ACTEX Professional Series

Insuring Long-Term Care

SECOND EDITION

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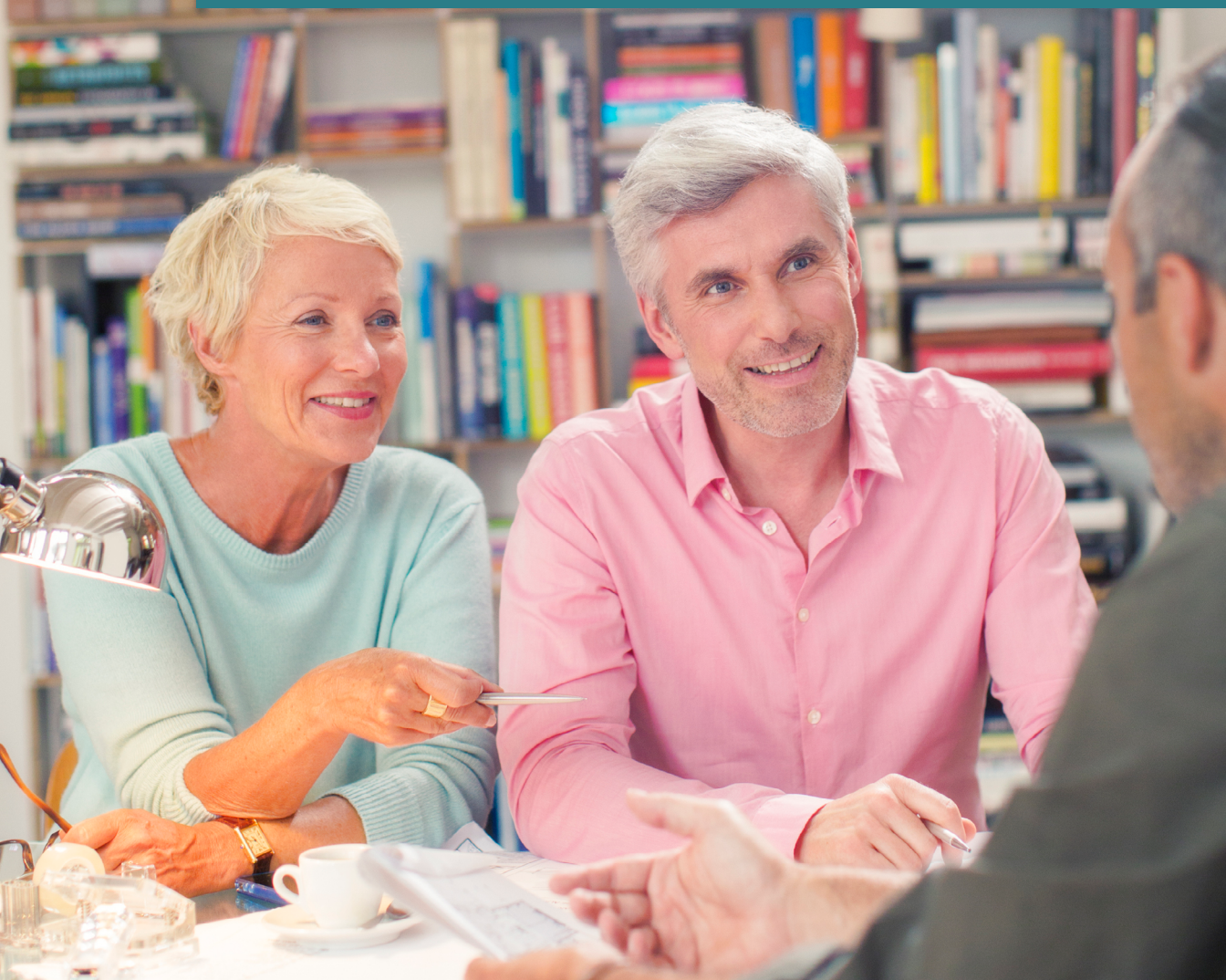
2nd



Insuring Long Term Care

2nd Edition

ACTEX Learning

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1 INTRODUCTION TO LONG-TERM CARE

By Robert Eaton and Matt Morton

INSURING LONG-TERM CARE

Long-term care (LTC) is mostly a newer problem for people. Only recently have we achieved the oldest ages where our bodies and minds are frail, and we can no longer care for ourselves. Traditional intergenerational families have – and still do for many – provide a support system for our elders as they begin to need help with activities of daily living.

