Appendix Ja:

A Profile of Declined Long-Term Care Insurance Applicants

LifePlans

A Profile of Declined Long-Term Care Insurance Applicants:

A View of Selected Socio-Demographic Characteristics

Prepared for

Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Office of Disability Aging and Long-Term Care Policy

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Background

The Patient Protection and Affordable Care Act was signed by the President on March 23, 2010. This act establishes a national voluntary insurance program, the CLASS Independence Benefit Plan, to provide community living assistance services and supports to working individuals who have functional limitations and require ongoing assistance in the community. Individuals would pay a premium to participate in the program, and these premiums must be set to assure actuarial solvency for a 75 year period. Because the program is designed to serve working people regardless of functional status at enrollment, the pool of participants is likely to be comprised of a high proportion of employed individuals with disabilities for whom the insurance would be a particularly attractive benefit. Another group who would find the program attractive would be those who have sought to purchase private long-term care (LTC) insurance but been precluded from doing so because of their health status. Current estimates are that slightly less than 20% of all applicants for private LTC insurance are not able to buy policies due to their health status.

A key assumption underlying the development of actuarially fair premiums is that the risk profile of people enrolling in the program matches the profile that has been priced for; put another way, in developing premiums, the Secretary will need to take into account the fact that the population enrolling in CLASS will look very different from a cross-section of the population, or from individuals who enroll in other voluntary insurance programs, like private LTC insurance. This is because in the insurance market, companies are able to underwrite "bad risks" out of the risk pool at the time of application whereas the government will not have the ability to do so. Therefore, obtaining a profile of likely early enrollees and providing descriptive information to inform projections is particularly important for policymakers.

Purpose

The purpose of this project is to provide general background on LTC underwriting practice in the private insurance sector and to obtain a profile of individuals applying for private LTC insurance policies who have not been able to purchase policies due to their health status. More specifically we intend to do the following:

1. Describe in general terms underwriting practices in the LTC insurance industry.

2. Estimate underwriting rejection rates by specific age classes across the major LTC insurance carriers;

3. Identify the primary reasons why individuals are not accepted into the risk pool and develop a distribution based on these reasons. More specifically, we will focus on primary diagnoses, cognitive status, and functional status;

4. Understand the relationship between age, gender, marital status and the reasons for decline in order to identify how underwriting declination distributions look for individuals in these various sub-groups.

5. Compare the profile of individuals not able to purchase LTC insurance due to health reasons to new purchasers in terms of age, gender and marital status.

Importance of Study

Currently, there is no aggregate industry-wide knowledge about the population of individuals who have applied for LTC insurance but not been able to purchase policies due to health status. Thus, the study makes an important contribution to the knowledge base. Second, obtaining a profile of these individuals would provide important insight into likely CLASS participants. These are individuals who have actively sought to protect themselves against catastrophic LTC costs through an insurance mechanism but have not been able to avail themselves of private alternatives. Given that they understand the risk, they are likely to be among the first to enroll in the CLASS program. Third and closely related, the information provided herein should assist the Department in modeling what early program participants may look like so that there is a more informed basis for setting premiums to assure program solvency. Finally, obtaining a profile of these individuals may also assist in the development of customized benefit eligibility tools for specialized populations that are not typically served by the private long-term care insurance market.

Data

To accomplish these goals, we contacted major private LTC insurance companies currently selling in the market to solicit their participation in the study. We asked them to provide us with data on the total number of individuals that had applied for insurance between January 1, 2009 and June 30th, 2010 and had not been accepted into the risk pool due to reasons related to medical underwriting. For each individual we requested the following:

- Date of application
- Company to which individual is applying for LTC insurance
- Age at application
- Gender
- Marital status at application
- Employment status: A few companies were able to provide this data
- Functional status: Results of any functional screens applied
    - ADL status
    - IADL status
- Cognitive status: Results of any cognitive screens applied
- Medical Status: Primary and secondary diagnoses identified

The following companies participated in the study and agreed to provide information on as many of the data elements that they capture in their underwriting and policyholder administration systems:

- Bankers Life and Casualty
- Blue Cross and Blue Shield of Alabama
- Genworth Financial
- John Hancock
- Knights of Columbus
- MedAmerica
- MetLife
- Sterling Life Insurance

These companies accounted for roughly 70% of all new sales over the study period. In total, these companies contributed a sample of 55,070 individuals who applied for LTC insurance and did not pass the medical underwriting screens used by the companies.

This data was also supplemented with contextual information derived from a survey of 21 private LTC insurers focused on their underwriting practices. The study, entitled "Results of the Long-Term Care Underwriting Survey for the Individual Market in 2009" summarizes in detail the way in which companies conduct the business of underwriting.

Table 1 arrays the data elements according to the number of valid cases in the data file. Companies vary in the extent to which they capture all of the data that they actually use in the underwriting decision making process. What is common across all companies however is that information on medical diagnoses is captured. For that reason, while we have some level of detail on all 55,070 individuals, not all information is uniform. Some of the analyses will exclude large numbers of individuals. Even so, given the size of the sample, the smallest cells still contain over 18,000 observations.

Table 1: Sample Size by Data Element

Data Element	Number of Cases with Information	Percent of All Cases
Age	54,638	99%
Gender	46,172	84%
Marital Status	34,455	63%
Employment Status	18,494	33%
Functional Status		
ADL Status	23,006	42%
IADL status	21,106	38%
Cognitive Status	34,360	62%
Medical Status (Primary Diagnosis)	53,782	98%
Total Cases	55,070	100%

Because companies do not use conventional standards for summarizing diagnostic information, clinical underwriting staff at LifePlans reviewed all of the cases to assure that appropriate and broad diagnostic categories could be used to characterize the entire sample. In the analyses that follow, thirteen broad diagnostic categories are used, thus ensuring consistency across the entire sample.

