



## ACTUARIAL STANDARDS BOARD

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● EXPOSURE DRAFT ●

**Proposed Revision of  
Actuarial Standard  
of Practice  
No. 18**

**Long-Term Care**

**Comment Deadline:  
September 1, 2021**

**Developed by the  
ASOP No. 18 Task Force of the  
Health Committee of the  
Actuarial Standards Board**

**Approved for Exposure by the  
Actuarial Standards Board  
March 2021**

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**TABLE OF CONTENTS**

Transmittal Memorandum	iv
<b>STANDARD OF PRACTICE</b>	
Section 1. Purpose, Scope, Cross References, and Effective Date	1
1.1 Purpose	1
1.2 Scope	1
1.3 Cross References	2
1.4 Effective Date	2
Section 2. Definitions	2
2.1 Assisted Living Facility	2
2.2 Home Care	2
2.3 Insurer	2
2.4 Long-Term Care (LTC)	2
2.5 Long-Term Care Benefit Plan (or LTC Benefit Plan)	2
2.6 Nonforfeiture Benefits	2
2.7 Nursing Home	3
Section 3. Analysis of Issues and Recommended Practices	3
3.1 Coverage and Plan Features	3
3.2 Assumption Setting	3
3.2.1 General Principles for all Assumptions	4
3.2.2 Morbidity Assumptions	4
3.2.3 Mortality Assumptions	5
3.2.4 Acceleration of Benefits under Life Insurance Contracts	5
3.2.5 Voluntary Termination (Lapse) Assumptions	5
3.2.6 Operating Expense Assumptions	6
3.2.7 Tax Assumptions	6
3.2.8 Investment Return Assumptions	6
3.2.9 Mix-of-Business Assumptions	6
3.2.10 Change-Over-Time Assumptions	6
3.2.11 Alternative LTC Arrangements	6
3.2.12 Sensitivity Testing	6
3.3 Premium Rate Recommendations (Including Fees or Other Revenue-Generating Devices)	7
3.4 Reserve Determination and Asset Adequacy Analysis	7
3.5 Experience Monitoring	7
3.6 Reliance on Data, Other Information, or a Model Supplied by Others	7
3.7 Documentation	8
Section 4. Communications and Disclosures	8
4.1 Required Disclosures in an Actuarial Report	8
4.2 Additional Disclosures in an Actuarial Report	8

**EXPOSURE DRAFT—March 2021**

4.3 Confidential Information	9
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**APPENDIX**

Appendix—Background and Current Practices	10
Background	10
Current Practices	12
Definition of Selected Terms	14

## **EXPOSURE DRAFT—March 2021**

March 2021

**TO:** Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Long-Term Care

**FROM:** Actuarial Standards Board (ASB)

**SUBJ:** Proposed Revision of Actuarial Standard of Practice (ASOP) No. 18

This document contains the exposure draft of a proposed revision of ASOP No. 18, *Long-Term Care*. Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each written comment letter or email received by the comment deadline will receive appropriate consideration by the drafting committee and the ASB.

The ASB appreciates comments and suggestions on all areas of this proposed standard. The ASB requests comments be provided using the Comments Template that can be found [here](#) and submitted electronically to **comments@actuary.org**. Include the phrase “ASOP No. 18 COMMENTS” in the subject line of your message. Also, please indicate in the template whether your comments are being submitted on your own behalf or on behalf of a company or organization.

The ASB posts all signed comments received on its website to encourage transparency and dialogue. Comments received after the deadline may not be considered. Anonymous comments will not be considered by the ASB nor posted on the website. Comments will be posted in the order that they are received. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

For more information on the exposure process, please see the ASB Procedures Manual.

**Deadline** for receipt of comments: **September 1, 2021**

### History of the Standard

ASOP No. 18 was adopted by the ASB in 1991 and further revised in January 1999. The revised version addressed several new developments in the field of long-term care insurance as well as content that was somewhat educational in nature or overlapped with other ASOPs. In 2019, the ASB recommended the ASOP be further revised due to recent regulatory developments and emerging government-run long-term care (LTC) insurance programs.