Demographics and social norms have shifted in the US, and many people wish to live independently in old age. For those who will have long-term care needs (about half of us who reach age 65), paying for this care can be costly.

Long-term care fits the mold of an insurable event: most people don't want to face long-term care needs (a confluence of incentives between insured and insurer), and the financial burden can be catastrophic (a good candidate for pooling risk). The market for the traditional, standalone long-term care insurance (LTCI) product has dwindled in recent decades. To fill this void, to meet the demand for a very real consumer need, new risk sharing products and polices have emerged. New types of financial and provider contracts are imagined and written each year to facilitate long-term care in private and public settings.

The market for traditional long-term care insurance is weak, but the need for insuring long-term care is strong.

This revised and updated text book explores the risks of long-term care and how US insurers have managed this risk, with an eye to educate actuaries and risk managers, and facilitate new means of insuring long-term care for consumers. This edition includes added material on actuarial considerations of hybrid products, the tax treatment of LTC policies and a deep dive into statutory and GAAP reserving methodology for LTC.

2 HISTORY OF LONG-TERM CARE PRODUCTS

By Ray Nelson, FSA, MAAA

This chapter provides an overview of the beginnings, growth, and evolution of Long-Term Care (LTC) insurance products.

THE BEGINNINGS

From the time that Medicare was enacted in 1965, insurers began to look for ways to enhance or supplement the coverage that was provided by the government plan.

The benefits provided by Medicare for Nursing Home care are quite limited, with Medicare only providing coverage for care that takes place in a skilled nursing facility so long as the insured needs skilled care and has had a prior hospitalization of at least three days within the 30-days prior to entering the nursing facility[1].

Initially, many companies offered insurance plans, (called Medicare Supplement plans), that were focused on covering the hospital and medical benefits, as well as co-pays and deductibles, that were not covered by Medicare. Generally, these initial Medicare Supplement plans did not focus on the Nursing Home benefits provided by Medicare.

Eventually, some insurance plans were developed to supplement the Nursing Home benefits provided by Medicare. Some plans, usually offered as riders to Medicare Supplement insurance, were designed to cover the Medicare co-pay amounts from days 21 through 100. Other plans provided a benefit extension for days 101 through 200. Eventually, some other plans also experimented with expansions to the benefits provided such as covering care for both skilled and intermediate coverage.

[1] In addition, Medicare benefits are limited to all approved charges for the first 20 days of the nursing home stay, and then pays for benefits after a co-pay for days 21 through 100. The amount of the co-pay, which was $176 in 2021, is indexed to equal one-eighth of the Medicare Part A deductible.

FIRST NURSING HOME PRODUCTS

By the early to mid-1980s, there were a handful of insurance companies that began to offer the first stand-alone products that covered care in Nursing Homes. These initial products usually provided coverage for care in all state licensed Nursing Homes, whether the care was for skilled, intermediate, or custodial care. Although some of these initial products reduced the benefit levels paid for custodial care, this limiting practice was not in place for very long.

These first insurance products used the same benefit trigger that Medicare used for paying Nursing Home benefits. In order to be eligible for benefits, the care needed to be medically necessary and would need to follow a prior hospitalization of at least three days within the 30-day period prior to entering the Nursing Home. After a short period, some companies experimented with offering an option that removed the three-day prior hospitalization requirement.

These first products provided benefits in Nursing Homes, generally allowing the insured to choose: a) the daily maximum benefit amount; b) the benefit period; and c) the elimination period. Although each company set the options that would be available, it would have been typical to see the following benefit options available:

- Daily maximum benefit amounts available in $10 increments, with a range of $20-$200.Some companies provided the Nursing Home benefit on an indemnity basis, meaning the full daily benefit was paid regardless of the actual expense. Some companies paid the actual charge, up to the daily maximum benefit.
- Companies generally offered multiple options for benefit periods (the length of time for which nursing home care would be covered) with a range from as low as 1 year to as high as 5 years.
- The elimination period, which is essentially a deductible period or the initial period of time in the nursing home for which the policy does not provide coverage, choices ranged from as low as 0-days (first day coverage) to as high as 100-days.

