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CIPR STUDY

The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations

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The State of Long-Term Care Insurance

The Market, Its Challenges and Future Innovations

Prologue

By Eric C. Nordman, CPCU, CIE
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This study would not have been possible without the contributions of several key regulators and other notable authors from the academic community, consumer interests and the insurance industry. They are listed on page ii. I would also like to thank CIPR Research Analyst Dimitris Karapiperis for his diligence in identifying authors, working with them on their submissions and working with me to deliver a cohesive report contributing to our collective knowledge on long-term care issues.

Disclaimer: This study represents the opinions of the author(s) and is the product of professional research. It is not intended to represent the position or opinions of the NAIC or its members, nor is it the official position of any staff members. Any errors are the responsibility of the author(s).

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Forward



Forward

By Dimitris Karapiperis, Analyst, NAIC Center for Insurance Policy and Research and Eric Nordman, Director, NAIC Center for Insurance Policy and Research

As baby boomers enter their golden years they will be confronted with one of the largest financial risks in the history of their generation. It is expected the overwhelming majority of elderly Americans will require long-term care (LTC) at some point in their lives. The potential large LTC expenditures, often exceeding the retirement income and savings of a large portion of middle-class retirees, could increase the financial stress for them and their families jeopardizing their standard of living and quality of life. For the more financially vulnerable among the elderly, the need for costly LTC could actually prove an insurmountable challenge. It is only after exhausting all their assets that they could turn to social programs like Medicaid for help. Although Medicaid is currently the largest payer for LTC, rising costs could place federal and state budgets under serious and increasing financial strain.

The recognition that over time the high cost of LTC could potentially exhaust the assets of even the more affluent senior households makes the need for insurance against this risk extremely critical. Private insurance has been seen as an important product for middle income households to plan and pay for their future LTC needs. However, despite the significant financial risk and the potentially catastrophic outcomes, only a small portion of LTC expenditures is currently funded by private insurance. Given the need for coverage and the obvious benefits of insuring against this risk, the fact only few Americans are buying long-term care insurance (LTCI) is often referred to as a puzzle. The low public awareness of the risks involved, the dependency on family caregivers and ultimately on social programs, as well as the high cost of private insurance may be among the main reasons for the low market penetration of private LTCI.

Long-term care insurance has been selling in the marketplace for the better part of 30 years. Early versions of the insurance were called nursing home insurance because policies covered only care provided in nursing homes, primarily skilled facilities. In the late 1970s and early 1980s there were only a small number of insurance companies providing such coverage. They entered the market at a time when LTC expenditures were less than \$20 billion but were

growing rapidly.¹ By 1980, expenditures grew to \$30 billion, and today expenditures on LTC exceed \$225 billion.^{2,3}

As required by state insurance laws, private LTCI policies were always sold as guaranteed renewable—they could only be cancelled for non-payment of premium—and as level-funded. While the premium charged varied by age at purchase, once an individual purchased a policy, the premium was designed (although never guaranteed) to be level for life. Finally, almost all policies reimbursed the actual costs of care up to a daily benefit maximum.

The level-funded nature of the product persists to this day and poses unique challenges to insurers. Insurers can only adjust premiums subject to regulatory approval if experience is countering their pricing assumptions. Most insurers' LTCI policies issued before the mid-2000s have seen adverse experience when compared to their original pricing assumptions. Rising claims, low mortality and lower than expected lapses have led to higher prices often unaffordable to a large segment of the affected population. A number of insurers have also opted out of the market, leaving only a relatively few insurers to provide much needed LTCI products.

This is an important social challenge and a serious policy dilemma for state insurance regulators, as well as for the insurance industry and other policy makers to devise efficient programs and mechanisms in order to deliver reasonably priced LTCI for the country's aging population. State regulators play a key role in ensuring pricing of LTCI policies is both reasonable and accurate while striving to promote LTCI that is both affordable and available.

The objective of this study is to gain a comprehensive understanding of LTC, one the great generational challenges of our time, and examine the role and contribution of the private LTCI market in the U.S. By bringing together thought leaders and researchers in the fields of LTC and insurance, state insurance regulators and other policymakers, insurance industry executives as well as consumer advocates, the study aims to stimulate debate to support innovation and the future development of LTC in the country.

In the following sections of the study, the contributing authors present their views and analyses and consider the many important questions that remain unexplored and unresolved. The views

¹ Long-Term Care for the Elderly and Disabled 1977. Congressional Budget Office, Congress of the United States, Washington, DC. February 1977.

² Health Care Financing Administration, Office of the Actuary, Data from the Office of National Health Statistics in Health Care Financing Review, Fall 1994, Vol. 16, No. 1.

³ Commission on Long-Term Care (2013). Report to Congress, Washington, D.C. Sept. 30.

expressed in this study are the opinions of the authors. They are not meant to represent the position or opinions of the NAIC/CIPR or its members, nor are they the official position of any staff members.

The study is organized as follows:

- Section 2 presents the current state of the LTCI market, the product evolution, consumer profiles and industry performance. It also discusses the market challenges for insurers.
- Section 3 explores the economics and benefits of private LTCI for consumers as well as caregivers. It demonstrates how critical insuring against this risk is from a variety of perspectives.
- Section 4 deals with the curious insurance puzzle and considers consumer attitudes towards LTCI and insurers' distribution challenges.
- Section 5 studies the demand for private LTCI and provides explanations for observed consumer behavior.
- Section 6 discusses how insurers have managed their LTCI business, their underwriting process and the development of new products.
- Section 7 explores the range of financing options for LTCI to find solutions which maximize the likelihood the elderly can actually afford to pay for LTC while lessening the burden on Medicaid.
- Section 8 examines LTC reform proposals by the federal government and pioneering plans promoted by states as they are trying to meet the challenge of providing LTC to their citizens.
- Section 9 presents Minnesota's work towards reforming the LTC financing system, offering an example of the national dialogue on new and innovative ways to finance LTC.
- Section 9 outlines the current regulatory framework for LTCI. It presents the NAIC model regulation for both initial rates and rate increases, as well as the *NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* which helps state insurance regulators navigate the various changes and revisions to the model.
- Section 10 offers a consumer perspective on the issues of financing LTCI and offers answers to a number of concerns with the current system of LTC financing.
- Section 11 presents the views of insurance company top executives on how best to meet the challenge of providing LTCI to those who need it.
- Section 12 presents a select group of state insurance regulators who, drawing from experience in their states, discuss their concerns with the current state of the LTCI

Forward

market. They also explore new ideas and solutions for making this product viable going forward and able to meet consumer needs.

The State of the Long-Term Care Insurance Market



The State of the Long-Term Care Insurance Market

By Marc A. Cohen, Chief Research and Development Officer, LifePlans, Inc.

Introduction

The long-term care insurance (LTCI) market experienced rapid growth in the mid- to late 1980s and 1990s as insurers began to provide limited coverage for home and community-based care, either through riders or as part of the underlying basic policy design. The attractiveness of these policies increased the demand and, coupled with the sense insurers could manage the underlying risk, fueled rapid growth in the market share of comprehensive policies.

An increasing number of companies joined the market so, by the end of the 1990s, more than 100 insurers were selling LTCI products. Throughout this period and up to today, there was a great deal of market concentration, with a relatively small number of companies—less than a dozen—accounting for more than 80% of sales in both the individual and group market.

In this section, we summarize the current state of the market in terms of size, product evolution, consumer profile and industry performance vis-à-vis claims payments practice, financial performance, consumer benefits and market challenges for insurers.

Market Size

After more than two decades of rapid growth, the LTCI industry has undergone significant contraction, both in terms of sales as well as insurers participating in the market. Table 1 summarizes key industry parameters as of 2014. As shown, in 2014, the total number of individuals with LTCI coverage was 7.2 million. This does not represent all people who have ever had policies—only those who still have them. Changes in covered lives reflect both growth in annual sales, as well as changes in the number of policyholders who maintain their coverage over time.

Earned premiums now total slightly less than \$12 billion (excluding premiums for combination products). To put this in perspective, the individual disability insurance market has in-force premiums of about \$4.7 billion, the combined short-term and long-term group disability market

has in-force premiums of about \$13.6 billion, and the group life insurance market \$28.2 billion.⁴ This suggests there is a great deal of room for growth in the market.

There is quite a bit of value in terms of the total dollars available in policies to finance LTC services. The maximum potential benefit value in policies is a little less than \$2 trillion. What could be paid out if everyone used 100% of their benefits and the likely payout of these policies is about \$800 billion. Given current annual total LTC expenditures of roughly \$225 billion, this represents a significant amount of financing over the life of the people with policies.

Table 1: Key Industry Parameters

Source: NAIC

Parameters	Values for 2014
Policies In-force	7.2 million
Earned Premiums	\$11.5 billion
Potential Value in All In-Force Policies	\$1.98 trillion
New Claim Reserves	\$8.7 billion
Cumulative Claims Paid 1992-2014	>\$95 billion
Number Filing New Claims	73,130
Number of In-force Claimants	254,910
Average Claim Reserve	\$119,391

Claims payments are also growing rapidly, with slightly less than \$100 billion already paid out in claims and roughly \$9 billion in new claim reserves being established just in 2014. More than 250,000 individuals are currently receiving benefits under their LTCI policy, and the average value of claim reserves being established is about \$119,000. This is more than enough to cover the roughly two years of care individuals are expected to need after age 65.⁵ It is not surprising then that as a share of total LTC financing, private insurance is growing. The share of private insurance financing of LTC has grown from 3% in 1991 to 12% in 2011. It is growing faster than

⁴ NAIC, 2013, Gen Re

⁵ Department of Health and Human Services 2015. "Long-Term Services and Supports for Older Americans: Risk and Financing ASPE Issue Brief" <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>

all other sources of financing, although it is still a modest slice of the aggregate national LTC expenditures.