## EXPOSURE DRAFT—March 2021

### Notable Changes from the Existing ASOP

A summary of the notable changes from the existing ASOP are summarized below. Notable changes do not include additional changes made to improve readability, clarity, or consistency.

1. The scope was expanded to include actuarial services for all programs that provide benefits for LTC, including actuarial services related to hybrid products, public programs, and long-range financial projections of Medicaid programs.
2. General ASOPs that have been revised or adopted since the last revision of ASOP No. 18, and that affect the actuarial services provided to LTC benefits programs, have been accounted for.

### Request for Comments

The ASB appreciates comments and suggestions on all areas of this proposed standard submitted through the Comments Template. Rationale and recommended wording for any suggested changes would be helpful. In addition, the ASB would like to draw the readers' attention to the following questions:

1. Is the expansion of the ASOP's scope to include long-range financial projections under Medicaid appropriate?
2. Is the expansion of the ASOP's scope to include other public programs appropriate?

The ASB voted in March 2021 to approve this exposure draft.

**EXPOSURE DRAFT—March 2021**

ASOP No. 18 Task Force

Bruce A. Stahl, Chairperson

Rhonda K. Ahrens	Seong-Min Eom
Frederick J. Andersen	Matthew H. Morton
Jamala Arland	Janet L. Perrie
Linda Chow	Matthew J. Winegar
Sivakumar Desai	

Health Committee of the ASB

Rick Lassow, Chairperson

Matt P. Chamblee	David T. Stefanski
Jinn-Feng Lin	Jennifer L. Stevenson
Daniel S. Pribe	Alisa L. Swann
D. Todd Sherman	Timothy J. Wilder

Actuarial Standards Board

Darrell D. Knapp, Chairperson

Elizabeth K. Brill	Cande J. Olsen
Robert M. Damler	Kathleen A. Riley
Kevin M. Dyke	Judy K. Stromback
David E. Neve	Patrick B. Woods

*The Actuarial Standards Board (ASB) sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs). These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.*

**ACTUARIAL STANDARD OF PRACTICE NO. 18**

**LONG-TERM CARE**

**STANDARD OF PRACTICE**

Section 1. Purpose, Scope, Cross References, and Effective Date

- 1.1 Purpose—This actuarial standard of practice (ASOP or standard) provides guidance to actuaries when performing actuarial services with respect to **long-term care (LTC) benefit plans**, including LTC insurance and public programs.
- 1.2 Scope—This standard applies to actuaries when performing actuarial services with respect to **LTC benefit plans** sponsored by **insurers** or other entities. The standard applies to actuaries designing, pricing, or determining funding of an **LTC benefit plan**. The standard also applies to actuaries measuring or evaluating **LTC liabilities** within an **LTC benefit plan**. The term “**long-term care benefit plan**” includes short-term (for example, less than twelve consecutive months) and long-term benefit durations. The standard does not apply to actuaries providing actuarial services related to **LTC benefits** for Medicaid-eligible recipients, unless the actuarial services are for a long-range financial projection of **LTC benefit expenditures** and eligible recipients under the Medicaid program.

If the actuary is reviewing actuarial services performed with respect to **LTC benefit plans**, the actuary should use the guidance in section 3 to the extent practicable.

Some products combine **LTC benefits** with other insurance benefits. If the actuary determines that the guidance in this standard conflicts with the guidance in another ASOP regarding actuarial services for benefits other than **LTC benefits**, the guidance in the other ASOP will govern with respect to those other specific benefits. For example, the pricing of a product that offers both a death benefit and an **LTC benefit** written on an individual policy form would be within the scope of this ASOP. Nevertheless, to the extent that the guidance in this standard conflicts with guidance in other ASOPs regarding the pricing of the death benefit, the guidance in other ASOPs would govern the pricing of such death benefits.

If the guidance in ASOP No. 3, *Continuing Care Retirement Communities*, related to performing actuarial services with respect to continuing care retirement communities conflicts with this ASOP, the actuary should follow ASOP No. 3.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4. If a conflict exists between this standard and applicable law, the actuary should comply with applicable law.

## EXPOSURE DRAFT—March 2021

- 1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.
- 1.4 Effective Date—This standard is effective for actuarial services performed on or after four months after adoption by the Actuarial Standards Board.

### Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice and appear in bold throughout the ASOP.

- 2.1 Assisted Living Facility—A facility that provides residents some assistance with activities of daily living. Residents have apartments, rooms, or shared dwellings and often share community living and dining areas with other residents. Usually meals, utilities, housekeeping, laundry, ambulation assistance, and personal care supervision are provided. Staff members may supervise the self-administration of medication.
- 2.2 Home Care—Care received at the patient’s home, such as part-time skilled nursing care, custodial care, speech therapy, physical or occupational therapy, part-time services of home health aides, or help from homemakers or chore workers.
- 2.3 Insurer—An entity that accepts the risk of financial losses or, for a specified time period, guarantees stated benefits upon the occurrence of specific contingent events, typically in exchange for a monetary consideration. For purposes of this standard, “**insurer**” also refers to an entity that sponsors **LTC benefit plans** that may be funded by sources other than premiums paid by the potential beneficiary.
- 2.4 Long-Term Care (LTC)—A wide range of health and social services, which may include adult day care, custodial care, **home care**, hospice care, intermediate nursing care, respite care, and skilled nursing care, but generally not care in a hospital. **Long-term care** is sometimes referred to as long-term services and supports or LTSS.
- 2.5 Long-Term Care Benefit Plan (or LTC Benefit Plan)—A policy, contract, or arrangement providing **LTC** benefits, either on a stand-alone basis or as part of a plan that provides other benefits as well (except where the **LTC** benefits are an immaterial feature). The plan may describe requirements for benefit eligibility, covered services, benefit amount, benefit payment duration (including short-term and long-term), maximum benefit amount, and other coverage features.
- 2.6 Nonforfeiture Benefits—Benefits that are available if premiums are discontinued.



## EXPOSURE DRAFT—March 2021

- 2.7 Nursing Home—A residential facility which provides long-term nursing care to those who are unable to handle their own daily living needs. They are typically staffed by nurses with a physician on call, and care may range from custodial to skilled.

### Section 3. Analysis of Issues and Recommended Practices

- 3.1 Coverage and Plan Features—The actuary should take into account all pertinent provisions found in the applicable **LTC benefit plan**, including benefit eligibility, covered services, benefit amounts, benefit payment duration, and other coverage features that may significantly impact cost. While these provisions apply primarily to stand-alone individual, association-sponsored group, or employer-sponsored group **LTC benefit plans**, the actuary also should take into account material **LTC** provisions found in the following arrangements:

- a. the acceleration of benefits otherwise payable upon death under a life insurance product;
- b. insurance products that provide ancillary **LTC** benefits;
- c. **LTC** benefits provided by various administrative and risk-assuming programs, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), government managed plans, and self-insured plans; and
- d. **LTC** benefits provided for individuals living within retirement communities, with benefits varying considerably among communities.

- 3.2 Assumption Setting—When developing actuarial assumptions, the actuary should take into account available experience data and reasonably foreseeable future changes. The actuary may include a margin or provision for adverse deviation (PAD) when setting assumptions and in such cases should include a margin or PAD that is appropriate for the intended purpose. Many **LTC benefit plans** may remain in effect for many years, and some assumptions depend upon the behavior of covered individuals, providers of care, and society as a whole. As such, the actuary should recognize that assumptions derived from actual experience today may not be valid in the future.

When setting, evaluating, or updating assumptions for which the actuary is taking responsibility, the actuary should consider using the following data or information:

- a. actual experience adjusted to current conditions where applicable, to the extent it is available, relevant, and sufficiently reliable;
- b. other relevant and sufficiently reliable experience, such as industry experience that is properly modified to reflect the circumstances, if actual experience is not available or relevant, or is not sufficiently reliable;

**EXPOSURE DRAFT—March 2021**

- c. future expectations or estimates, including those inherent in market data, when available and appropriate; and
  - d. other relevant sources of data or information, including noninsured data as necessary and appropriate.
- 3.2.1 General Principles for all Assumptions—The actuary should develop assumptions in a manner consistent with how the assumptions will be applied. For example, a lapse assumption will be developed differently if it is to be applied to the total projected lives or to the projected active lives. The actuary should be familiar with applicable regulatory considerations as they relate to and govern assumption selection. The actuary should refer to ASOP No. 23, *Data Quality*, and ASOP No. 25, *Credibility Procedures*.
- 3.2.2 Morbidity Assumptions—The actuary should develop morbidity assumptions consistent with all significant plan features, including the types of **LTC** benefits being provided, the types of optional benefits being provided, the plan’s benefit eligibility criteria, the claim adjudication process, the benefit amounts and benefit limits, and the exclusions.