These initial products were generally available to insureds between the ages of 60 and 79 at the time of issue, though some companies offered at additional ages. The underwriting used by insurers to determine if an applicant would qualify for coverage was primarily based upon answers to health questions provided on an application for the coverage. In some policies there were benefits beyond the Nursing Home benefit with some policies providing limited Home Health Care benefits (often only available after a covered Nursing Home stay). Some early products began to include offers to inflate the daily maximum benefit,

usually by 5% simple interest, for a fixed period of time (10-20 years). These initial policies were often conditionally renewable, though guaranteed renewable products became the standard rather quickly.

INITIAL LTC INSURANCE REGULATION

As companies were creating and developing these initial LTC products, state regulators were also grappling with appropriate standards to apply to these new types of products. In an effort to help standardize the state regulation of these products and assure that appropriate consumer protection was in place, the National Association of Insurance Commissioners (NAIC) created the first Long-Term Care Insurance Model Act and Model Regulation in 1986. These Models were developed based upon input from state insurance regulators, insurers, and consumer group representatives.

Both the NAIC LTC Model Act and Regulation have evolved over time as LTC products have changed and evolved. Some of the key provisions introduced in the initial (and early revisions of the Models) included the following:

- Definition of LTC insurance: Though the Model Act includes a lengthy definition of what LTC insurance is and is not, a key portion of the definition establishes the minimum period of time that an LTC policy will cover. The definition notes the LTC insurance "means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve (12) consecutive months . . .".
- Levels of Care: No LTC policy could provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Conditions for Benefit Eligibility: No LTC insurance policy could condition benefits on a prior hospitalization requirement.
- Policy Renewability: The Model Regulation mandated that policies must be either "guaranteed renewable" or "noncancelable".

The NAIC Model Act and Regulation were reviewed and updated frequently, often times reflecting new/recent product trends, which in turn helped to accelerate the evolution of the products seen in the marketplace. Two provisions that appeared relatively early on (late 1980's/early 1990's) in the Models were related to Inflation Protection and Nonforfeiture.

For a time, there was significant debate among regulators, insurers, and consumer groups as to whether LTC policies should be mandated to include both inflation protection and nonforfeiture benefits. Though such provisions do provide significant benefits and protections to the purchaser, it was also noted that

both benefits would add significant cost to the policy and potentially greatly limit the market for LTC insurance products. Eventually it was agreed that consumers should be able to choose their respective benefits, and that in all cases the consumer should have the option to purchase inflation and/or nonforfeiture benefits. As such, the Models were amended to include the following requirements for insurers:

- Inflation Protection: Insurers must offer inflation protection at the time of purchase no less favorable than one of the following:
  - Benefit levels increasing annually by at least 5% compounded,
  - A guaranteed right to purchase additional benefits periodically, (without providing evidence of insurability), with the increase in benefits being at least 5% compounded per year, or
  - Cover a specified percentage of the actual/reasonable charges with no specified amount or limit. These benefit increases would continue for the life of the policy regardless of the insured's age or claim status. Companies were permitted to offer additional inflation options so long as they also offered at least one option in compliance with the above.
- Nonforfeiture Option: Insurers must offer a nonforfeiture benefit option at the time of purchase. Eventually the minimum nonforfeiture benefit that had to be offered was commonly referred to as a Shortened Benefit Period paid-up option. This option provided an insured that lapsed any time after their third policy anniversary with a nonforfeiture credit equal to 100% of the sum of all premiums paid (with a minimum credit of 30 times the daily nursing home benefit at the time of lapse). This nonforfeiture option would provide paid-up coverage for the same policy benefits, amounts/levels, elimination periods, etc. with the exception being that the benefit period would end when the total amount paid was equal to the nonforfeiture credit.

PRODUCT EVOLUTION

LTC products quickly evolved in the 1990's as more and more insurers entered the marketplace. Sales of LTC insurance products also increased rapidly during this time.

Significant product evolutions were seen in many different areas of the base product benefits as well as optional benefits offered. Some of the most notable evolutions seen were:

Home Health Care (HHC) Benefits

The limitation imposed on HHC benefits in the early policies were quickly removed, with HHC being covered without regard to there being a prior nursing home stay. HHC benefits were generally provided, at an additional cost, via an optional rider. Benefit maximums, both daily maximums and benefit periods, for HHC were generally separate from the maximums for Nursing Home care. This too changed quickly as noted in the Product Design section that follows.