What Table 1 does not show is how the in-force policy counts have changed over time as a function of both individual and group sales. Figure 1 shows the total number of in-force individual and group policies from 1992–2014. Noteworthy is the fact the in-force numbers have stayed relatively static over the last seven years. Of the 7.2 million policies, roughly 70% (5 million) are individual policies and 30% are group policies.

Figure 1: Long-Term Care Insured Lives (Thousands)

Source: NAIC Experience Reports, 2000–2014

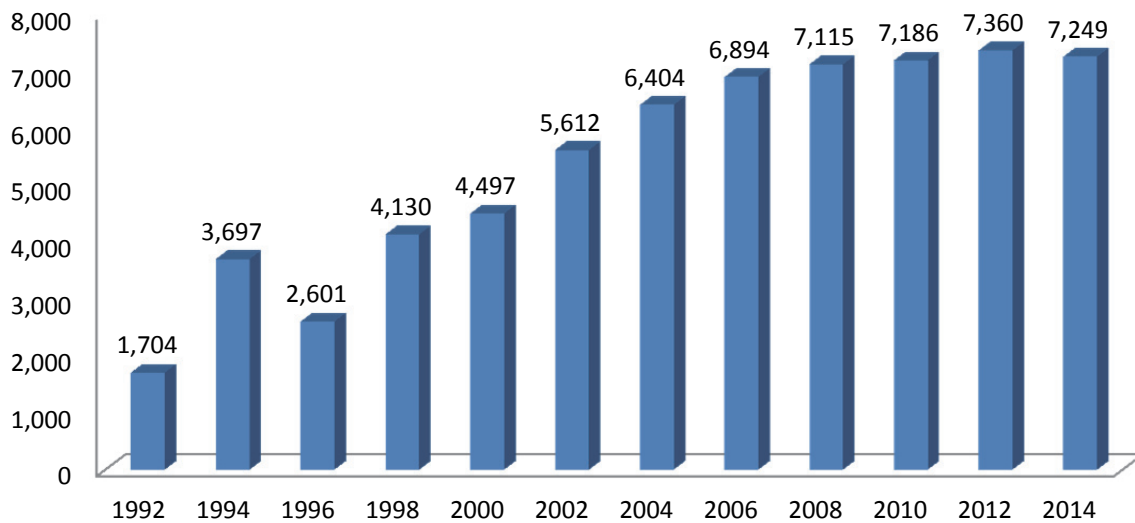


Figure 2 highlights the relatively dramatic decline in sales in the individual market over the past decade. Individual sales are well below their 1990 levels. Not shown in this figure is the concurrent rapid decline in group market sales. Whereas between 2006 and 2012 group sales represented between 35% and 45% of total sales, by 2014, they had declined to well under 20%. Given the strong belief a robust employer market is important for expanding the market, this trend is concerning.

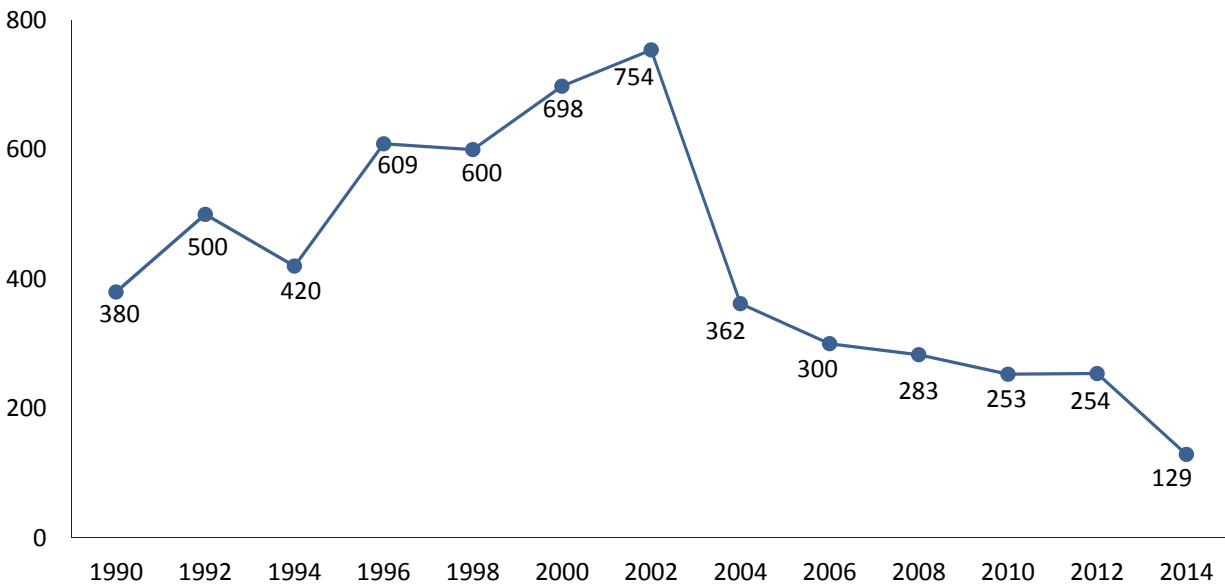
Today, roughly 34,000 businesses offer LTCI to their employees, which represents less than 0.5% of all employers in the U.S., but 20% of companies with at least 10 employees.^{6,7,8,9}

⁶ Pincus J, K. Wallace-Hodel, K. Brown, 2013. “The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage,” SCAN Foundation, March 2013.

Typically, employee take-up rates are between 5% and 7%. Some have suggested there are at least 5,500 employers, representing an additional 3 million employees who have similar characteristics as employers currently offering policies.¹⁰ This further supports the notion there is room for market growth in this segment.

Figure 2: Individual Market Sales: 1990–2014 (Thousands)

Source: LifePlans Analysis Based on AHIP, LIMRA and LifePlans Sales Surveys, 1990–2015



One area of continued growth in the market is with combination or hybrid products. These products combine LTC benefits with either life insurance or an annuity. They can pay out if LTC is needed, but if not needed, there is a death benefit or annuity payout. In cases where an individual uses some, but not all, of LTC benefits, the remainder would be payable as a death benefit. This is one of the principal appeals of combo products. If LTC is never needed, there is still a return on the money invested in the premium.¹¹

⁷ Mercer, 2010. Mercer National Study of Employer-Sponsored Health Plans.

⁸ Pincus J, K. Wallace-Hodel, K. Brown, 2012. "The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage," The SCAN Foundation.

⁹ Note: There does appear to be a discrepancy between the number of employers offering the coverage as reported by the Mercer study and by the Life Insurance Marketing Research Association (LIMRA), which reports the number of employers offering coverage in 2010 to be 11,500.

¹⁰ Pincus J, K. Wallace-Hodel, K. Brown, 2012. "The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage," The SCAN Foundation.

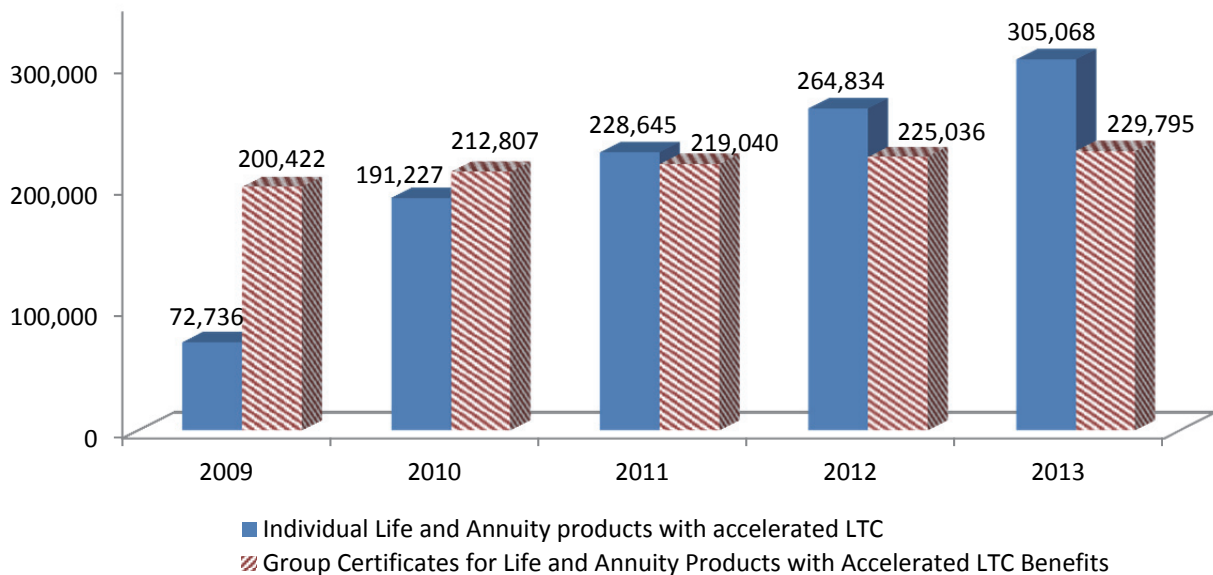
¹¹ Tell, EJ. 2013. "Overview of Current Long-Term Care Finance Options," The SCAN Foundation.