Findings

A. Background on Long-Term Care Underwriting

There are a variety of ways that companies approach the underwriting process. The specific strategy can reflect attitudes toward risk selection, competitive positioning, sales and marketing, and pricing philosophy. Regardless of the specific approach used by companies, the overall purpose of underwriting is to assure that individuals purchasing insurance are representative of the anticipated risk profile that has been assumed in the underlying pricing of the product. More specifically, the underwriting process is all about risk selection and enabling companies to guard against adverse selection; that is, underwriting is used to protect against the likelihood that individuals presenting with a "riskier profile" than anticipated, will not end up dominating the risk pool. The potential for adverse selection is always a factor to be dealt with since those who would likely place the highest value on having insurance protection are also the ones who believe they are most likely to receive benefits. Clearly, some companies are more successful at underwriting than others and in fact, poor underwriting practice and experience has

resulted in a number of major LTC insurance carriers having to exit the market or request significant rate increases.

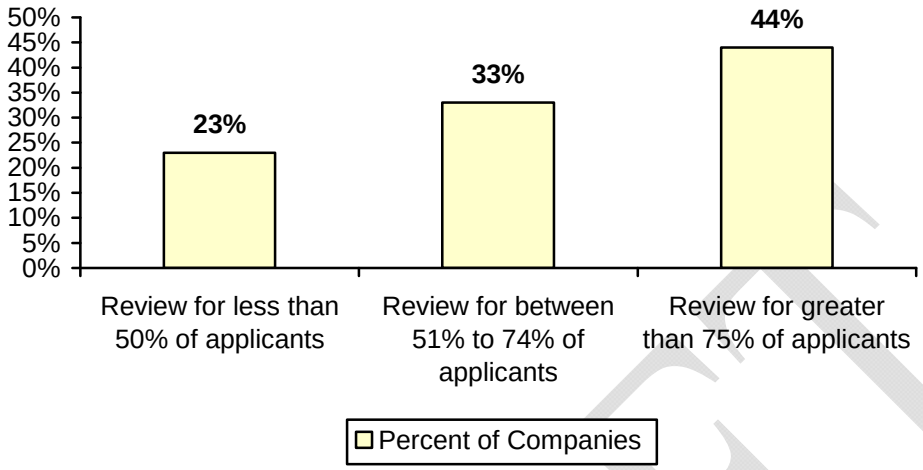
In general, underwriting practice can be characterized in terms of two broad dimensions: (1) medical criteria and (2) tools and requirements gathering. Regarding medical criteria, there are three domains on which companies focus their attention and these are the medical, functional, and cognitive status of individuals. In essence, the company is trying to identify those factors that put the individual at immediate or near term need for the services that are being insured for, namely, human assistance required to compensate for an individual's inability to perform Activities of Daily Living (ADLs) due to functional deficits or to cognitive issues. Diagnoses are actually markers for current or future manifestations of functional need. Thus, having a particular diagnosis, like acute heart disease, would not automatically disqualify someone from buying a policy. Rather, what is important is whether that diagnosis is likely to lead to a functional deficit necessitating ongoing human assistance. As such, the factors that are typically taken into account in evaluating the status of applicants for LTC insurance include:

- Age
- Gender
- Medical History
- Build
- Cognition
- Home Environment
- Social Support
- Activities of Daily living (ADLs)
- Physical Conditions
- Instrumental Activities of Daily Living (IADLs

The second dimension, Underwriting Requirements, relates to the specific type of information that a company needs to obtain in order to make the determination of insurability. There are multiple sources of such information. The most common tools include information provided from the application, telephone interviews, medical records or attending physician statements, medical exams, in-person assessments and pharmacy databases. When and how companies choose to deploy these tools varies greatly. By way of example, the graph below, derived from an analysis of a national survey of LTC insurance carriers, shows the frequency of use of Attending Physician Statements or Medical Records.[1] As shown, there is a great deal of variation across the roughly 20 companies participating in the study. Not shown in the graph is that roughly half of all companies view medical history for up to three years whereas the other half, focus on a longer window of at least four or more years. Both underwriting criteria and requirements vary across companies.

[1] Results of the Long-Term Care Underwriting Survey for the Individual Market in 2009. LifePlans, Inc. Waltham, MA November, 2010.

Figure 1: Use of APS or Medical Records Across Companies (2009)



In terms of the impact of underwriting on pricing, most actuaries assume that the impact of being able to select out those who are at immediate or short-term future risk will reduce anticipated claims costs during the first five to seven years after policy issue. After that time, the independent impact of underwriting on the risk profile of policyholders is assumed to diminish. Put another way, an age 65 applicant who undergoes underwriting is assumed to have superior claims experience during the first five to seven years after policy issue compared to a similarly aged individual who does not go through underwriting. However, by age 70 to 72, the anticipated claims experience of both individuals -- assuming everything else is constant – will converge and be roughly equivalent.