Product Designs

While initial product designs contained separate benefit maximums for Nursing Home (NH) and Home Health Care (HHC) benefits, many carriers started to offer products that provided both NH and HHC benefits under one single set of benefit maximums. These types of products were typically called "Pool of Benefit" or simply "Pool" policies as all benefits covered by the policy were subject to one total benefit maximum. "Pool" policies generally contained daily maximum amounts, though some used weekly or even monthly maximum amounts to allow for more flexibility. These policies generally measured the lifetime benefit maximum in terms of either days of care or in benefit dollars.

Another product design feature that varied by carrier was whether policy benefits were paid based on an indemnity benefit amount or actual expense incurred. Early products often paid the Nursing Home benefit based on an indemnity amount – meaning that for a covered NH stay, the policy's daily benefit amount was paid regardless of the actual charges. Many newer products in this time referred to the daily benefit amount as a "daily maximum" and the policy would cover actual charges up to the daily maximum. (As noted earlier, some companies defined the maximum as a weekly or monthly maximum in order to increase flexibility.) These expense-incurred policies which provided coverage of actual charges up to the defined daily/weekly maximums were the most common design with products that covered Home Health Care as the cost for HHC could vary significantly based upon the amount and type of care than the insured requires. During this time, there were a handful of companies that sold products using a disability based model meaning that the policy would pay benefits in the amount of the full daily benefit, so long as the insured could demonstrate that they met the policy's benefit qualifications (also called benefit triggers). The cost of care, or even whether care was being received or not, did not impact the benefit payment in these disability-based policies.

Other Facilities/Alternate Care

While the initial policies were designed to provide benefits for nursing home patients, there was a recognition that there were many different types of facilities which provided varying levels of care. Early on, some policies included provisions for Alternate Facility Care that provided potential coverage for some lesser facilities so long as the facilities met policy definitions and the care provided in such facilities was in lieu of a nursing home stay. As products evolved, it became more common for LTC policies to define and provide coverage in Assisted Living Facilities (ALFs) in the same manner and to the same extent as was provided for nursing homes. Many policies continued to include provisions for Alternate Care to account for new locations or types of care that might develop in the future where needed care could be provided in a more cost-efficient manner than in nursing facilities.

Unlimited Benefit Periods

Although initial policies limited benefits to periods such as 1, 2, 3, 4 or 5 years, some carriers began to start offering what was referred to as Unlimited or Lifetime benefit period options. Quickly this option was offered by almost every carrier and the Lifetime/Unlimited option became the most frequently chosen benefit period option for most carriers.

Benefit Triggers (ADLs & Cognitive Impairment)

Once the 3-day prior hospitalization requirement was retired from use, companies were initially left with a benefit trigger most commonly referred to as 'medical necessity'. If care was recommended by a doctor as being medically necessary, then benefits were eligible to be paid (assuming other contract provisions such as provider eligibility were met). Companies were not entirely comfortable with the subjective nature of such triggering language and sought language that would be more objective and uniform. Using geriatric research, it was believed that two types of measures might be more appropriate for determining one's LTC needs: a physical/functional measure and a cognitive measure.

- Research showed that everyday basic Activities of Daily Living (ADLs) could possibly be used as a means to evaluate LTC needs. Most LTC insurance products began to define five or six ADLs from in the contract from the list of: Bathing, Continence, Dressing, Eating, Toileting and Transferring. Benefit eligibility was defined as needing assistance with some minimum number of the defined ADLs (most common being two or three). There was much variance from company to company on the ADLs

shown, the number needed to trigger benefits (2 or 3), and even the definition of assistance with ADLs. Some policies defined an ADL deficiency as needing 'hands- on assistance' to complete the ADL while others used 'stand-by' assistance (some used 'hands-on or stand-by' assistance).

- The cognitive measure trigger was difficult to define and quantify as diseases like Alzheimer's were difficult to diagnose with certainty and standardized cognitive tests were in their early stages of development. Though varied as to the level of assistance or supervision that might be needed, policy language also included a Cognitive Impairment trigger in addition to an ADL trigger.

Though specific language varied from policy to policy, at this time many policies incorporated a triple trigger – meaning an insured could qualify for benefits if the long-term care was found to be needed due to either: a) Medical Necessity, or b) assistance with X out of Y ADL's, or c) Cognitive Impairment. Several carriers removed the more objective trigger of Medical Necessity and went only with the two benefit triggers of ADLs or Cognitive Impairment.