In order to estimate morbidity, the actuary, where appropriate, should develop claim incidence rates, claim termination rates, costs of eligible benefits, and proportion of available benefits expected to be used. The actuary may need to exercise special care when projecting total claim costs rather than the components separately, as the total claim costs may be affected by factors such as discount rates, and as specific sensitivity tests on morbidity components may not be as reliable as when modeling the components separately. When developing morbidity assumptions, whether in total or in separate components, the actuary should take into account the following, as applicable:

- a. the fact that the claim cost elements may vary by the type of care provider such as **nursing home, assisted living facility, and home care**;
- b. participant behavior driven by available benefit choices and benefit limitations;
- c. the effect of induced demand for **LTC** services due to the presence of **LTC** benefits;
- d. the availability of benefits from other public and private programs such as Medicare, Medicaid, and Medicare supplement policies;
- e. the availability of **LTC** services;

## EXPOSURE DRAFT—March 2021

- f. the effect of selection at the time of policyholder decision points (for example, decisions at the time of rate increase);
- g. premium rate classification of applicants;
- h. the underwriting processes, which may include the intensity of application questions, the marketing methods, the number and types of underwriting requirements, the number and definitions of underwriting classes, the effect of regulations on the underwriting process, and the experience of the underwriting personnel;
- i. the claims process, which may include the effect of regulations on the claim process, the experience of the claim personnel, processes for confirming eligibility (initial and ongoing), fraud detection, and the impact of reimbursement versus indemnity coverage;
- j. the impact of offering optional benefits at any point in time with the potential for adverse selection; and
- k. interaction and correlation of assumptions, such as the effect of mortality on claim termination rates.

3.2.3 Mortality Assumptions—When developing mortality assumptions, the actuary should take into account the effects of underwriting, classification of applicants, and selection on expected mortality experience and use a mortality table that appropriately reflects the expected mortality of the participants in the plan. The actuary should take into account that mortality differs between healthy and disabled lives. Also, the actuary should take into account whether deaths are fully reported and reasonably represented as a proportion of total decrements.

3.2.4 Acceleration of Benefits under Life Insurance Contracts—For **LTC** insurance benefits provided by the acceleration of benefits otherwise payable upon death under a life insurance product, the actuary should ensure that assumptions concerning the amount and timing of payments are determined consistently for the contingencies of both mortality and **LTC** morbidity.

3.2.5 Voluntary Termination (Lapse) Assumptions—When developing voluntary termination (lapse) assumptions, the actuary should take into account product features, premium mode, premium payment method, **nonforfeiture benefit**, and rating agency rating. The actuary also should take into account reasonably available information regarding the method of marketing, the motivations for purchasing and continuing coverage, product and premium competitiveness, and the quality of service of the entity providing the benefits. The actuary should take into account any effect of rate changes or offering reduced benefits on voluntary lapses. The actuary should take into account whether lapses are reasonably represented as a proportion of total decrements.