The underwriting process actually begins with the development of the insurance application. Most applications typically include a number of "knock-out" questions that if answered in the affirmative, lead to an automatic declination. Such questions are focused on issues that indicate a more immediate need for term-care services. Some of the more common questions include:

1. Do you require human assistance or supervision to perform any of your activities of daily living?

2. Are you currently receiving home health care or have you recently been in a nursing home?

3. Have you ever been diagnosed with, treated for, or consulted with a medical professional for the following:

- Acquired immune deficiency syndrome (AIDS) or HIV positive, or AIDS related complications (ARC)
- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Cystic fibrosis
- Cirrhosis of the liver
- Diabetes requiring insulin (other than during pregnancy)
- Huntington's chorea
- Memory loss, senility, dementia, confusion or organic brain syndrome
- Metastatic Cancer (Cancer that has spread from the original organ)
- Multiple sclerosis or Demyelinating disease
- Muscular dystrophy
- Neurogenic bladder
- Parkinson's disease
- Polycystic Kidney Disease
- Post polio syndrome
- Schizophrenia
- Systemic lupus Erythematosus
- Mini-stroke, transient ischemic attack (TIA), stroke, Cerebrovascular Accident (CVA)

4. Do you currently use or need any of the following: Wheelchair, Walker, Chair/Stair lift, Oxygen, Respirator, Dialysis, Multi-pronged Cane, Motorized Cart or Hospital Bed?

5. Do you currently receive disability benefits, Social Security disability benefits or Medicaid?

If an individuals answers in the affirmative to these questions, it is likely that they will not be able to purchase a policy.

Most policies are sold by agents and many companies provide an "Agent Guide," which is a tool the agent uses to pre-screen potential applicants even before they complete an application. Given that the sale of LTC insurance is challenging, agents do not want to go through the trouble of taking an application and then having it rejected during the underwriting process. Therefore, a certain amount of "field underwriting" occurs. The agent guide is a tool that allows the agent to obtain some very basic information and in some sense "pre-qualify" a potential applicant. Agent guides can consist of a few pages of diagnoses that represent automatic-declines or a large booklet containing a great deal of medical underwriting information. The implication is that individuals who make application and go through the underwriting process are already a "select" group; they are

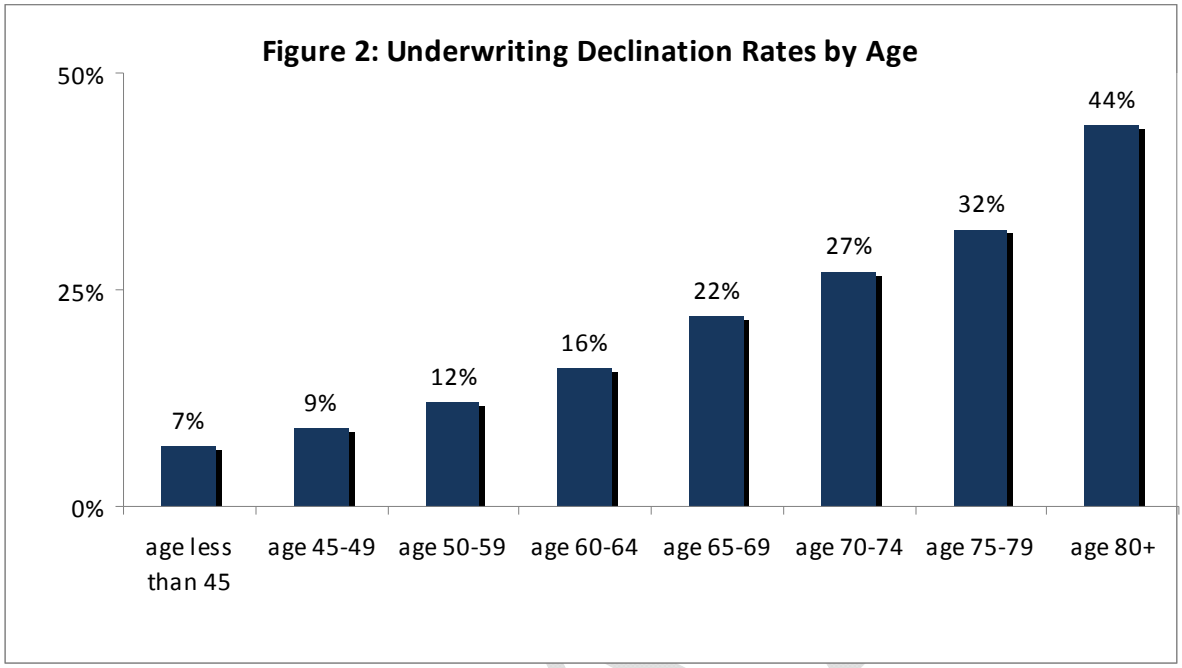
the people that the agents have pre-screened into the applicant pool.[2] Thus, data in subsequent analyses is not representative of the entire pool of individuals likely to apply for the CLASS program, but rather, those that are more likely to represent near term future need rather than immediate need for LTC services. This latter group will have already been screened out of the pool of applicants through agent activity.

Typically underwriting standards and protocols are considered to be a company asset and are treated confidentially. A company that is particularly strong at underwriting and able to balance sales and marketing needs with risk selection requirements is clearly at a competitive advantage in the marketplace. Thus, it is not surprising that there remains variation in the marketplace regarding precise practice. Moreover, unlike life insurance, where there is much greater experience and knowledge about factors related to mortality risks, in LTC, such knowledge is still evolving. Put simply, most LTC underwriters are hard-pressed to be able to consult a morbidity table that allows them with certainty to predict unfolding LTC needs. The need for LTC in general, and the demand for specific service modalities in particular, is characterized by the intersection between health and functional status as well as lifestyle preferences and views of family responsibility. This makes underwriting for LTC a particular challenge.