Expansion of Benefit Availability

As products (and underwriting practices) evolved, companies became more comfortable in expanding the availability of coverage. Issues ages ranges were increased, both young and old. Some carrier offering benefits to insureds as old as age 89 (though benefit periods available at advanced ages were often limited). Issue ages were also pushed down initially to age 50, but eventually many carriers went down to age 30 or even age 18.

Additional Benefits/Offers and Options

Many additional benefit options were created as carriers tried to differentiate themselves in the marketplace. The list of such options would be extremely lengthy, but some of the most impactful options which appeared in some carrier offerings were:

- **Inflation Offers** – Though required to offer a 5% compound for life inflation option for life, many carriers created additional (less costly) options. The most common of these was a 5% simple inflation option.
- **Return of Premium Riders** – Some carriers created return of premium options meant to be attractive to younger issue ages. Variations of this benefit saw premiums returned upon death only, upon death or lapse, or at a target duration (such as 10 or 20 years). There was usually an

offset to the return of premium benefit for any claims paid. Some options increased the percentage of premiums returned over time, with only a small portion being paid for a lapse in the early years and increasing to 80% or 100% of premiums at duration 10 or later.

- **Shared Care** – Some carriers developed an option to let spouses 'share' their policy benefits. One variation saw both spouses maintain their own separate benefit maximum for an initial period of time (say 2 or 3 years) and then have access to an excess benefit pool (say another 2 or 3 years) that is shared between the spouses. Another variation saw both spouses covered under the same benefit pool from the start.
- **Restoration of Benefits** – Many policies contained some form of benefit restoration language which allowed the policy to restore the full maximum benefit period/amount should a policyholder's claim episode end for some period of time (usually 90 or 180 days) without receiving care. Policy language for this benefit evolved over time as initial language allowed for more cases of benefit restoration than had been anticipated in pricing.
- **Survivorship Options** – Some companies developed options when two spouses purchased a policy for a benefit that would waive future premiums for a surviving spouse once one spouse had died. It was common for this benefit to trigger after some minimal period, (say 10 years), after the policy issue date. This option was also built-in to the base coverage by some insurers.
- **Limited Pay** – Some companies offered policies that would become paid-up (no future premiums required) after some number of years. This option was targeted to younger insureds to allow for higher premiums to be collected in the initial years so that coverage would be fully paid-up by the time the insured reached retirement years. Insurers that offered limited pay generally offered 10-pay or 20-pay options (meaning premiums were paid for the first 10 or 20 years only). A couple of insurers offered the extreme option of single pay.

Health Insurance Portability and Accountability Act (HIPAA)

In 1996 Congress passed HIPAA which became effective January 1, 1997. HIPAA helped clarify the tax treatment of LTC insurance and the benefits paid by these insurance products. As such, HIPAA also created standards that policies had to meet in order receive the clarified favorable tax treatment. Policies sold on or after January 1, 1997 had to meet the new HIPAA requirements in order to be considered 'tax-qualified' policies under HIPAA.

Policies sold prior to January 1, 1997 were grandfathered in as tax-qualified policies so long as no material changes (increases) to the coverage were made after 1/1/97. Benefits paid under tax-qualified policies, (with some rare exceptions), are not considered taxable income to policyholders, and premiums paid for tax-qualified plans, (subject to attained age limits), can be included with the insureds medical expenses when filing their tax return.

Many of the LTC standards prescribed by HIPAA were consistent with the NAIC Model Act and Regulation. In fact HIPAA directly references the NAIC Models as adopted in January of 1993 for many provisions and requirements. A key provision included in HIPAA was the definition of a "chronically ill individual". The term "chronically ill individual" was defined in HIPAA as:

any individual who has been certified by a licensed health care practitioner as:

- being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity, or
- requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

HIPAA also included language for a third potential benefit trigger that allowed for a level of disability similar to the level of disability described in the ADL trigger. This was included in case some future measurement of disability was developed that could replace ADLs. To date, no such measurement has been developed.

HIPAA clarified that tax qualified LTC policies could only pay benefits to "chronically ill" individuals. This served to standardize the benefit trigger language of tax qualified LTC policies that were sold in the market from 1997 forward.

After January 1, 1997 most companies that were selling LTC policies, exclusively sold tax qualified LTC plans. There were some companies that continued to offer both tax qualified and non-qualified plans, but the vast majority of LTC policies sold after 1/1/97 were tax-qualified plans.

LTC product and market changes did not end with HIPAA. There were many later product innovations and market evolution events which took place in the 2000's. Many of these will be discussed in future sections.