Life insurance/LTC hybrids pay for LTC expenses by accelerating the payment of the death benefit, which is typically paid monthly over a set period—typically 24 to 48 months. In some cases, individuals can purchase a rider extending the LTC benefit, if the death benefit is exhausted. An annuity/LTC combination adds an LTC rider to an annuity. The idea is if an individual becomes disabled and requires LTC services, benefits are first paid out of the existing policy value. If that value is depleted, then additional benefits would come out of the LTC rider, which typically pays up to three times the amount paid under the account value.

Combo products are commonly designed with a single premium. In 2011, the average single premium for a life/LTC hybrid was \$70,000, for a face amount of roughly \$146,000 (about two years of LTC benefits). Some life products have regular premiums, and the average annual amount is almost \$5,500, for a face amount of \$278,000.¹² Figure 3 shows the growth in LTCI combination products over a five-year period through 2013.

Figure 3: Growth of Long-Term Care Insurance Combination Products

Source: LifePlans Analysis of NAIC LTC Experience Exhibit Reports and LIMRA, 2009.



¹² LIMRA, 2009. “Individual Life Combination Products: Life with Long-Term Care & Life with Chronic Illness Riders,” 2011 Annual Review.

Insurance Companies in the Market

There has been a rapid change in the number of insurers participating in the market. In fact, it is challenging to obtain an accurate count of the total number of insurers selling LTCI policies in the marketplace. Some insurers report sales of less than 10 policies a year, and others show no policies in one year and then a small number of policy sales in a subsequent year.

In 2000, America's Health Insurance Plans (AHIP) conducted a survey and found that 125 insurers were selling policies in the marketplace. By 2002, however, this number had fallen to 104, a 17% decline in just two years.¹³ This survey has not been replicated since 2002.

Today, the most reliable source of information on insurer-specific activity is provided by the NAIC. A report published in 2011 focused on the top 100 insurers reporting premium and claims information on any LTCI policies they have in-force in 2010. The report showed fewer than 20 insurers were actively selling standalone LTCI policies in 2010. By 2012, only 11 companies were selling at least 2,500 new standalone individual or group policies annually in the marketplace.^{14,15} By 2014, this number was again less than 15 companies—12 selling more than 2,500 individual policies and five selling group policies.^{16,17}

It is important to note these figures do not include insurers selling various combination products such as life insurance-LTC or annuity-LTC products. These products still account for a small—but growing—part of the overall market. Some of the larger sellers of combination products include Lincoln Financial, Pacific Life, State Life, Genworth, Transamerica, Northwestern Mutual and John Hancock.

During 2014, insurers writing at least 2,500 individual or group policies included:¹⁸

1. Bankers Life and Casualty
2. Genworth Financial
3. John Hancock Financial Services (Individual Market)

¹³ America's Health Insurance Plans, 2004. "Long-Term Care Insurance in 2002," June 2004.

¹⁴ LifePlans, Inc., 2012. "2011 Long-Term Care Top Writers Survey Individual and Group Association Final Report," Waltham, MA, March 2012.

¹⁵ This figure is difficult to determine with precision. Broker World estimates that in 2010 there were 25 companies selling stand-alone policies, but many of these were selling a very small number on an annual basis.

¹⁶ LIMRA, 2015. "U.S. Group Long-Term Care Insurance," Annual Review 2015.

¹⁷ LIMRA, 2015. "U.S. Individual Long-Term Care Insurance," Annual Review 2014.

¹⁸ Other insurers selling fewer policies include Auto-Owners Insurance Group, Country Life, Humana, United of Omaha, and United Security as reported in Brokers World, 2012.

4. Knights of Columbus
5. MassMutual Financial Group
6. MedAmerica Insurance Company
7. Mutual of Omaha
8. New York Life Insurance
9. Northwestern Long Term Care Insurance Company
10. TransAmerica Life Insurance
11. LifeSecure
12. Thrivent

Currently, individuals with LTCI policies are either being serviced by insurance companies that continue to sell in the market or by those who have exited and are no longer selling policies. The latter are considered to be in “closed blocks.” In order to determine the size of the closed block market, we analyzed and updated information from recent NAIC Experience Exhibit reports.

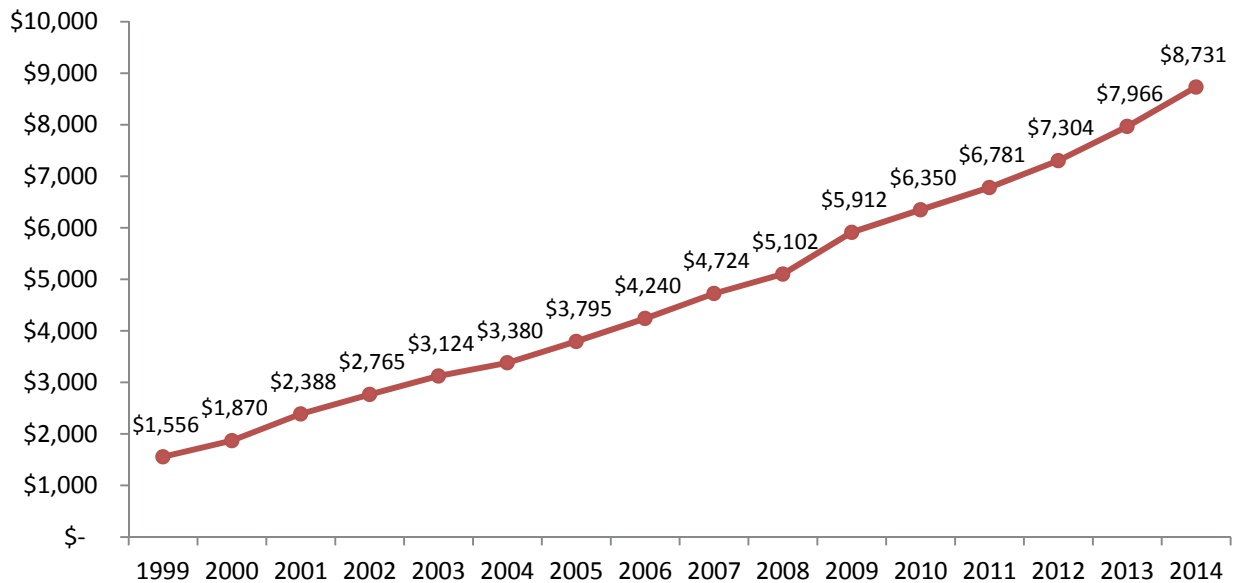
In general, insurance company size, product offering and geographic location do not differentiate firms that have left the market versus those that have remained. Closed blocks currently represent more than 55% of earned premiums and roughly 60% of cumulative total claims paid.

Claims Activity and Performance

As the industry continues to mature, claims payments are increasing even as the average age of new purchasers has been declining. Figure 4 shows the growth in new claims over the period. The average growth in annual incurred claims over the period is 12%. Although not shown in the figure, through 2014, insurers reported paying out on a cumulative basis over the last two decades slightly less than \$100 billion in incurred claims. On an annual basis, the liability covered from private LTCI is now roughly \$9 billion, which is less than 5% of total expenditures on LTC services in the U.S.

Figure 4: Annual Incurred Claims (\$ Millions)

Source: NAIC LTC Experience Exhibit Reports through 2014



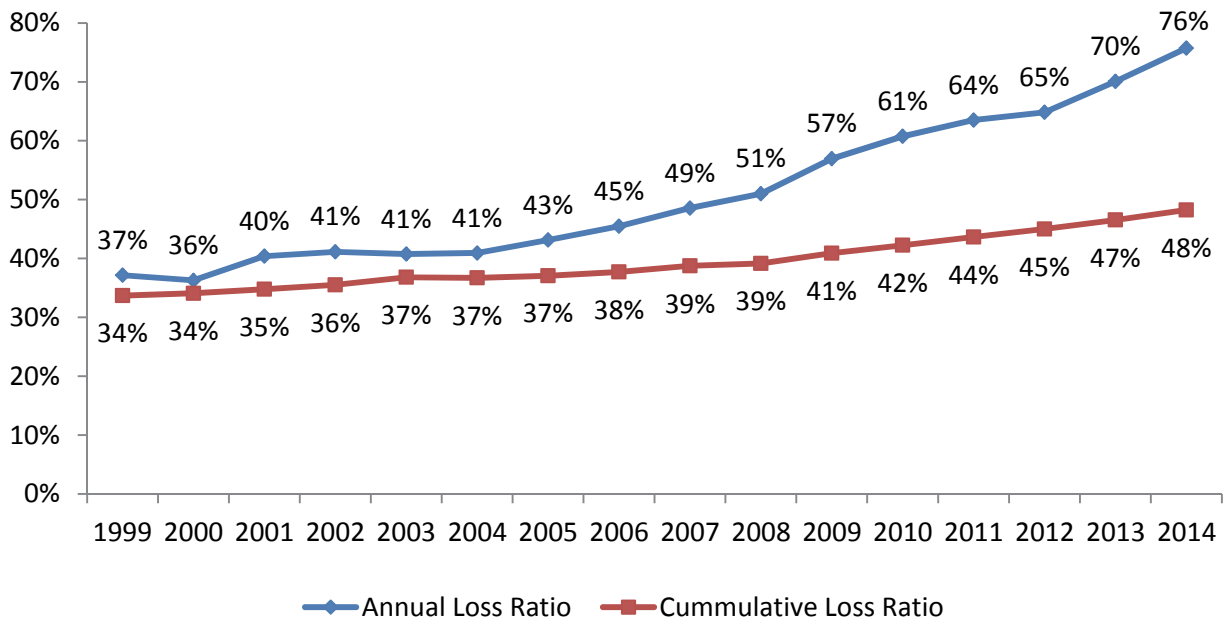
The growth in incurred claims in and of itself does not translate to underlying profitability or performance for the industry, nor does its relationship to changes in earned premiums (which are not shown in Figure 4) relate directly to profitability. Financial performance and profitability are related in part to the actual relationship between claims and premiums over the life of a policy.