B. Underwriting Declination Rates by Age

In 2009, underwriting rejection rates across the industry were at 19.4%. As shown in Figure 2 below, declination rates are highly sensitive to age. This data is based on a recently completed survey of 21 LTC insurance companies representing the vast majority of sales in 2009. For applicants under age 45, declination rates are below 10% whereas for those over age 80, rates increase to slightly more than two in five or 44%. This is not surprising given that functional and cognitive decline – and associated need for LTC services -- is related to age.

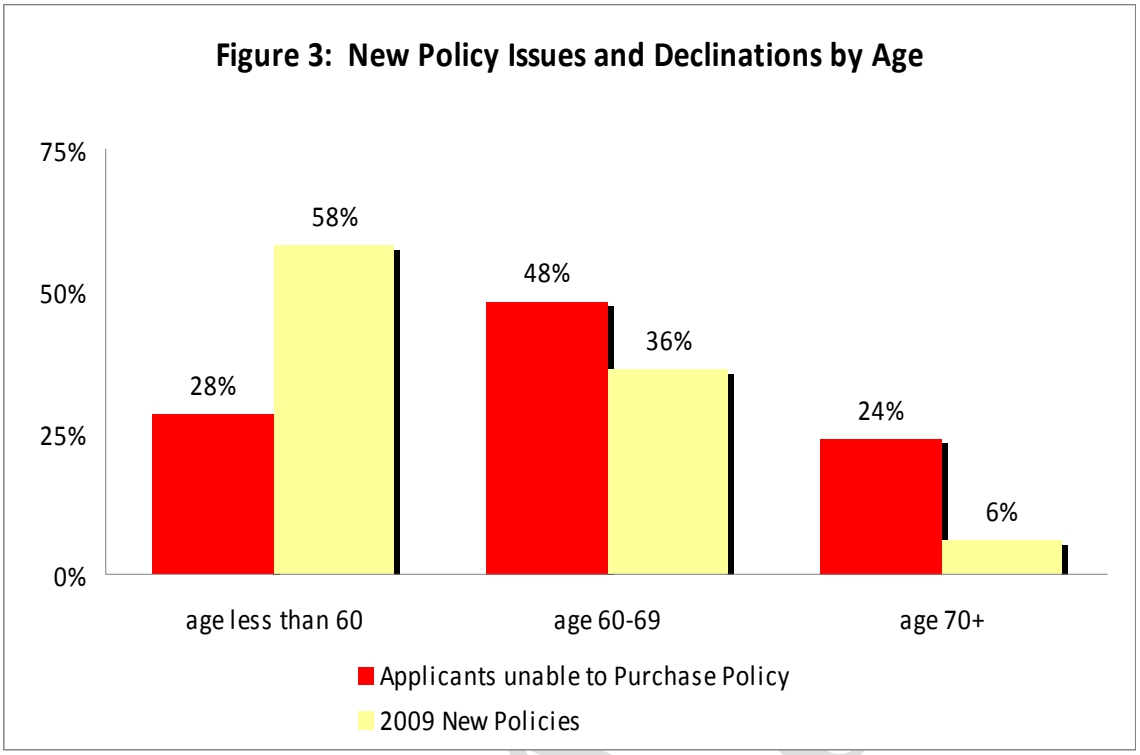
[2] Note that in roughly 8% of the cases individuals are still declined based solely on information found in the application alone. This suggests that agent pre-screening is not always effective.



Source: Results of the Long-Term Care Underwriting Survey for the Individual Market in 2009. LifePlans, Inc. Waltham, MA. November, 2010.

Note: Data weighted to represent market share of participating companies.

If we compare the age profile of individuals unable to purchase insurance due to health reasons with those who were issued policies during the same period, we find that the former tend to be older. In fact, the average age of individuals declined for coverage in the underwriting process in 2009 was 64 years whereas the average age of new purchasers was 57 years.



C. Socio-Demographic, Functional, and Cognitive Characteristics of Individuals Declined from Purchasing LTC Insurance

Table 2 summarizes additional socio-demographic characteristics of individuals who were declined from purchasing LTC insurance compared to individuals who were issued policies. As shown, compared to new buyers, declined individuals tend to be somewhat older, more male, and much less likely to be employed. Regarding employment, the results suggest that in general, being employed – which is also typically correlated with younger ages -- is negatively associated with underwriting declinations. **The implication is that as a potential underwriting screen, the employment requirement does provide some level of protection.**

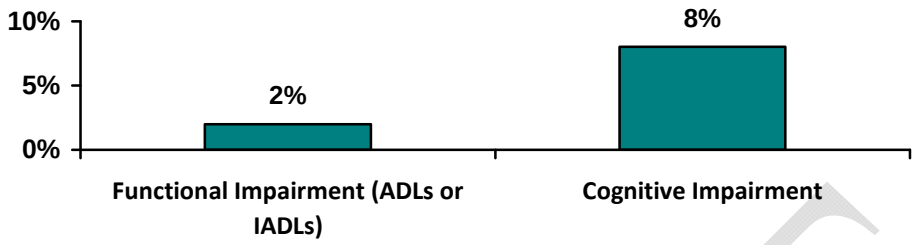
Table 2: Socio-Demographic Characteristics of Individuals Declined from Purchasing LTC Insurance and New Buyers of Insurance

Characteristics	Percent Declines	Percent New Issues
Age[2]	64	57***
Less than 50	5%	7%
50-54	8%	15%
55-64	40%	45%
65-69	24%	17%
70-74	12%	9%
75 and over	12%	7%
Gender[1]		
Male	48%	43%***
Female	52%	57%
Marital Status[2]		
Married	76%	76%
Single	24%	24%
Employment Status[2]		
Employed	51%	71%***
Not Employed	49%	29%

Source: Analysis of 2010 Underwriting Declination Database.
[1] Results of the Long-Term Care Underwriting Survey for the Individual Market in 2009. LifePlans, Inc. Waltham, MA November, 2010.
2 Who Buys Insurance in 2005: A Fifteen Year Profile of Buyers and Non-Buyers of Long-Term Care Insurance, AHIP, Washington, D.C. 2006.
Note: *** Significant at the .001 level.