## EXPOSURE DRAFT—March 2021

- 3.2.6 Operating Expense Assumptions—When developing operating expense assumptions, the actuary should consider reflecting the cost of product development, marketing, producer compensation, regulatory compliance, underwriting, **LTC benefit plan** administration, and entity business plan, as applicable.
- 3.2.7 Tax Assumptions—When developing tax assumptions, the actuary should reflect the tax reserve basis of the **LTC benefit plan** and the premium, income, or any other applicable tax rates of the entity.
- 3.2.8 Investment Return Assumptions—When developing investment return assumptions, the actuary should take into account investment assumptions and economic market assumptions that reflect real world or market consistent theory, where appropriate, and that include assumptions for reinvestment, asset default, asset underperformance, and investment expenses. Where appropriate, the actuary also should take into account the assets of the **insurer** and the **insurer's** investment strategy and refer to ASOP No. 7, *Analysis of Life, Health, or Property/Casualty Insurer Cash Flows*.
- 3.2.9 Mix-of-Business Assumptions—The actuary should reflect the characteristics of the anticipated distribution of business such as age, gender, marital status, underwriting classes, distribution system, and **LTC benefit plan** options (such as benefit period, elimination period, inflation option, daily benefit, and other coverage options).
- 3.2.10 Change-Over-Time Assumptions—When developing the assumptions, the actuary also should consider identifying and reflecting assumptions for which experience may be likely to change over the term of the **LTC benefit plan**. Though not necessarily limited to these factors, changes in the experience may be attributable to changes in health of the participants, changes in participant behavior, changes in care management, changes in sites of care, changes in environment, and changes in lifestyle.
- 3.2.11 Alternative LTC Arrangements—For alternative **LTC** arrangements as described in section 3.1(a)-(d), the actuary should recognize that the methods and assumptions appropriate for analyzing or evaluating such products might be different from those used for stand-alone insured **LTC benefit plans**.
- 3.2.12 Sensitivity Testing—Prior to the finalization of assumptions, the actuary should perform sensitivity testing of reasonable variations in assumptions, and reasonable correlations of assumptions. The actuary should perform a more expansive range of sensitivity testing when credibility of the assumptions is lower. Also, the actuary should consider testing the projections under stressed assumptions. The actuary should consider including appropriate margin or PAD to recognize the results of the sensitivity testing.

## EXPOSURE DRAFT—March 2021

- 3.3 Premium Rate Recommendations (Including Fees or Other Revenue-Generating Devices)—When recommending an initial premium rate schedule, the actuary should use methods and assumptions conforming to applicable regulatory requirements such that the premium rate schedule has a reasonable likelihood of being sufficient without future rate adjustments to the recommended schedule.

When developing recommendations regarding revisions to existing premium rate schedules, the actuary should review any material variations in experience and consider reflecting changes in expectations that would make changes in premium rates for in-force business advisable, subject to regulatory review.

- 3.4 Reserve Determination and Asset Adequacy Analysis—In calculating reserves, the actuary should use appropriate methods and assumptions taking into account the benefit features of the particular **LTC benefit plan** in question, including any optional benefits.

Reserves typically required by and appropriate for **LTC benefit plans** are premium reserves, contract reserves, and claim reserves for both reported claims and incurred but not reported claims.

In setting statutory reserves, the actuary should be familiar with applicable sections of the following: the *Standard Valuation Law*, the *Valuation Manual*, Actuarial Guideline LI, and asset adequacy analysis standards.

Because **LTC benefit plans** are often long-term in nature, cash flow testing is a potentially important part of the management of an **LTC benefit plan**. The degree of rigor in analyzing an **LTC benefit plan** has increasing importance if the **LTC benefit plan** is a more significant portion of the sponsoring entity's business. Therefore, when performing asset adequacy analyses, the actuary should refer to ASOP No. 7 and ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries of Life or Health Insurers*.

- 3.5 Experience Monitoring—When practicable, and when emerging experience may be material to the sponsoring entity, the actuary should inform the sponsoring entity that experience data should be collected in a manner that permits an actuary to compare prior assumptions with emerging experience and assess the implications of any significant differences.

To the extent that industry or general population data were used in determining assumptions for estimating benefit costs or establishing reserves, an actuary reviewing **LTC benefit plan** experience should monitor for significant changes that may have emerged in such data. To the extent the actuary plans to rely upon the data when setting assumptions, as described in section 3.2, the actuary should take into account emerging experience.

- 3.6 Reliance on Data, Other Information, or a Model Supplied by Others—When relying on data, other information, or a model supplied by others, the actuary should refer to ASOP No. 23, ASOP No. 41, *Actuarial Communications*, and ASOP No. 56, *Modeling*, for guidance.