Insurers typically focus on two performance measures related to this parameter: 1) the annual and cumulative loss ratio; and 2) the actual-to-expected loss ratio. The loss ratio focuses on the relationship between claims and premiums and can be viewed on the basis of a single year (e.g., claims incurred during the year compared to premiums earned during the year) or on a cumulative basis (e.g., total claims incurred to date compared to total premiums earned to date). The higher the loss ratio, the greater are claims in relation to earned premiums.

Over the life of a group of policies, claims payments will ultimately exceed the amount of annual premium payments. The difference is expected to be paid for by the reserve the insurer establishes. The reserve is funded in large part during the years where annual premium exceeds the level of annual claims incurred. It is the excess premium plus the interest earned on the excess premium that funds the future gap between premiums and claims. Figure 5 highlights the annual industry-wide loss ratio, as well as the cumulative loss ratio.

Figure 5: Annual and Cumulative Loss Ratios

Sources: LifePlans, Inc. and NAIC LTC Experience Exhibit Reports



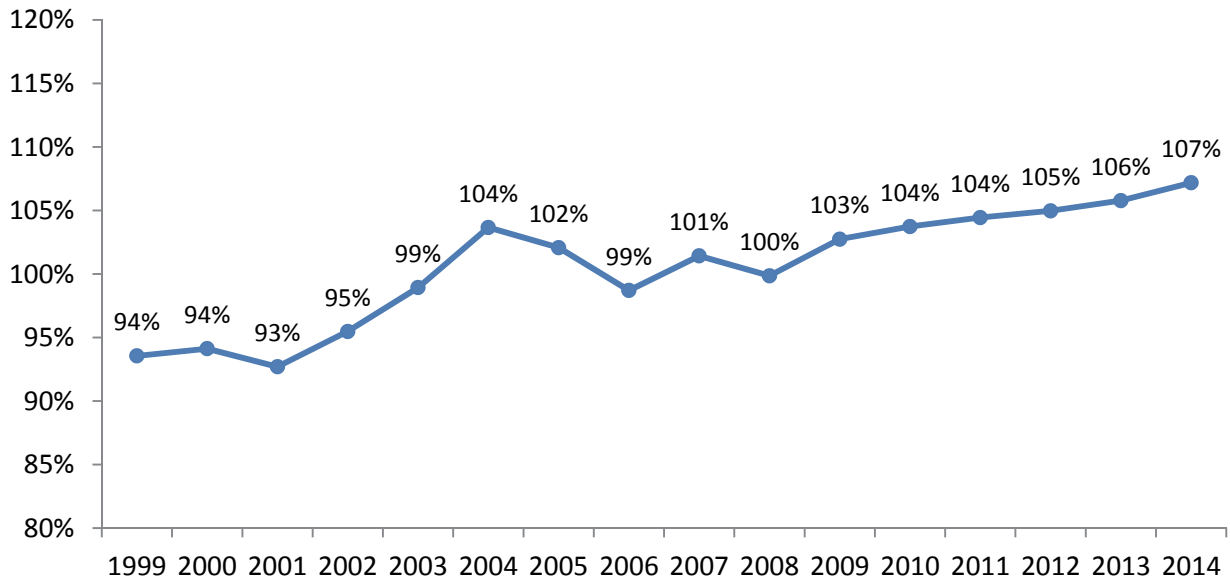
As expected, claims represent a growing percentage of premium payments over time. This reflects both the aging of the in-force policyholder base, as well as the wearing off of the underwriting effect on morbidity. The slow-down in sales of new policies—with lower initial annual loss-ratios—also contributes to the rate at which such ratios are increasing for the industry. The growth in the loss ratio does not represent a problem for the industry as long as the premiums collected are sufficient to fund the expected liabilities priced into the policy. What it does show is how claims are growing and this is typically compared to what the ratio was expected to be. Thus, the most important performance measure is whether the actual incurred claims by an insurer are in line with expected claims paid.

If an insurer anticipated that during a specific year its incurred claims compared to its earned premiums would be 50%, and in fact the ratio of incurred claims to premiums was actually 55%, this would indicate worse than anticipated experience. The converse is also true: If an insurer expected to pay out in claims the equivalent of 50% of its earned premium, and instead paid out 45%, this would suggest better than anticipated experience. An actual-to-expected ratio of 100% suggests experience is exactly in line with what was anticipated. The expected claims underlying the pricing in a policy represent the best estimate for the amount of money the insurer is going to need to pay out on an annual basis, given the age, gender, marital status, and health status of policyholders. If the actual experience does not conform to the initially priced

assumptions, insurers can request rate relief from state insurance departments, and they would be required to file a new set of claims assumptions, which would result in changes to premiums. Figure 6 shows industry-wide average cumulative actual-to-expected losses between 1999 and 2014.

Figure 6: Industry-Wide Actual Losses to Expected Losses (Cumulative)

Source: LifePlans, Inc. Analysis NAIC LTC Experience Exhibit Reports



As shown, there has been variability in cumulative industry performance over the last decade and a half. If we focus exclusively on the last 10 years, in most of these years the actual-to-expected loss experience has been more than 100%, and this has been deteriorating in recent years. Moreover, given this represents cumulative experience, for the ratio to increase by seven percentage points between 2008 and 2014 suggests the annual performance for these years must have been much worse than this. In fact, on an annual basis, between 2010 and 2014, the actual to expected incurred ratio has increased from 111% to 124%. This suggests deterioration in industry-wide performance regarding underlying morbidity assumptions used in the initial pricing of policies.

Market Sizing Summary

Clearly, the industry has undergone significant transformation over the past two decades. There are fewer insurers currently selling policies in the market, there is greater market concentration, and morbidity experience has presented a challenge to Insurers. On the other hand, more than 7 million policies are in-force and there has been significant growth in

combination or hybrid policies. Table 2 summarizes a number of key parameters and their change between 2000 and 2014.

Table 2: Summary of Key Industry Parameters: 2000-2014

Source: LifePlans, Inc. Analysis of NAIC LTC Experience Exhibit Reports

Industry Parameters	2014	2010	2000	Change
Earned Premium	\$11,530,271	\$10,614,816	\$5,155,000	123%
Incurred Claims	\$8,731,136	\$6,350,413	\$1,870,000	366%
Loss Ratio	76%	60%	36%	111%
Actual Losses Incurred to Premiums Earned (%) (cumulative)	48%	42%	34%	41%
Actual Losses Incurred to Expected Losses Incurred (cumulative)	107%	104%	94%	14%
Number of Covered Lives	7,249,783	7,185,760	4,497,120	61%
Industry Concentration: Number of Covered Lives				
Top 5 Insurers	56%	55%	41%	37%
Top 10 Insurers	71%	69%	63%	13%
Top 15 Insurers	80%	78%	74%	8%
Top 20 Insurers	85%	84%	81%	5%
Insurers with Largest Market Share	17%	15%	10%	70%

Product Evolution

As mentioned, in the early 1990s, most insurers began providing more comprehensive policies covering care in a variety of settings, including at home. While early policies expressed the home care benefit as a percentage of the nursing home benefit—typically 50%—today’s policies are integrated in terms of their benefit payments. That means individuals have access to a

“pool of benefits” which can be used to reimburse the costs of services once they are determined to be eligible for benefits. The eligibility threshold is in line with federal Health Insurance Portability and Accountability (HIPAA) standards—having two or more limitations in activities of daily living or having a severe cognitive impairment. Table 3 highlights changes in product design over 25 years.

Table 3: Characteristics of Policies Selling in the Market: 1990-2015

Source: LifePlans, Inc. Analysis of AHIP Reports*

Policy Characteristics	Average for 2015	Average for 2010	Average for 2005	Average for 2000	Average for 1995	Average for 1990
Policy Type						
Nursing Home Only	<1%	1%	3%	14%	33%	63%
Nursing Home & Home Care	99%	95%	90%	77%	61%	37%
Home Care Only	<1%	4%	7%	9%	6%	---
Daily Benefit Amount for NH Care	\$159	\$153	\$142	\$109	\$85	\$72
Daily Benefit Amount for Home Care	\$152	\$152	\$135	\$106	\$78	\$36
Policy Deductible Period	93 Days	90 Days	81 Days	47 Days	46 Days	20 Days
Nursing Home Benefit Duration	3.8 Years	4.8 Years	5.4 Years	5.5 Years	5.1 Years	5.6 Years
Inflation Protection	75%	74%	76%	41%	33%	40%
Annual Premium	\$2,772	\$2,283	\$1,918	\$1,677	\$1,505	\$1,071

* LifePlans analysis of 7,341 policies sold in 2015; 8,099 policies sold in 2010; 8,208 policies sold in 2005; 5,407 policies sold in 2000; 6,446 policies sold in 1995; and 14,400 policies sold in 1990.

Coverage limited to nursing home or institutional alternatives-only has virtually disappeared from the market. Deductible periods have increased and are roughly equal to three months of care. Moreover, the percentage of individuals purchasing some level of protection for increasing LTC costs (i.e., inflation) is about three in four, with roughly half buying compound inflation protection.