As mentioned, companies tend to focus on the medical, functional and cognitive status of individuals when deciding whether or not to issue a policy. Figure 4 below shows the percentage of individuals who were declined due to a functional or cognitive impairment.

Figure 4: Percentage of Applications Declined Due to Functional and Cognitive Issues



Clearly, agents are doing a good job in terms of pre-screening; only 2% of applicants present with ADL or IADL limitations. As well, individuals with current dementia are for the most part screened out of the applicant pool by agents. For the most part, the 8% of applicants who are declined due to cognitive impairment, are not yet exhibiting outward signs of dementia, but instead, are at the very earliest stages of cognitive decline.

Table 3 shows the relationship between age and various socio-demographic characteristics of individuals not able to purchase a policy due to health issues. Each age grouping is assigned a letter so that in the table itself, one can identify those variables which are significantly different from similar variables in other age groups. Thus, for example, the percentage of female declines in the under age 60 age group is significantly higher than what is found in the 60-69 and over 70 age groups. The key findings from the data are that:

- Although relatively small, there is a higher percentage of individuals in the over age 70 group who are declined from insurance due to ADL and IADL limitations.

- The rate of declines due to cognitive impairment is less than 2% for the under age 60 group, but more than one-in-four (27%) for the over age 70 group.

- The rate of employment among declines is 74% for the under age 60 group and 26% for the over 70 age group.

Table 3: Relationship between Age and Socio-Demographic Characteristics of Underwriting Declines

		Age category					
		Less than age 60 (A)		age 60-69 (B)		age 70 or above (C)	
		Count	Column N %	Count	Column N %	Count	Column N %
Gender	Male	5992	40.5%	11658	50.4%A	4070	51.8%A
	Female	8794	59.5%BC	11455	49.6%	3786	48.2%
Marital Status	Married	8802	76.4%C	13735	78.0%AC	3458	68.6%
	Single	2336	20.3%	3385	19.2%	1352	26.8%AB
	Divorced	158	1.4%BC	160	.9%	46	.9%
	Widow	141	1.2%	175	1.0%	153	3.0%AB
	Partner	83	.7%	148	.8%	26	.5%
ADL Loss	No	7733	99.8%C	11411	99.8%C	3666	99.5%
	Yes	17	.2%	25	.2%	20	.5%AB
IADL Loss	No	7012	99.4%C	10650	99.3%C	3285	98.6%
	Yes	43	.6%	70	.7%	46	1.4%AB
Cognitive Status	Normal or No Screen	8663	81.6%BC	12263	67.9%C	3050	54.9%
	Pass	1763	16.6%	4848	26.9%AC	1024	18.4%A
	Impaired	188	1.8%	938	5.2%A	1485	26.7%AB
Employment Status	Employed	4583	73.8%BC	4131	44.6%C	798	26.4%
	Not Employed	1627	26.2%	5135	55.4%A	2220	73.6%AB

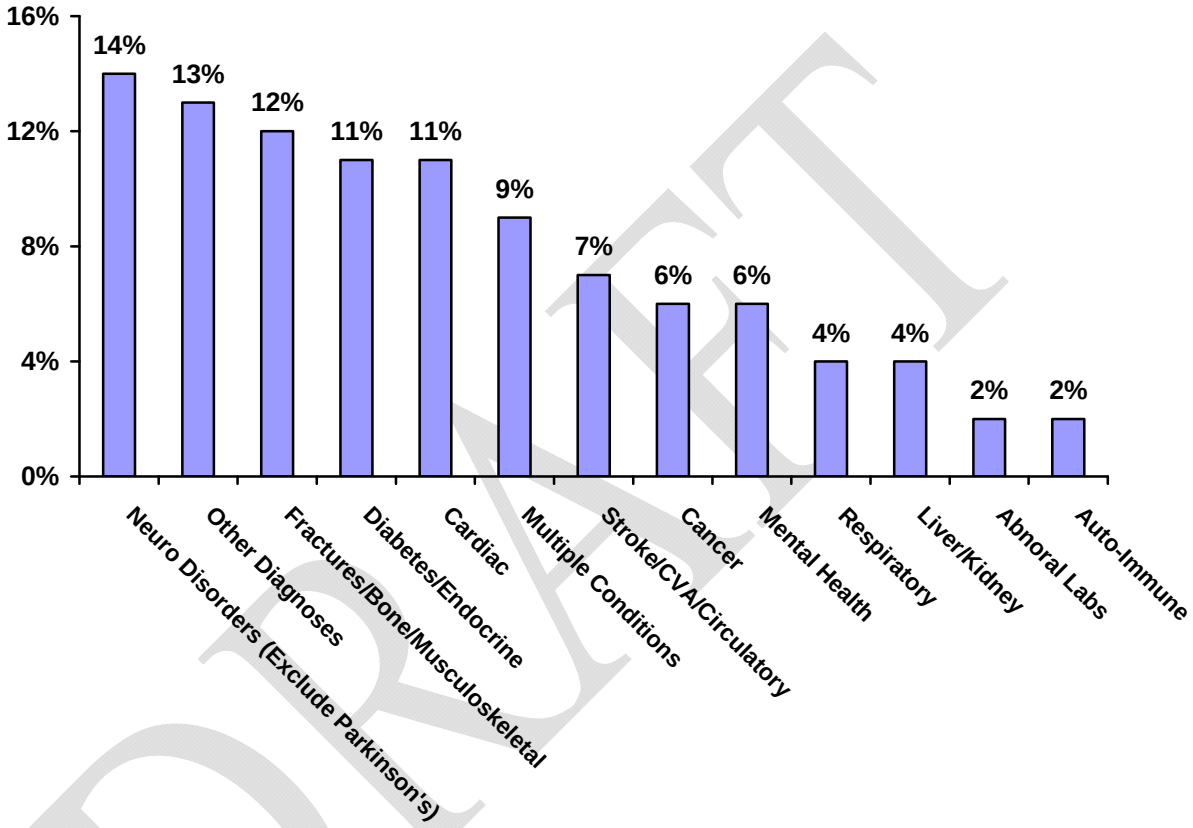
Note: Numbers in specific cells that have letters next to them indicate that there is a statistically significant difference between that result and similar cells under other age categories. Thus, for example, within the age 60 group, 74% of the declines were employed and this is significantly higher than the corresponding percentages for the age 60-69 and over age 70 groups.

