them or act in a way that threatens his health and safety, such as wandering from his home or leaving oven burners on. As a result, that person needs substantial supervision, not substantial assistance with ADLs. Analysts who uniformly assess policyholder eligibility based on ADLs will end up denying otherwise covered claims.

Insurers, many of whom have issued a variety of different long-term care policies with differing benefit triggers, can contribute to the confusion by providing policyholders with general purpose claims forms that comingle ADLs and IADLs. Policyholders may be given forms that contain a single list of "activities of daily living" that identifies the six statutorily required ADLs alongside IADLs that are irrelevant to tax-qualified long-term care claims. It is easy to see how this can confuse both the analyst and the policyholder. An analyst who is presented with a claim that is filed on com-

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pany-prepared forms may ignore his training and defer to the forms rather than the policy language, either because he is too embarrassed to seek clarification from a manager or because he assumes that the company's forms take precedence over his training. These forms can be equally confusing to a policyholder and her LHCP, since one or both may incorrectly conclude that a policyholder who needs substantial assistance with housekeeping and medication management is Chronically Ill. If your company's claim forms conflate ADLs and IADLs, we recommend refining the documents to either to create tax-qualified-specific forms that exclude IADLs or to specify that the ADLs are the only relevant activities for determining eligibility under tax-qualified policies.

PROVIDER ELIGIBILITY

Analyzing policyholder eligibility is (or at least should be) a relatively straightforward process. However, determining provider eligibility is anything but. Insurance policies are, at base, contracts between policyholders and their insurers. As a result, claim handlers and insurance professionals are taught that the policy language is paramount and governs the parties' rights and obligations. This generally is a valid conclusion, except when it comes to determining provider eligibility under a tax-qualified long term care policy.

Determining provider eligibility can be troublesome because the insurance policy intersects with state statutes and regulations governing long-term care insurance and the various service providers, including home health care agencies and home health care aides. Claims analysts must know how to apply the policy language within the context of the relevant state statutes and regulations.

While tax-qualified policies may contain variations on the definitions of Home Health Care Agency and Home Health Care Provider, a Home Health Care Agency generally is defined as:

> An entity which provides Home Health Care Services and:
>
> 1. Has an agreement as a provider of Home Health Care Services under the Medicare program; or
>
> 2. Is licensed by state law as a Home Health Care Agency.

A Home Health Care Agency also means a registered nurse, a licensed practical nurse, or a licensed vocational nurse operating within the scope of his or her license.

A Home Health Care Provider typically is defined as:

> An entity which provides home health care or Hospice Services and:
>
> 1. Has an agreement as a provider of home health care services or Hospice Services under the Medicare program; or
>
> 2. Is licensed or accredited by state law as a home health care agency or hospice, if such licensing or accreditation is required by the state in which the care is received; or
>
> 3. Is a licensed therapist, a registered nurse (R.N.), a licensed practical nurse (LP.N.), or a licensed vocational nurse (LV.N.) operating within the scope of his or her license.
>
> A Home Health Care Provider cannot be a member of your immediate family living with you.

At first blush, these definitions appear to be virtually identical. Both define eligible providers to include entities that are certified under Medicare and individuals who are licensed as registered nurses, practical nurses or vocational nurses. The definitions are not identical, however. The HHCA definition requires an eligible agency to be licensed. The HHCP definition, on the other hand, requires the agency to be licensed only if the state in which the care is provided requires a license.

Applying the plain meanings of these definitions to two identical claims from the same state could result in two very different outcomes. For instance, in a state like Missouri, which requires home health care agencies to be licensed only in certain situations, an unlicensed agency would not be an eligible provider under the HHCA definition because it requires the agency to be licensed, regardless of whether the state requires licensing. That same agency, however, would qualify as an approved agency under the plain meaning of the HHCP definition because Missouri does not require licensing for all agencies.

These conclusions should make sense to an analyst who was trained to apply the policy language as written. Unfortunately the analysis cannot stop there. The relevant state's statutory and regulatory scheme must also be taken into account. In the

context of this hypothetical, the problem is that the agency should qualify as an eligible provider under both definitions according to Missouri's statutory and regulatory scheme. Thus, analysts must be familiar with the applicable state laws and regulations if they are going to correctly determine provider eligibility.

To determine if an agency that is providing ADL assistance in Missouri is an eligible provider under the HHCA definition, the analyst should first look at Missouri's Long-Term Care Act. That act contains a section outlining the minimum standards for long-term care policies that provide home and community based care benefits.[4] That section reads, in relevant part:

> (10) Minimum standards for home health and community care benefits in long-term care insurance policies.
>
> (A) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:
>
> ***
>
> 6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.[5]

Since part two of the HHCA definition states that the agency must be "licensed by state law as a Home Health Care Agency," one must also look at Missouri's regulations governing home health care agencies to determine whether Missouri requires agencies to be licensed. If no license is required, then the insurer must deem the agency an eligible provider, despite the policy language, in order to comply with Missouri statute. The Missouri statute governing home health agencies defines a "home health agency" as "… an agency or organization that provides two or more home health services at the residence of a patient according to a physician's written and signed plan of treatment."[6] The statute then defines "home health services" as "any of the following items and services provided at the residence of the patient on a part-time or intermittent basis: nursing, physical therapy, speech therapy, occupational therapy, home health aid, or medical social services." [7] If an agency provides fewer than two "home health services," it is not a "home health agency" under Missouri law and is not required to be licensed.[8]

After considering all of the relevant information, including the statutory and regulatory context of the claim, the analyst considering our hypothetical should conclude that enforcing the HHCA definition's agency licensing requirement violates Missouri's statutory prohibition against requiring the provision of home health care services "at a level of certification or licensure greater than that required by the eligible service."[9] The agency therefore should be approved as an eligible provider.

Determining provider eligibility can be an involved and challenging process, but it is a necessary one. In an effort to facilitate this process, long-term care insurers should consider either preparing or commissioning the preparation of a 50-state survey summarizing each state's statutes and regulations governing long-term care insurance and provider licensing requirements. This will allow analysts and their supervisors to work more efficiently, while also helping to better ensure that the company reaches the correct result.

CONCLUSION

Incorporating the practices discussed in this article into existing claim handling procedures will improve the claim handling process. Claim handlers who understand how to properly determine policyholder and provider eligibility will handle claims more efficiently and will improve the accuracy of claim decisions. These improvements will benefit both the insurance companies and their policyholders. Insurance companies will see savings from both an operations and litigation standpoint, while policyholders will have their claims handled more efficiently and accurately. ■

ENDNOTES

1. Tax-qualified long-term care policies typically define Licensed Health Care Practitioners as "any physician and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury."
2. 26 USC § 7702B(c)(2)(B) (2013).
3. 28 USC § 7702B(c)(2)(A)(i)-(iii) (2013); IRS Notice 97-31, 1997-1 C.B. 417. As discussed earlier, most tax-qualified policies define a Chronically Ill individual as one who is either: (1) "unable to perform (without substantial assistance from another individual) at least [two] Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or (2) "requir[es] substantial supervision to protect such individual from threats to health and safety due to Severe Cognitive Impairment" (emphasis added).
4. See 20 C.S.R. § 400-4.100(10) (2013).
5. See 20 C.S.R. § 400-4.100(10)(A)6 (2013).
6. See § 197.400(3) R.S.Mo. (2013).
7. See § 197.400(4) R.S.Mo. (2013).
8. See § 197.405 R.S.Mo. (2013).
9. See 20 C.S.R. § 400-4.100(10)(A)6 (2013).

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