The average daily nursing home benefit has increased significantly over the period—by an annual rate of roughly 4%. Given the mix of home care and nursing home service use, this is roughly in line with the rate of inflation in these services over the period. The \$159 daily benefit amount in 2015 would cover about 70% of the average daily cost of nursing home, around 150% of the daily cost of assisted living, and roughly eight hours of home care a day seven days a week.¹⁹ Over the period, there has been a decline in the number of policies with unlimited benefits, a particularly risky policy design, given the uncapped liability faced by the insurer. The desire of insurers to move away from this policy design stems in part from pressure by ratings agencies and fewer reinsurance options.²⁰ It represents one of a number of actions insurers have taken to “de-risk” the product. It is reflected in the fact the average duration of coverage has fallen to about 3.8 years.

Finally, annual premiums have increased significantly over the period, as policy value has increased and as insurers have a body of credible experience on which to make changes to a number of key underlying pricing assumptions. Clearly, new policies reflect a more conservative set of pricing assumptions, especially with respect to interest rates and voluntary lapses. Whereas premium increases in the 1990s were related to the addition of more policy benefits, more recent changes are related to the truing up of pricing assumptions unrelated to benefit changes. Much of the rate increase activity is related to the fact voluntary lapse rates are among the lowest for any insurance product in the market, interest earnings on reserves have been exceptionally low by historical standards, and morbidity experience has been somewhat worse than anticipated. All of these factors together have resulted in significant financial shortfalls for insurers in the face of increasing claims liabilities.

Stand-alone LTCI product designs have largely stabilized over the past five years. As shown, however, there has been growth in linked or combination products—primarily, life and annuity products. The insurance continues to be sold on an individual and group basis, primarily through the employer market.

Consumer Profiles

Roughly 7.2 million individuals have an LTCI policy. The LTC Financing Strategy Group estimated penetration among individuals who are considered to be suitable purchasers (i.e., have incomes

¹⁹ Market Survey of Long-Term Care Costs, 2010. “The 2010 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs,” Met Life Mature Market Institute. This data has been updated to 2015 levels for the purpose of this analysis.

²⁰ Moody’s Investor Service, 2012. “Long-Term Care Insurers Face Uncertain Future,” Global Credit Research, New York. Sept. 19, 2012.

in excess of \$20,000 and are not currently eligible for Medicaid) is 16% of the over age 65 group and about 5% of the 45–64 age group.²¹ The profile of individuals purchasing LTCI has changed dramatically over the last 20 years. As products have become more comprehensive and costly, the proportion of middle income buyers of insurance has declined.

Table 4 summarizes key characteristics of buyers in the individual market. The average age of buyers continues to decline, and most purchasers are working, married, college-educated and have significant levels of income and assets. In the group market, the average age is roughly 46 years. Not shown in the table is the fact most people purchase the insurance to protect current consumption patterns (e.g., maintain standard of living, avoid dependence, maintain affordability of services) rather than to protect assets.²²

Table 4: Characteristics of Individual Buyer of Long-Term Care Insurance by Purchase Year

Source: AHIP 2012 Report

Characteristic	2010	2005	2000	1995	1990
Average Age	59 Years	61 Years	65 Years	69 Years	68 Years
% > 70	8%	16%	40%	49%	42%
% Married	69%	73%	70%	62%	68%
Median Income	\$87,500	\$62,500	\$42,500	\$30,000	\$27,000
% > \$50,000	77%	71%	42%	20%	21%
Median Assets	\$325,000	\$275,000	\$225,000	\$87,500	N.A.
% > \$75,000	%	%	%	%	53%
% College Educated	71%	61%	47%	36%	33%
% Employed	69%	71%	35%	23%	33%

One of the ways policymakers have worked to expand the private insurance market to reach middle income adults is to support Partnership Programs. These programs, which represent a partnership between state Medicaid programs and the private insurance industry, are designed to enable individuals who purchase qualified LTCI policies to access Medicaid benefits without having to spend down their assets to Medicaid levels, if and when their LTCI benefits are

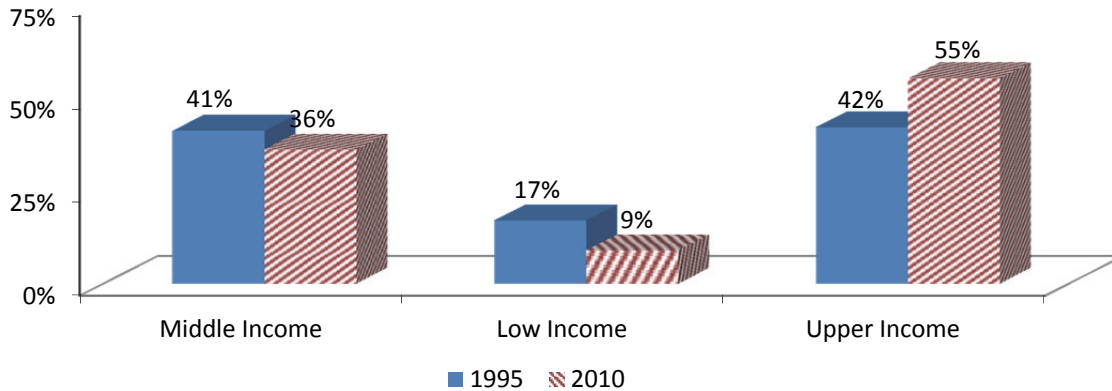
²¹ LTC Financing Strategy Group, 2008. Washington, D.C.

²² Authors' analysis of data summarized in AHIP Study of Buyers and Non-Buyers of Private LTCI in 2010, Washington, DC.

exhausted. A growing number of states—upwards of 45 by the end of 2012—have implemented such programs.²³ Even so, few people age 50 and over—less than 25%—actually know whether their state has a Partnership Program. However, the Program does hold appeal, as 45% of a random sample of individuals over age 50 indicated they would likely purchase a policy if their state participated in a Partnership Program.²⁴ By 2015, Partnership policies were a very meaningful proportion of sales: slightly more than two in five new policies sold were Partnership Policies.²⁵

Another way to reach middle income buyers which has been encouraged is the provision of tax incentives. Today, more than half the states provide tax incentives for the purchase of LTCI policies, and most of these are linked to qualified policies.²⁶ Even so, there is little evidence such policies have led to a discernible effect on LTCI take-up rates. This is not too surprising given the value of incentives is fairly low compared to the costs of the policies themselves.²⁷ As shown in Figure 7, any positive impacts associated with Partnership policies and tax policies on middle class take-up rates have been more than offset by overall price changes in the product: the share of the middle income market purchasing LTCI is declining.

Figure 7: Share of Middle Income Buyers
Source: LifePlans, Inc. Analysis of Buyers and Census Data



Note: Low income is defined as less than 33% of income distribution, middle income equals 33%–66% of income distribution and high income is greater than 66% of income distribution.

²³ Website on Partnership Programs: <http://w2.dehpg.net/LTCPartnership>

²⁴ Who Buys Long-Term Care Insurance in 2010-2011? A Twenty-Year Study of Buyers and Non-Buyers, AHIP, 2012

²⁵ Presentation to the 16th Intercompany Long-Term Care Insurance Conference (2016). New Research, San Antonio, Texas, March 15.

²⁶ Stevenson, D., R. Frank, and J. Tau, 2009. "Private Long-Term Care Insurance and State Tax Incentives," *Inquiry*, Vol. 46, No. 3, pp. 305-321.

²⁷ Wiener, J. M., J. Tilly, and S. M. Goldenson 2000. "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance," *Elder Law Journal* 8(1):57-99.

For individuals who have been approached by agents and choose not to buy a policy, most—between 55% and 60%—cite cost as the primary impediment to purchase. Other far less prevalent reasons for non-purchase include the difficulty of choosing a policy, a lack of confidence in insurers to pay benefits as stated and the desire to wait to see if better policies come on the market.²⁸

Consumer Experience

As claims grow, a concern raised by consumer advocates and regulators alike is whether the claims process is efficient and fair to those filing for benefits. As part of a broader longitudinal study funded by the U.S. Department of Health and Human Services (HHS), roughly 1,400 claimants were asked a series of questions about their experience filing a claim with the Insurer.²⁹ Individuals were interviewed at four-month intervals after having filed a claim or having expressed intent to file a claim at a baseline interview. The majority of those filing claims (89%) reported they were approved and had become “claimants,” while 7% reported they were still waiting for a decision. Only 4% reported their claims were denied. Of these denials, the majority stated the reason for the denial was they were not disabled enough to meet policy definitions. More than half of these initial denials were subsequently accepted for claim payment during the next 12-month period.

All individuals filing for claim were also asked if they had any disagreements with their insurer over coverage or eligibility for benefits and if so, were they resolved to their satisfaction. An overwhelming majority of those who had been approved (97%) either reported no disagreements or that their disagreements were resolved satisfactorily. Not surprisingly, 60% of the small number of individuals whose claims were initially denied reported having disagreements with their insurer which were not initially resolved to their satisfaction. However, four months later, among those who were approved and those denied, 94% reported having no disagreements with their insurance company or reported that their disagreements were resolved satisfactorily. In total, 77% did not find it difficult to file a claim.

Taken together, these data suggests that at the time people need to rely on their insurance, the vast majority are able to do so. That is, claims denial rates are low, typically the reasons why

²⁸ AHIP, 2012. “Who Buys Long-Term Care Insurance in 2010 – 2011? A Twenty-Year Study of Buyers and Non-Buyers (in the Individual Market)

²⁹ U.S. Department of Health and Human Services, 2008. “Following an Admissions Cohort: Care Management, Claim Experience and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Twenty Eight Month Period.” Final Report, Washington, DC.