C. Profile of Declines by Medical Diagnoses

In explaining to applicants why they may have been declined from insurance, almost all companies point to the presence of specific medical diagnoses. This is the case even when such diagnoses may not have yet manifested themselves into functional or cognitive decline. It is enough for an underwriter to know that such diagnoses will likely lead to dependency in ADLs to screen the individual out of the risk pool. The analysis of diagnostic information highlights the fact that the diagnoses that are recorded in the case files of applicants are many and varied. In order to assure that a profile could be

developed, clinical underwriters reviewed the diagnostic information provided by companies and developed a common basis for coding diagnoses into any one of thirteen primary categories. Figure 5 shows the distribution of the declined applicants by these primary categories.

Figure: 5: Distribution of Underwriting Declines by Medical Diagnosis



Note: "Other" is comprised of Dementia, Parkinson's disease, current use of Durable Medical Equipment, ADL or IADL impairments, use of specific excluded drugs, soft-tissue issues.

As shown, there is a wide distribution of diagnoses that can lead to an underwriting decline. No single diagnostic category accounts for more than 15% of declines. The most prevalent categories include neurological issues, fractures, bones and musculoskeletal issues, cardiac problems and individuals presenting with multiple conditions. Roughly 6% of declines are comprised of individuals with mental health issues, the most common being depression.

Table 4 highlights the relationship between medical diagnoses and age. Key findings from this table include:

- Individuals age 70 and over are most likely to be declined because of neurological problems other than Parkinson's and the presence of multiple conditions.

- Diabetes, Endocrine, Cancer and Cardiac problems are the most prevalent reasons for declines for individuals in the age 60-69 age group.

- Fractures, bone issues and other musculoskeletal problems, as well as mental health, auto-immune and other diagnoses not captured by these other major categories are most prevalent in the under age 60 declines.

Table 4: Distribution of Declines by Medical Diagnosis by Age and Gender

		Age category					
		Less than age 60 (A)		age 60-69 (B)		age 70 or above (C)	
		Count	Column N %	Count	Column N %	Count	Column N %
Primary	Diabetes/Endocrine	1751	11.9%C	3348	13.0%AC	933	7.2%
	Cancer	901	6.1%C	1810	7.1%AC	616	4.7%
	Stroke/CVA/Circulatory	779	5.3%	2056	8.0%A	959	7.4%A
	Fractures/Bone Problems/Musculoskeletal	2156	14.6%BC	3199	12.5%C	1053	8.1%
	Neurological issues (Excluding Parkinson's)	1182	8.0%	2593	10.1%A	3717	28.5%AB
	Cardiac Problems	1376	9.3%	3156	12.3%AC	1158	8.9%
	Respiratory	512	3.5%C	970	3.8%C	359	2.8%
	Mental Health	1445	9.8%BC	1337	5.2%C	254	1.9%
	Abnormal Labs/Unstable condition	424	2.9%	592	2.3%	242	1.9%
	Other	2692	18.3%BC	3271	12.7%C	898	6.9%
	Auto-Immune	533	3.6%BC	594	2.3%C	135	1.0%
	Liver/Kidney	557	3.8%C	921	3.6%C	399	3.1%
	Multiple conditions	417	2.8%	1819	7.1%A	2322	17.8%AB

Note: The letters in specific cells designate that the proportion is significantly different than that found in the identified columns. Thus, for example, the proportion of individuals under age 60 declined due to Diabetes/Endocrine issues is higher than the corresponding percentage of declines for the over age 70 group.

D. Profile of Declines by Employment Status

While the CLASS Program is structured in a manner that maximizes participation -- even among those who already may have functional dependencies -- the one requirement that does afford some level of control regarding enrollment is the work requirement. To enroll in the program, an individual must be employed. Therefore, if one wants to obtain a profile of likely early enrollees to the program, a focus on the sub-set of ***employed individuals*** declined for private LTC insurance is clearly warranted. This group is already educated about the risk and need for coverage, has expressed its preferences through a willingness to pay for private insurance, and is likely to be highly motivated to participate in a public program, even if benefits levels are less than what they might have desired in the private market. In the analyses that follow, we segment data in terms of employment status. We have definitive employment status on roughly 18,500 declines.