## EXPOSURE DRAFT—March 2021

- 3.7 Documentation—The actuary should consider preparing and retaining documentation to support compliance with the requirements of section 3 and the disclosure requirements of section 4. If preparing documentation, the actuary should prepare documentation in a form such that another actuary qualified in the same practice area could assess the reasonableness of the actuary’s work or could assume the assignment if necessary. The degree of such documentation should be based on the professional judgment of the actuary and may vary with the complexity and purpose of the actuarial services. In addition, the actuary should refer to ASOP No. 41 for guidance related to the retention of file material other than that which is to be disclosed under section 4.

### Section 4. Communications and Disclosures

- 4.1 Required Disclosures in an Actuarial Report—When issuing an actuarial report to which this standard applies, the actuary should refer to ASOP Nos. 7, 22, 23, 25, 41, and 56. In addition, the actuary should disclose the following in such actuarial reports, if applicable:
- a. characteristics of the product including optional benefits and guarantees (see section 3.1);
  - b. key assumptions and the manner in which the actuary established those assumptions to reflect expected future experience (see section 3.2);
  - c. the range of sensitivity tests evaluated, and any subsequent margin as a result of sensitivity testing (see section 3.2.12);
  - d. the premium rate recommendation and support thereof including a description of any provisions for adverse deviations (see section 3.3);
  - e. a description of the method and assumptions used in calculating reserves, as well as a description of any method used to test reserve adequacy (see section 3.4); and
  - f. the need to collect and monitor experience data (see section 3.5).
- 4.2 Additional Disclosures in an Actuarial Report—The actuary also should include disclosures in accordance with ASOP No. 41 in an actuarial report for the following circumstances:
- a. if any material assumption or method was prescribed by applicable law;
  - b. if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

**EXPOSURE DRAFT—March 2021**

- c. if in the actuary’s professional judgment, the actuary has deviated materially from the guidance of this ASOP.
- 4.3 Confidential Information—Nothing in this ASOP is intended to require the actuary to disclose confidential information.

## **Appendix**

### **Background and Current Practices**

*Note:* This appendix is provided for informational purposes and is not part of the standard of practice.

#### Background

Reasons for This Actuarial Standard of Practice—The utilization of long-term care (LTC) services has been increasing rapidly, and that growth is expected to continue in the decades ahead. Paying for these services is expected to be a challenge for society for the foreseeable future. Many of the funding methods in use involve long-term contractual commitments and estimation of expected costs many years in the future—work that requires actuarial analysis and training.

The LTC insurance industry is relatively young, and estimating future results is a difficult process for which standards beyond those already established for other products are appropriate. Some of the reasons that actuarial activity in LTC insurance is such a challenge include the following:

1. A limited amount of homogenous data is available, especially on insured lives at older ages and later policy durations. While the Society of Actuaries (SOA) produced a somewhat credible stand-alone LTC insurance experience study in 2015, it was based on experience through only 2011.
2. Long-term care insurance coverage has been redirected toward combination products in recent years. The SOA experience study may be different than experience expected from the combination market.
3. New financing approaches are regularly being introduced, such as the funding arrangements for LTC services being provided through the Washington State public program, through some states considering similar or “catastrophic” LTC programs, and by the continuing care retirement community model being applied in the home care setting. Even traditional stand-alone policies have scaled back their benefits with smaller lifetime maximums, daily benefit maximums, and automatic benefit increases to reduce the company’s risk exposure. These approaches might have quite different experience than traditional stand-alone LTC insurance benefits.
4. Underwriting, marketing, distribution, and claim payment practices can be quite dissimilar under different LTC insurance financing plans, producing diverse results. This compounds the difficulty of developing homogeneous experience data from which to estimate future activity.