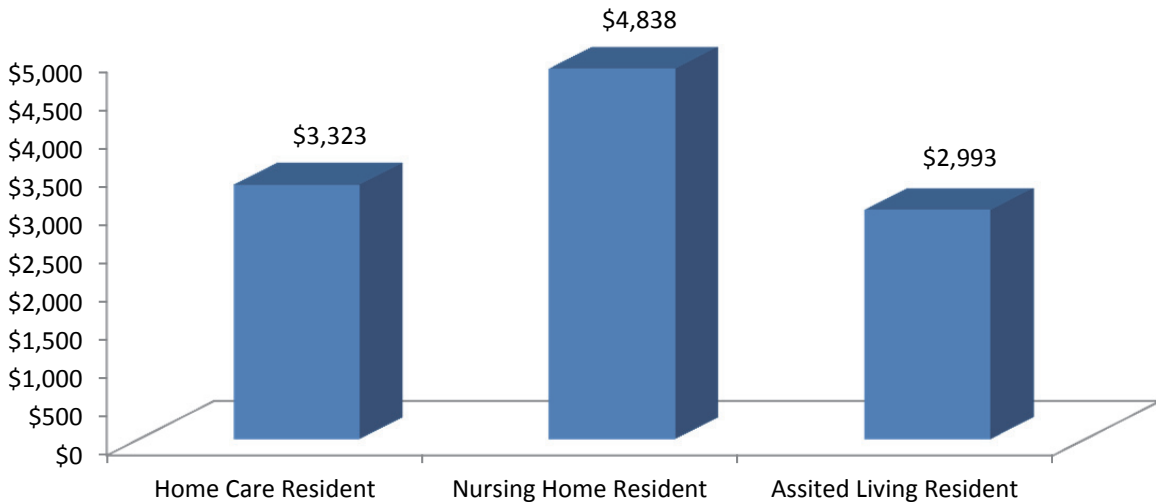
people are denied payments are in line with the policy requirements and when disagreements do arise, they tend to be dealt with constructively by the insurer. This does not mean process errors and incorrect decisions do not occur. Clearly, they do. However, based on the evidence, these tend to be more the exception than the general rule regarding industry performance.

In terms of the financial benefits to consumers, data indicate between 69% and 75% of claimants reported their policies were paying for most or all of their care at any given time during the course of a year.³⁰ Clearly, those who purchase LTCI do so in the hope should they need care, their policies will pay for most of it and their out-of-pocket expenses will be reduced.

Figure 8 shows the average amount of money a privately insured disabled elder saves each month he or she receives services. As shown, between \$3,000 and \$5,000 a month is currently being saved on LTC expenses, depending on service setting. This underscores a previous point that within a very short time, the insurance premiums paid out will be more than offset by the benefits received if services are needed.

Figure 8: Impact of LTC Insurance on Monthly Out-of-Pocket Expenditures (2014)

Source: Department of Health and Human Services, MetLife



³⁰ Department of Health and Human Services, 2007. "Following an Admissions Cohort: Care Management, Claim Experience and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Sixteen Month Period," Washington, DC.

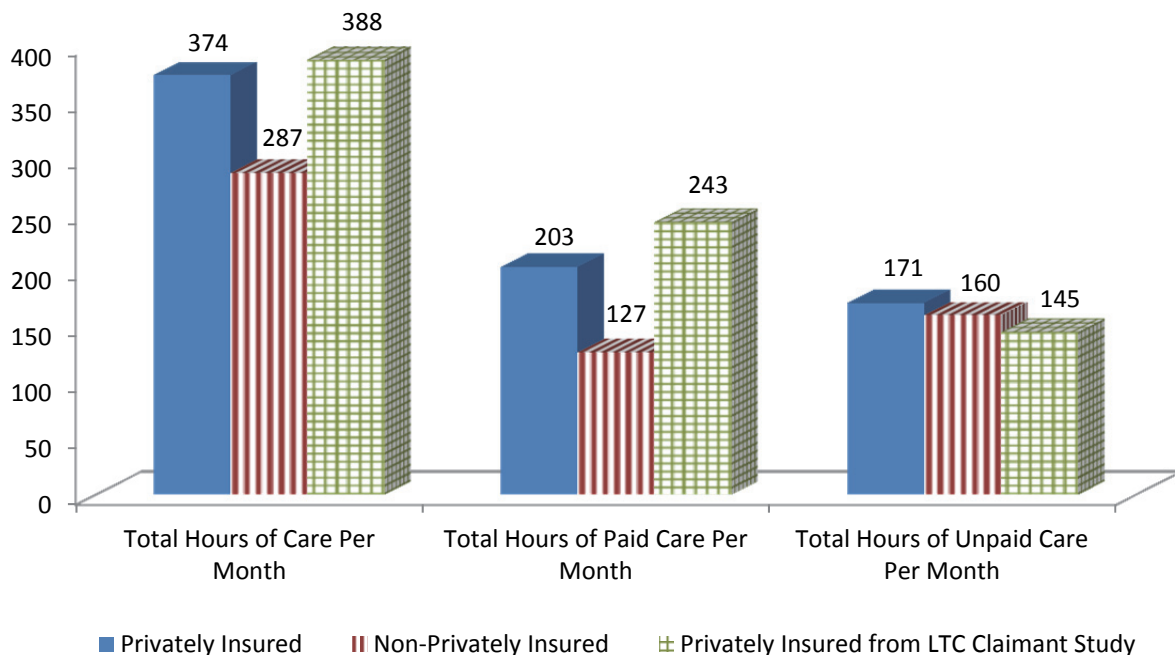
Since the average amount of time spent in a nursing facility is about two years, the reduction in out-of-pocket nursing home costs is about \$116,000. To the extent people in assisted living facilities receive benefits for about 2.3 years, which they typically do because of their lower level of disability, their out-of-pocket payments are reduced by more than \$80,000. Finally, the reduction in out-of-pocket home care costs in the home care setting is about \$78,000. In this case, individuals typically have a higher level of need than in assisted living settings, and the duration of care is typically about two years.

A closely related and important issue is the extent to which having LTCI leads to more hours of care received and potentially to a reduction in unmet needs. Given the costs of care, it is conceivable non-insured individuals may face greater financial pressures to rely on unpaid (family) caregivers or cut back on the total hours of care. Figure 9 compares the total hours of paid and unpaid care received for individuals with and without LTCI coverage.

Figure 9 clearly demonstrates individuals who are privately insured receive more hours of paid care than those without insurance. In fact, depending on data source, insurance leads to between a 60% and 91% increase in the amount of paid care an individual received.

Figure 9: Monthly Hours of Care for Disabled Home Care Recipients by Insurance Status

Source: AHIP



Equally important, the level of unpaid assistance for the insured samples is only between 6% and 15% lower than for those without insurance. The implication is insurance-financed benefits do not replace family caregiving, but rather they change the nature of caregiving away from direct hands-on assistance with activities of daily living (ADLs) to greater amounts of companionship care. In total, privately insured individuals receive between 30%–35% more total hours of care than do those without insurance. This is true holding constant the level of disability across samples. Not shown in Figure 9 is the fact the reported level of unmet/under-met needs among the privately insured individuals is lower than what is reported for those without insurance. In fact, privately insured disabled individuals were only 0.71 times as likely to report having an unmet/under-met need as those without private insurance.³¹ Thus, the extra hours afforded by the insurance leads to a reduction in reported levels of unmet/under-met need.

Insurer Challenges

With few exceptions, most insurers which stopped selling LTCI policies did so over the past decade. In fact, more than half of insurers in the sample have exited the market (or specific market segments) in the past eight years. In a relatively recent report published by the HHS, executives at major insurers who had exited the market reported their primary reasons for doing so.³² In broad terms the reasons can be related to profit, risk, internal management, sales and distribution, public and regulatory policy, or other issues posing challenges to insurers. Product performance—not hitting profit objectives—was the most cited reason for leaving the market. Incorrect assumptions about two underlying pricing assumptions—voluntary lapses and interest rates—have had a lot to do with this and have been key drivers behind the need of many insurers to increase rates on products.

The concern about the ability to obtain needed rate increases from state insurance departments was the second most cited reason for market exit. Slightly more than half of respondents also cited high capital requirements as a reason for exiting the market. It is noteworthy only a single insurer cited an unfavorable public policy environment specifically as a reason for exiting the market.