As mentioned, many companies do not track in their system whether or not an applicant is employed. We do know from previous studies of buyers and non-buyers of LTC insurance that roughly 70% of all applicants for LTC insurance are employed. Tables 2 and 4 highlighted the fact that the rate of employment among individuals declined for insurance is much lower than for the population of applicants as a whole, at least with respect to those ages 60 and over.

Table 5 shows the relationship between key demographic characteristics of the sample by employment status. As shown, employed declines are more likely to be younger, male, and married, but less likely to have functional or cognitive issues than their non-employed counterparts.

Table 5: Relationship between Socio-Demographic Characteristics and Employment Status

	Employed	Not Employed
Age		
age 60	48%**	18%
age 60-69	43%	57%**
age 70 or above	9%	25%**
Average age	60	65**
Gender		
Male	54%**	45%
Female	46%	55%**
Marital Status		
Married	72%**	67%
Single	27%	33%**
Widow	1%	0%
ADL Loss	0.1%	.2%**
IADL Loss	0.4%	1.2%**
Cognitively Impaired	3%	6%**

Not shown in the table is the fact that employed applicants who were declined due to health status are slightly older (age 60) than are all employed applicants (age 58). Moreover, they tend to be somewhat more male (54%) than the total pool of all employed applicants (45%).

Table 6 summarizes the relationship between employment status and primary diagnosis among declines. The only statistically significant differences in the medical diagnosis profile between the two groups are that mental health issues and stroke/CVA/Circulatory problems are more prevalent among those not working. Among those employed, there is a somewhat higher proportion of individuals with a myriad of other diagnoses which are reflected in the "Other" category.

Table 6: Declines by Medical Diagnosis by Employment Status

		Employed	Not-Employed
Primary	Diabetes/Endocrine	12.3%	11.4
	Cancer	8.3%	8.5
	Stroke/CVA/Circulatory	7.7%	9.1***
	Fractures/Bone Problems/Musculoskeletal	13.4%	13.2
	Neurological issues (Excluding Parkinson's)	9.2%	9.5
	Cardiac Problems	13.2%	12.9
	Respiratory	3.3%	3.2
	Mental Health	7.1%	8.5***
	Abnormal Labs/Unstable condition	2.2%	2.0
	Other	15.5%***	14.1
	Auto-Immune	3.2%	3.1
	Liver/Kidney	3.9%	3.8
	Multiple conditions	.6%	.6

Clearly, one's medical status is closely related to age. To gain a better understanding of the relationship between primary diagnoses and age, Table 7 arrays the data by age, employment status and diagnosis.

Table 7: Declines by Medical Diagnosis and Employment Status by Age

		Employed			Not-Employed		
		< age 60 (A)	age 60-69 (B)	age 70+ (C)	< age 60 (D)	age 60-69 (E)	age 70+ (F)
Primary	Diabetes/Endocrine	11.5%	13.6%AC	10.3%	7.8%	12.1%D	12.6%D
	Cancer	7.6%	9.0%	8.6%	6.1%	9.1%D	8.8%D
	Stroke/CVA/Circulatory	5.5%	9.4%A	11.0%A	5.7%	9.0%D	11.8%DE
	Fractures/Bone Problems/ Musculoskeletal	15.3%BC	11.8%	10.8%	14.7%	13.1%	12.5%
	Neurological issues (Excluding Parkinson's)	8.1%	8.9%	17.0%AB	10.0%	8.5%	11.4%E
	Cardiac Problems	10.0%	15.8%A	18.4%A	7.1%	12.1%D	18.8%DE
	Respiratory	2.9%	3.6%	4.4%	2.0%	3.5%D	3.5%D
	Mental Health	9.4%BC	5.6%C	2.0%	15.7%EF	8.1%F	4.3%
	Abnormal Labs/Unstable condition	2.4%C	2.3%C	.9%	2.2%	2.1%	1.8%
	Other	18.6%BC	13.1%	10.5%	18.8%EF	15.0%F	8.6%
	Auto-Immune	3.9%BC	2.6%	1.6%	5.1%EF	3.1%F	1.8%
	Liver/Kidney	4.1%	3.8%	3.8%	4.0%	3.7%	3.8%
	Multiple conditions	.7%	.3%	.7%	.9%	.5%	.5%

The key observations from this table are that:

- Among declines under age 60, mental health is more prevalent than for other age groups and it is also highly correlated with employment status: those who are not-working are roughly twice as likely to have mental health issues cited as a primary reason for a decline and this is true across all age segments.

- Fractures/Bone Problems/Musculoskeletal issues as well as Auto-immune issues are more prevalent among the under age 60 employed declines than among other age groups.

- Diabetes and Endocrine problems are most prevalent among employed individuals age 60-69. Also, individuals age 60-69 who are employed are more likely to have cardiac issues than are those who are not-employed.

- Among individuals age 70 and over, Stroke, CVA/ Circulatory issues, along with Neurological and Cardiac problems comprise the major reasons for decline. Neurological problems are more prevalent among the employed.

Table 8 below further segments the data by focusing on age and gender differences in the profile of medical diagnoses for individuals who are employed and were declined coverage.

