Health Practice Note 1995–9
November 1995

Long-Term Care Insurance Business

Introduction

This practice note was prepared by a work group organized by the Joint Committee on Health Financial Issues of the American Academy of Actuaries and the Society of Actuaries.The work group was charged with developing a description of some of the current practices used by health actuaries in the United States and sources of relevant information.

The practice notes represent a description of practices believed by the work group to be commonly employed by health actuaries in the United States in 1995.The purpose of the practice notes is to assist actuaries who are faced with the requirement of preparing a statutory statement of opinion by providing examples of some of the common approaches to this work.However, no representation of completeness is made; other approaches may also be in common use.It should also be recognized that the information contained in the practice notes provides guidance, but is not a definitive statement as to what constitutes generally accepted practice in this area.Moreover, these practice notes are based upon the model Standard Valuation Law and the model *Minimum Reserve Standards for Individual and Group Health Insurance Contracts* of the National Association of Insurance Commissioners (NAIC).To the extent that the laws of a particular state differ from the NAIC models, practices described in these practice notes may not be appropriate for actuarial practice in that state.This practice note has not been promulgated by the Actuarial Standards Board, nor is it binding on any actuary.

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Comments are welcome as to the appropriateness of the practice notes, desirability of annual updates, substantive disagreements, etc.Comments should be sent to Peter L. Perkins at his Directory address.

Q. What does this practice note address?

A. This practice note addresses questions and issues regarding the valuation actuary's responsibilities under the Standard Valuation Law, the NAIC model *Actuarial Opinion and Memorandum Regulation,* and the Actuarial Standards Board's actuarial standards of practice (ASOPs) related specifically to determining adequate reserve levels and asset adequacy for long-

term care (LTC) insurance coverages.Such coverages include both individual and group coverages but do not include accelerated benefits on life insurance coverages.Long-term care insurance coverages include, but are not limited to, nursing home, home health care, adult day care, and assisted living facility care if provided.

While many valuation issues are common to life and health insurance in general, the degree of emphasis varies by type of business, and each product type presents its own unique problems, responses, methods, and bases for setting assumptions.This practice note is one of several health insurance product practice notes that has been compiled to provide information to valuation actuaries.

The actuary may refer to Health Practice Note 1995–1, *General Considerations,* for general items of concern.

Q. What are some sources of information that may be helpful in setting assumptions for LTC insurance products?

A. In addition to the standards defined in the ASOPs (especially No. 5, *Incurred Health Claim Liabilities*; No. 18, *Long-Term Care Insurance*; and No. 22, *Statutory Statements of Opinion Based on Asset Adequacy Analysis by Appointed Actuaries for Life and Health Insurers*), and the NAIC *Minimum Reserve Standards for Individual and Group Health Insurance Contracts* model, other sources for information include the Society of Actuaries' report of the LTC Valuation Task Force (April 1995), and an LTC Experience Committee Intercompany Study (1984–1991 Experience).The Health Insurance Association of America (HIAA) has also published a report on termination experience during calendar year 1994.The Society of Actuaries' *Health Section News* (April 1992) contains the results of a study by HIAA of ratios of active life reserves to gross premiums.This study has been updated and should be in an upcoming issue of the *Health Section News.*Further, minutes of the Valuation Actuary Symposiums, *Transactions*, and the *Record of the Society of Actuaries* contain articles on level premium reserving.The NAIC *Long-Term Care Insurance Model Act and Regulation* and the Society of Actuaries' Specialty Guide on LTC are additional sources.

Q. What is the standing of the Society of Actuaries' Report on the LTC Insurance Valuation Methods Task Force?

A. The report has been accepted by the Society of Actuaries' Board of Directors.The report has been submitted by the NAIC (Life and Health Actuarial Task Force) for review and *potential* use in modifications to the NAIC *Minimum Reserve Standards for Individual and Group Health*

Insurance Contracts model.There is no requirement to use the tables or recommendations contained in the report.

Q. What are the differences between the SOA Report and the NAIC *Minimum Reserve Standards for Individual and Group Health Insurance Contracts* model (ignoring state variations)?

A. The SOA report suggests inputs for several variables that need to be considered when calculating LTC active life reserves.In conjunction with the report, a diskette has been made available to facilitate the actuary's use of the report.In many situations, the suggested inputs—while appropriate for LTC insurance—may not be automatically acceptable under the valuation standards for states or under the NAIC *Minimum Reserve Standards for Individual and Group Health Insurance Contracts* model (hereafter *Minimum Reserve* model).

Specifically,

1. The mortality table suggested in the report is the 1983 GAM, while the *Minimum Reserve* model requires the use of the whole life valuation mortality table (generally 1980CSO) or other table *approved* by the commissioner.

2. The report recommends gender-specific reserves, while the *Minimum Reserve* model is silent. In HIAA's recent study, only 8 of 31 carriers used gender-specific reserves.

3. The use of termination rates in the report (and diskette) is based on 80% of lapse *plus* mortality, while the *Minimum Reserve* model allows 80% of the total termination rate or the mortality rate if higher.

4. When using selection factors, the report recommends limiting them to 9 years, while the *Minimum Reserve* model has no limitation.

5. When using lapse assumptions, the report recommends the use of antiselection factors, while the *Minimum Reserve* model is silent.

6. The report (and diskette) includes implied base morbidity tables subject to adjustments, while the *Minimum Reserve* model implies the use of pricing or experience morbidity with adjustments for conservatism consistent with a gross premium valuation test.

7. The report suggests that the appointed actuary may determine that contract reserves that allow for amortization of initial expense over more than one year may be appropriate, while the *Minimum Reserve* model defines the minimum standard as one-year full preliminary term.

Q. How are LTC insurance products combined with other products for cash flow testing?

A. Many actuaries are not including the LTC insurance business in cash flow models for other products but are doing separate cash flow tests over a period similar to that used for life or disability income products.Results of the separate tests are combined only for determination of yearly sufficiencies.

Q. How are LTC reserves affected by limitations on premium rate increases adopted by a few states?

A. Many actuaries have not found that the amount of business subject to premium increase limitations is a material portion of the total LTC business and consequently have not made any adjustment.

Q. How have LTC reserve assumptions been affected by nonforfeiture laws adopted by a few states?

A. The answer may vary depending upon whether the nonforfeiture benefit is payable in cash or is payable as LTC benefits subject to eligibility after lapse.For cash benefits, many actuaries are holding the greater of the cash value and the reserve at the same duration.For nonforfeiture benefits payable as LTC benefits, some actuaries are adjusting the underlying morbidity table, while others are only adjusting for the different level of benefits.

Q. What methods are being used to establish claim reserves?

A. There is not a great deal of commonality in the methods used by actuaries.All of the methods outlined in ASOP No. 5 were used in one form or another by the actuaries contacted.