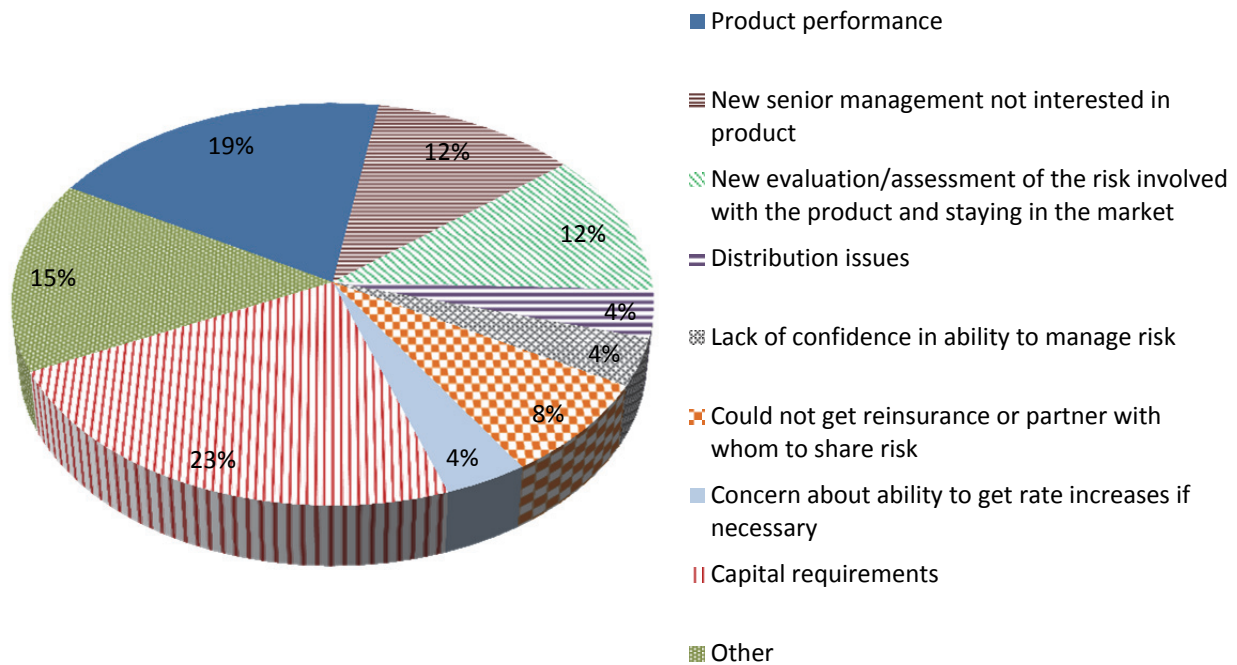
³¹ AHIP, 2014. “The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing,” Washington, DC.

³² U.S. Department of Health and Human Services. 2013. “Exiting the Market: Understanding the Factors behind Carriers’ Decision to Leave the Long-Term Care Insurance Market,” July 2013. Washington, DC. <https://aspe.hhs.gov/basic-report/exiting-market-understanding-factors-behind-carriers-decision-leave-long-term-care-insurance-market>

Figure 10 highlights the point that a high capital requirement to support the product was cited most frequently as the most important reason for market exit. Product performance is the second most cited reason. Product performance is the second most cited reason. Other reasons cited include a concern continued focus on LTCI detracted from other core products, and that tax qualification guidelines inhibited certain innovative product design. In terms of classifying these reasons into major categories, slightly less than half are related to profitability, about a quarter to risk issues and a quarter split out across the other reasons.

Figure 10: Single Most Important Reason an Insurer Left the Market

Source: U.S. Department of Health and Human Services



Concerns related to capital requirements and rate increases may represent something unique about the structure and regulatory requirements relating to LTCI having a major impact on profitability. Long-term care insurance is a guaranteed renewable product, which means as long as an individual pays the premium, the insurance company must continue to honor the coverage. Premiums are not guaranteed, although they are designed to be level-funded over the life of the policy. This means if the actual experience of any of a number of underlying pricing assumptions (claims, interest rate, mortality, voluntary lapse rates, etc.) varies from what was anticipated, the financial viability of the product can be threatened, unless there is an adjustment to rates.

Rate adjustments can only occur with the permission of individual state insurance departments. Rate increases would typically be sought for policies which have been in the market for enough time to gain credible experience. This means policyholders would typically be older and more likely to be on fixed incomes at the time an insurer might be seeking a rate adjustment. Given the sensitivity around increasing rates for older policyholders, it is not surprising insurers are concerned about their ability to raise rates. In fact, many insurers have experienced significant challenges obtaining the level of rate increases they request, even when such increases may be actuarially justified. For example, an insurer may request (and require) a 35% rate increase, yet be allowed to adjust premiums by only 15%. This does not mean regulators have ignored requests for rate adjustments. With few exceptions, most insurers have increased rates on some—if not all—of their policy series, and clearly the increases have been significant.³³

The capital requirements for LTCI are high relative to other products such as health and life insurance. High capital requirements are due to the long-term nature of the coverage and other “unknowns” which make the product inherently more risky. Thus, the actual required capital is very high per dollar of earned premium or reserves because of the perceived product risk, the long-term nature of the guaranteed renewable coverage, and the fact rating action impacts are muted as policyholders continue to age.³⁴ The implication is that it has been very difficult for insurers to effectively manage the product and assumes its underlying profitability.

Concluding Thoughts on LTCI Market

By almost all measures, the private market for LTCI has under-performed. Yet no one disputes the need for a product which insures against the financial risk associated with LTC services, nor is there an argument about the fact this need will increase over time. There are a number of actions insurers should consider in order to make the product more manageable. These include (but are not limited to): 1) changing the underlying funding structure so products might be priced on a “term-basis” up to a certain age—much like life insurance; 2) indexing both premiums and benefits to account for increases in the cost of services in order to reduce the uncertainty around the inflation risk, as well as lower initial premiums; and 3) finding creative ways to reduce selling costs.

³³ California Department of Insurance website relating to rate histories of LTC insurance companies. <http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/ltc-rate-history-guide/index.cfm>

³⁴ Personal communication with Don Charsky, FSA President of Ability Re and Ray Nelson, FSA Senior Actuary at Ability Re.

For their part, state insurance regulators could provide insurers with more certainty regarding the anticipated actions which would be taken in the context of requested rate adjustments. State insurance regulators must of course balance insurer solvency and consumer protection, and it is not the role of regulators to guarantee a certain level of profit to insurance companies. Nevertheless, the concern about being able to obtain rate changes, when state-approved actuarial assumptions have not been met, is real: The product is priced to be guaranteed renewable but not non-cancellable.³⁵

There are a variety of reasons why it is difficult to sell the product and these have been outlined—along with potential solutions—in Frank et al. 2013.³⁶ Some of the reasons relate to household behaviors associated with savings, purchase of insurance and health-related behaviors (i.e., demand) and others with the efficiency of the private insurance market (i.e., supply). Solutions include strategies linking LTCI to health insurance, simplifying the product, providing more support for employer-sponsorship of insurance, educating the public about the risk and costs of LTC, forcing active choice, providing state-based organized reinsurance pools to provide a “back-stop” for industry experience and implementing targeted subsidies. All of these strategies are designed to increase demand—both through lowering selling costs and through changing peoples’ attitudes about the value of LTCI—and help address risk challenges facing the industry.

Without question, current strategies have not worked well in assuring broad consumer appeal and insurer enthusiasm. Although the market has experienced a very major contraction in the number of insurers actively selling policies, it is worth noting the LTCI market covers more than 7 million Americans, and there is a great deal of coverage available to these individuals. Moreover, at claim time, consumers are receiving significant benefits from their policies, and insurers service these claims well.

Continued demographic, budget and mortality trends mean the demand for LTC services will only grow putting families/elders at risk. For the market to thrive and grow, the industry needs to be outward-looking focusing on new product designs provided at more affordable price points as well as distribution partnerships with public payers, providers, and health plans.

³⁵ A guaranteed renewable product in this context means that the insurer cannot cancel a policy if the individual continues to pay premiums. However, the insurer does have the right to change premiums based on credible experience for a class of individuals. A non-cancellable policy implies that the insurer cannot change premiums once they are set, regardless of whether or not pricing assumptions are met.

³⁶ Frank, R., M. Cohen, and N. Mahoney, 2013. “Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance,” unpublished policy brief submitted to The SCAN Foundation.

There remains a critical role for public sector support of the market on both the demand and supply fronts. While LTCI has an important role to play—a role which has not yet been fully realized—it will likely be in the context of new models of public and private financing partnerships. Only in this way will the nation be able to address the challenge of meeting the LTC needs for its citizens.

Economics and Benefits of Private Long-Term Care Insurance



Economics and Benefits of Private Long-Term Care Insurance

By Marc A. Cohen, Chief Research and Development Officer, LifePlans, Inc.

Introduction

Long-term care (LTC) represents one of the greatest financial risks facing Americans during retirement. These services, which typically include institutional care (i.e., nursing home and assisted living facilities) and home-based assistance, are provided to meet the health or personal care needs of individuals for an extended period of time. More specifically, when an individual can no longer perform basic living activities like bathing, dressing and others—activities of daily living (ADLs)—without human assistance or supervision, they have an LTC need. Although the need for LTC can arise at any age (40% of people who need care are under the age of 65), the doubling of the elderly population over the coming decades means a substantial increase in the numbers of people who will need LTC. This is because as people age, the risk of becoming dependent for help with ADLs increases. Currently, upwards of 12 million people have some level of need, and among those, 6.3 million have high need because they have limitations in two or more ADLs or are severely cognitively impaired and require help.^{37,38} By 2050, the number of people who need assistance due to a high need is projected to approach 15 million.

As the need for care increases, so too does the cost associated with meeting this need. Paying for LTC continues to be one of the great financial risks facing Americans during retirement. Current estimates suggest the annual costs of care in a nursing home are roughly \$85,000, and home health care can cost upwards of \$25,000 per year.³⁹ Moreover, recent data suggests on average, Americans turning age 65 today can expect to incur \$138,000 in future costs with roughly half being paid out of pocket.⁴⁰ Currently, less than one-third of individuals have more than \$70,000 in non-housing assets saved for retirement, and almost half less than \$10,000. Moreover, in 2014, adults ages 65 and older had median financial assets of only \$76,000 and

³⁷ Kaye, H.S., C. Harrington, and M.P. LaPlante, 2010. "Long-term care: Who gets it, who provides it, who pays, and how much," *Health Affairs*, 29(1):98

³⁸ ASPE, 2015. "Long-Term Services and Supports for Older Americans: Risk and Financing," Issue Brief. HHS Office of the Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, Washington, DC.

³⁹ Genworth Financial, 2015. "Genworth 2015 Cost of Care Survey Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes," Richmond, Virginia.