## EXPOSURE DRAFT—March 2021

5. There is a very real possibility that consumers' behavior will change in the future in ways that will affect LTC insurance costs. The following are examples of such possible changes.
  - a. The use of LTC services may tend to change when such services are provided in an insured environment with increasing availability of public LTC coverage.
  - b. Medical advances might reduce LTC insurance costs by preventing or curing maladies requiring LTC services (for example, a cure for Alzheimer's disease). However, medical advances could also increase the life expectancy of impaired persons and enable some persons who would have died to survive in an impaired condition.
  - c. Current attitudes associated with nursing home care, assisted living facility care, and home health care might change over time. For example, the number of deaths in LTC facilities that were attributed to COVID-19 may orient more people toward care in the home, altering the average utilization.
  - d. Changes in the family structure in society may reduce the number of family members available to care for the impaired, increasing the need for paid LTC services.
  - e. Changes may occur in government payment for long-term care, which could impact payment for LTC services under private insurance. Such governmental changes could also affect LTC utilization patterns or the rules relating to taxes on LTC insurance premiums and benefits.
  - f. New LTC services may be developed and the availability of existing services may increase substantially. As new services become available, they can cause changes in consumers' use of previously existing care services, as well as changes in total service utilization.
  - g. Impact of rate increases continue to change the in-force mix and policyholder behavior.

The belief is held by some, including some regulators, that standards or controls beyond those for other coverages are needed to protect consumers in the LTC insurance field. This is partly because most LTC users are senior citizens, who are perceived as having few financial options.

Further, many LTC insurance financing mechanisms involve financial commitments of very long duration. Many LTC insurance policies are guaranteed renewable for the life of the insured. It is also a product characterized by an extremely high degree of advance funding, with most of the claim dollars paid out long after the policy is put into effect.

For all of the reasons stated above, an actuarial standard of practice for LTC insurance is appropriate.

Current Practices

An Evolving Type of Coverage—Long-term care insurance is still a developing practice, and many diverse methods exist to measure the cost of a benefit design, devise a funding system, and evaluate liabilities. A basic part of an actuary's work in this field involves taking into consideration the pertinent provisions in the LTC benefit plan, such as the following:

1. **Benefit Eligibility (Definition of Insured Event)**—In order to qualify for benefits, an insured person may have to satisfy an elimination period and must provide satisfactory evidence of benefit eligibility. Long-term care benefit plans may define benefit eligibility in several ways. The most common criteria for benefit eligibility are functional or cognitive impairment (as defined for tax qualified plans in an LTC insurance plan) and sometimes medical necessity. Benefit eligibility also frequently depends on the use of covered services or services on a day for which the benefit is payable.
2. **Covered Services**—An LTC benefit plan may provide coverage for only a limited set of LTC services or a very broad set. A particular plan might cover only nursing home care, or only home care, or could cover a combination of both. Any number of additional types of care, such as assisted living facility care, adult day care, and respite care, may also be covered. When coverage is included for different types of services, the coverage can either be integrated or non-integrated. One example of integrated benefits is a single lifetime benefit maximum that may be utilized for any combination of nursing home care or home care.
3. **Benefit Amount**—The amount payable for a given service, or for a given day of care, may either be a fixed contractual amount, such as \$100 per day of eligibility, or may be related to the actual cost of services provided that day. In the latter case, the reimbursement may be either the full cost of services or a percentage of the cost, and it may be capped at a particular daily maximum. If there is a daily maximum, it may vary depending on the type of service. The fixed daily benefit amount or maximum daily benefit may be increased under an inflation protection provision.
4. **Benefit Payment Duration**—There are different ways in which benefit length and frequency may be structured for payment. Some examples are as follows:
  - a. **Benefit Period of Consecutive Days**—The maximum benefit period is defined as a stated number of days or years, and benefits are payable during a continuous period of time of that length, starting from the first day of eligibility. Under this approach, days without covered services may not result in a benefit payment but do not extend the benefit period.
  - b. **Benefit Days**—The maximum benefit period is defined as a stated number of days or years, and benefits are payable for days on which the insured person meets the eligibility requirements, until the maximum number of days or benefits have been paid. Under this approach, any day for which the insured is ineligible for benefits

## **EXPOSURE DRAFT—March 2021**

does not count as part of the benefit period, and the benefit period is thereby extended.

- c. **Maximum Benefit**—The maximum benefit is defined in terms of a total dollar amount, and benefits are payable until that amount has been paid. The total dollar amount may be increased under an inflation protection provision.
5. **Other Coverage Features That May Significantly Impact Cost**—Some examples of additional features that may be found in LTC insurance plans are the following:
- a. an alternative plan of care provision, under which services not expressly covered under the insurance contract may become covered, usually when viewed as an appropriate substitute for a covered service;
  - b. a shortened benefit period provision, i.e., a type of nonforfeiture benefit under which the insured has paid-up coverage with a benefit period whose length is determined by the nonforfeiture benefit value that has accrued;
  - c. a restoration of benefits provision, under which an insured who has used a portion of the maximum benefit can have the full benefit restored after a stated minimum time period during which the insured person either did not use, or was ineligible for, benefits; and
  - d. a shared benefit maximum provision for spouses.