Table 8: Employed Declines by Medical Diagnosis by Age and Gender

		EMPLOYED Individuals by AGE Group					
		Less than age 60		age 60-69		age 70 or above	
		Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
		(A)	(B)	(A)	(B)	(A)	(B)
Primary	Diabetes/Endocrine	15.6%B	7.9%	16.1%B	9.6%	11.5%	7.8%
	Cancer	7.8%	7.5%	9.7%B	7.8%	11.0%B	4.1%
	Stroke/CVA/Circulatory	6.6%B	4.5%	10.6%B	7.7%	11.9%	9.3%
	Fractures/Bone Problems/Musculoskeletal	14.3%	16.2%	9.1%	16.0%A	7.4%	17.5%A
	Neurological issues (Excluding Parkinson's)	7.4%	8.6%	8.7%	9.4%	16.8%	17.5%
	Cardiac Problems	14.6%B	6.0%	19.2%B	10.6%	21.9%B	11.5%
	Respiratory	2.9%	2.8%	3.2%	4.4%A	3.8%	5.6%
	Mental Health	6.7%	11.8%A	4.6%	7.2%A	.9%	4.1%A
	Abnormal Labs/Unstable condition	2.7%	2.2%	2.9%B	1.4%	1.3%	0.0%
	Other	14.4%	22.3%A	10.0%	17.8%A	7.6%	16.4%A
	Auto-Immune	1.8%	5.8%A	1.4%	4.6%A	.2%	4.5%A
	Liver/Kidney	4.6%	3.7%	4.1%	3.3%	4.7%B	1.9%
	Multiple conditions	.6%	.8%	.5%	.4%	.9%	0.0%

Key observations from Table 8 include:

- Under age 70, among employed applicants, males tend to have higher rates of Diabetes/Endocrine, Stroke/CVA/Circulatory, and Cardiac problems than do females.

- Across all ages, mental health and auto-immune issues as primary decline reasons among employed individuals are higher for females than for males.

Conclusions

Information from this analysis has clearly demonstrated that individuals who are unable to purchase private LTC insurance due to the medical underwriting process tend to be somewhat older, male and less likely to be employed than the total applicant pool. While few exhibit outward signs of functional impairment or dementia, this is likely the result of agents pre-screening activities. Thus, the pool of applicant declinations is more representative of individuals who are at risk for **near term need** rather than **immediate need.** For that reason, the roughly 8% of individuals who are declined for not passing a cognitive screen are likely at the early stages of cognitive decline and for the most part do not have dementia at the time of application.

The distribution of the sample by medical diagnosis suggests that there are a variety of reasons why someone may not be accepted into the risk pool. No single diagnostic category accounts for more than 15% of the declinations and there are clear patterns across age, gender and employment status. Estimating the prevalence of these diagnoses in the general target population for the CLASS Program is an important next step, as it will enable policymakers to begin to characterize with more precision the risk profile of enrollees. As such, this will enable more accurate pricing so that the premiums adequately reflect underlying risk and support ongoing program financial solvency.

A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM

For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

Files Available for This Report

[HTML versions of Appendices will be added as they are formatted]

Main Report [48 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/index.shtml
http://aspe.hhs.gov/daltcp/reports/2011/class/index.pdf

APPENDIX A: Key Provisions of Title VIII of the ACA, Which Establishes the CLASS Program [6 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appA.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appA.pdf

APPENDIX B: HHS Letters to Congress About Intent to Create Independent CLASS Office [11 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appB.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appB.pdf

APPENDIX C: Federal Register Announcement Establishing CLASS Office [2 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appC.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appC.pdf

APPENDIX D: CLASS Office Organizational Chart [2 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appD.pdf

APPENDIX E: CLASS Process Flow Chart [2 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appE.pdf

APPENDIX F: Federal Register Announcement for CLASS Independence Advisory Council [3 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appF.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appF.pdf

APPENDIX G: Personal Care Attendants Workforce Advisory Panel and List of Members [6 PDF pages]
Full Appendix http://aspe.hhs.gov/daltcp/reports/2011/class/appG.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appG.pdf

Ga: Federal Register Announcement for Personal Care Attendants Workforce Advisory Panel http://aspe.hhs.gov/daltcp/reports/2011/class/appGa.pdf

Gb: Advisory Panel List of Members http://aspe.hhs.gov/daltcp/reports/2011/class/appGb.pdf

APPENDIX P: June 22, 2011 Technical Experts Meeting [77 PDF pages]

Full Appendix http://aspe.hhs.gov/daltcp/reports/2011/class/appP.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appP.pdf

Pa: Agenda and Discussion Issues and Questions http://aspe.hhs.gov/daltcp/reports/2011/class/appPa.pdf

Pb: Presentation Entitled “Core Assumptions and Model Outputs” http://aspe.hhs.gov/daltcp/reports/2011/class/appPb.pdf

Pc: Presentation Entitled “Actuarial Research Corporation’s Long Term Care Insurance Model” http://aspe.hhs.gov/daltcp/reports/2011/class/appPc.pdf

Pd: Presentation Entitled “The Avalere Long-Term Care Policy Simulator Model” http://aspe.hhs.gov/daltcp/reports/2011/class/appPd.pdf

Pe: Presentation Entitled “Alternative Approaches to CLASS Benefit Design: The CLASS Partnership” http://aspe.hhs.gov/daltcp/reports/2011/class/appPe.pdf

APPENDIX Q: Table 2: Actuarial and Demographic Assumptions [2 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appQ.htm
http://aspe.hhs.gov/daltcp/reports/2011/class/appQ.pdf

APPENDIX R: Figure 1: Daily Benefit Amount for Increased Benefit [2 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/class/appR.pdf