Apart from the actual provisions in the LTC insurance plan, numerous forms of individual LTC insurance are being offered, ranging from stand-alone nursing home or home care coverage to combination or integrated products that cover a broad range of services in many locations. Long-term care insurance plans are available on both tax-qualified and nontax-qualified bases. There are also LTC insurance riders to life, disability, and annuity products that can enhance benefits, accelerate benefits, waive surrender charges, guarantee purchase rights, or offer conversion options.

The group market consists of both insured and self-insured plans. In either instance, the employer or other sponsor may fund none, a portion, or all of the required contribution. Group coverages also can be extended to eligible groups such as association members, affinity groups, and congregate community residents.

Furthermore, some states are expressing interest in public LTC programs. Washington State implemented a payroll tax funded program for up to \$36,500 of benefits for eligible residents who have the inability to perform at least three Activities of Daily Living. From time to time states consider covering care that exceeds a specified number of months, for example after thirty-six months of care is required.

The Medicaid program is a healthcare program jointly funded by the federal and state governments. The Medicaid programs are managed by the state government with oversight by

## EXPOSURE DRAFT—March 2021

the Center for Medicare and Medicaid Services. The Medicaid program provides healthcare services to low-income individuals and families, individuals with disabilities, and the elderly. The Medicaid program provides a wide array of coverage, including hospital, physician, pharmacy, and long-term services and supports. Eligibility standards for the Medicaid program depend on a number of requirements including financial requirements associated with assets and income. Long-term services and supports for the Medicaid program include nursing home, custodial care, home health care, adult day services, respite care services, and other home and community-based services.

### Definitions of Selected Terms

Activities of Daily Living (ADLs)—Basic functions used as measurement standards to determine levels of personal functioning capacity. Typical ADLs include bathing, continence, dressing, eating, toileting, and transferring (between bed and chair or wheelchair).

Adult Day Care—A program of social and health-related services designed to meet the needs of functionally or cognitively impaired adults, provided in a non-residential group setting other than the adult client's home.

Cognitive Impairment—A deficiency in a person's short- or long-term memory; orientation with respect to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

Continuing Care Retirement Community (CCRC)—A residential facility for retired people that provides stated housekeeping, social, and health care services in return for some combination of an advance fee, periodic fees, and additional fees.

Custodial Care—Care to help a person perform ADLs and other routine activities; also known as *personal care*. It is usually provided by people without professional medical skills. It is less intensive or complicated than skilled or intermediate nursing care and can be provided in many settings, including nursing homes, assisted living facilities, adult day care centers, or at home.

Functional Impairment—The inability to perform a specified number of ADLs.

Guaranteed Renewable Contract—A contract that provides the insured has the right to continue the insurance in force for a specified period by the timely payment of premiums and that the insurer may not unilaterally change the contract during that specified period, except that the insurer may revise premium rates on a class basis.

Hospice Care—A program that provides health care to a terminally ill person and counseling for that person and his or her family. Hospice care can be offered in a hospice setting established for this single purpose, a nursing home, or at home, where nurses and social workers can visit the person regularly.

## **EXPOSURE DRAFT—March 2021**

Instrumental Activities of Daily Living (IADLs)—Functions, more complex than ADLs, that are used as measurement standards of functioning capacity; examples include preparing meals, managing medications, housekeeping, telephoning, shopping, and managing finances.

Intermediate Nursing Care—Care needed for persons with stable conditions that require daily, but not 24-hour, nursing supervision. Intermediate nursing care is less specialized than skilled nursing care and often involves more custodial care.

Respite Care—Temporary care for frail or impaired persons that allows volunteers to have a rest from care giving.

Skilled Nursing Care—Care provided by skilled medical personnel, such as registered nurses or professional therapists, but generally not care in a hospital.