⁴⁰ ASPE, 2015. "Long-Term Services and Supports for Older Americans: Risks and Financing," Issue Brief, Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy, Washington, DC.

median home equity of only \$80,000.^{41,42,43} Thus, this significant financial risk confronts the vast majority of Americans. The fact that about a quarter of individuals with high need will spend more than two years needing intensive levels of care highlights the significant financial risk this presents as people age.

Out-of-pocket spending for paid care is high, but it is small compared to the economic value of unpaid LTC provided by families and communities. In 2013 alone, family and friends provided an estimated 37 billion hours of uncompensated LTC for adults, worth an estimated \$470 billion.⁴⁴ This represents a figure which is more than double what public programs spend on LTC. In addition, the personal costs of providing such care are significant. The majority of unpaid working family caregivers report reducing work hours, taking unpaid leave, experiencing declines in their personal health and well-being, and putting their own retirement funds at risk when caring for a disabled family member.^{45,46} As a result, they lose an estimated \$3 trillion in lost lifetime wages and benefits.⁴⁷ Employers also incur significant costs with estimates showing annual absenteeism financial losses of between \$17 billion and \$33 billion and schedule-related changes costing \$17.7.^{48,49}

Finally, there are stressors on the public LTC financing system. Given the growth in the elderly population and increases in longevity, public payments for LTC are significant and growing. The largest public payer of LTC is the means-tested Medicaid program, which pays roughly two-thirds of total costs. In 2012 this federal-state program expended \$220 billion and represented

⁴¹ Jacobson G, C. Swoope, T. Neuman, and, K. Smith, 2015. "Income and assets of Medicare beneficiaries, 2014-2030," Menlo Park, CA, Henry J. Kaiser Family Foundation, <http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030>.

⁴² Feder J., and H. Komisar, 2012. "The Importance of Federal Financing to the Nation's Long-Term Care Safety Net," The SCAN Foundation.

⁴³ Porteba, J., and S. Venti, and D. Wise, 2012. "Where they Prepared for Retirement? Financial Status at Advanced Ages in the HRS and AHEADS Cohorts," NBER Working Paper No. 17824, <http://www.nber.org/papers/w17824.pdf>

⁴⁴ Reinhard, S. C., and L. F. Feinberg, and R. Choula, and A. Houser, 2015. "Valuing the Invaluable: 2015 Update: Undeniable Progress, but Big Gaps Remain," AARP Public Policy Institute, <http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf>

⁴⁵ AARP Public Policy Institute, 2011, "Valuing the Invaluable: 2011 Update, The Economic Value of Family Caregiving," <https://www.caregiver.org/selected-caregiver-statistics>

⁴⁶ Genworth Financial, 2015. "The Expanding Circle of Care: Beyond the Dollars 2015," Richmond, Virginia, <https://pro.genworth.com/riiproweb/productinfo/pdf/157453C.pdf>

⁴⁷ Houser, A., et al. 2008., "Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update," AARP Public Policy Institute http://www.aarp.org/relationships/caregiving/info-11-2008/i13_caregiving.htm

⁴⁸ Gallup Healthways Wellbeing Survey, 2011. "Caregiving Costs U.S. Economy \$25.2 Billion in Lost Productivity," <https://www.caregiver.org/selected-caregiver-statistics>; MetLife Study of Working Caregivers and Employer Health Costs: National Alliance for Caregiving. 2010. <https://www.caregiver.org/selected-caregiver-statistics>

⁴⁹ Met Life Mature Market Institute, 2013. "The MetLife Study of Working Caregivers and Employer Health Costs: National Alliance for Caregiving."

roughly 9% of total personal health care spending.⁵⁰ In order to qualify for public payments through the Medicaid program, individuals must impoverish themselves by first depleting their assets to pay for care. Often people cannot receive care in the setting of their choice because Medicaid restricts the providers it will cover and there is still a bias toward nursing home settings. The program typically does not pay for care in more preferred assisted living environments. Even with these restrictions, due to the aging of the population along with reductions in retirement savings, Medicaid is one of the fastest growing health programs in the country. Its growth is creating significant budgetary pressures on the states.

Medicare plays only a very minor role in financing LTC. The purpose of the program is to cover acute and post-acute medical care for people age 65 and older. Medicare also will pay acute care costs for younger individuals who qualify for Social Security benefits due to a disability. Medicare will pay small amounts of supportive service so long as they are accompanied by a skilled care need. For example, it will pay medically necessary home health services but only for home-bound beneficiaries. It will not cover supportive non-skilled home care services for those who need care due to functional impairment, frailty or cognitive impairment. The program also covers skilled nursing facility (SNF) care following a hospital stay of at least three consecutive days for those who require daily skilled nursing and/or rehabilitation services for up to 100 days of care.

The difficulties public financing systems have securing adequate resources to respond to the growing demand for LTC means the more than 10,000 people a day who are turning age 65 have little but their own resources to rely on to pay for future LTC costs in settings of their choosing. The implication is that for individuals and families facing LTC needs, the gap between their resources and the costs of care is significant and expected to grow in the years ahead.

Private insurance covers a small—less than 10%—but growing share of LTC expenses. Yet the market is underdeveloped and has not fared well over the last decade.⁵¹ Between 7 million and 8 million people have long-term care insurance (LTCI) policies.⁵² That number is less than 10% of the people who are estimated to be able either to afford private insurance or to qualify

⁵⁰ National Health Policy Forum, 2014. “National Spending for Long-Term Services and Supports,” Washington, DC. March 27, 2014, <https://www.nhpf.org/library/details.cfm/2783>

⁵¹ M. Cohen, R. Kaur, and B. Darnell, 2013. “Exiting the Market: Understanding the Factors behind Carriers’ Decision to Leave the Long-Term Care Insurance Market,” Report to the Office of the Assistant Secretary for Planning and Evaluation, Aging, Disability and Long-Term Care Policy, Department of Health and Human Services, Washington, DC., <https://aspe.hhs.gov/basic-report/exiting-market-understanding-factors-behind-carriers-decision-leave-long-term-care-insurance-market>

⁵² AHIP, 2014. “The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing,” Washington, DC., November 2014, <http://www.ahip.org/Epub/The-Benefits-of-LTC>

based on underwriting criteria.⁵³ The reasons for this under-demand include: 1) misperceptions about need, costs, and coverage; 2) consumer myopia and confusion about a product often complex and difficult to understand; 3) mistrust of insurance products for which premiums have risen and value in the policy declined; 4) and a lack of information about the product as well as shrouded attributes relating to the insurer. Supply side issues plaguing the industry include: 1) adverse selection; 2) high selling costs; 3) over-estimates of lapse rates; 4) and inefficient risk-bearing due to common shocks—that is, risks common to the entire population and not just individual insureds.⁵⁴ Although the market is currently experiencing challenges, the total value of potential insurance payments to policyholders is substantial. Policies are expected to pay out roughly \$1.4 trillion over the coming decades.⁵⁵

Current negative trends in the market do not diminish the very unique advantages to addressing LTC through an insurance mechanism. In this section of the study, we will review information demonstrating the importance of using insurance to meet the LTC financing challenge, point out some of the important benefits of doing so, and show how insurance programs can reduce public expenditures. Part of the reason why this is important is to assure public dollars are allocated to lower income individuals who cannot afford or qualify for private alternatives.

Why Insurance?

Insurance for LTC presents a reasonable basis on which to address the LTC risk. The distribution of need for expensive LTC is skewed and unpredictable, even for people now turning age 65. Table 5, which is based on new data and modeling from the Urban Institute, highlights this fact and focuses on people with “high” need—that is, those who have at least two limitations in performing ADLs or are cognitively impaired. Ignored for the purposes of this discussion are the millions of people who have lower levels of need, and still incur significant financial and family caregiving related costs.

As shown in Table 5, given this definition of LTC need, slightly more than half (52%) of individuals turning age 65 will have a high need over their lifetime. This need on average is

⁵³ J. Cutler, B. Spillman, and EJ Tell, 2010. “Private Financing of Long-Term Care: Market Penetration and Market Potential,” Presentation to Academy Health ARM Conference, Boston, MA.

⁵⁴ R. Frank, M. Cohen, and N. Mahoney, 2013. “Making Progress: Expanding Risk Protection for Long-Term Care Services and Supports through Private Long-Term Care Insurance,” *The Journal of the Business School Alliance for Health Management*, Kellogg School, Northwestern University, September, Volume 1, Issue 4. <http://www.hmpi.org/journal.html> and the SCAN Foundation.

⁵⁵ AHIP, 2014. “The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing,” Washington, DC., November 2014, <http://www.ahip.org/Epub/The-Benefits-of-LTC>

expected to last about two years, although for 26% of individuals, it will last longer. Moreover, there is an inverse relationship between length of need and income. For example, whereas 22% of individuals in the highest income quintile will require care for more than two years, for individuals in the lowest quintile, the proportion increases to 31%. Finally, people in the lower income quintiles rely on unpaid care for a longer portion of their impairment periods than do people with higher incomes. Specifically, about 44% of the impairment period for individuals in the lowest quintile is spent receiving paid care, whereas the comparable figure for those in the higher quintiles is 53%. Also noteworthy is the fact slightly less than half of individuals will not have a high LTC need at all, although as mentioned, they may experience lower levels of need and associated costs.

Table 5: Lifetime Need for LTC for Persons Turning 65 in 2015-2019 by Gender and Income

Source: Department of Health and Human Services

	% With LTC Need	Average Years of High LTC Need	Average Years with Paid LTC	Distribution of need (% of cohort)				
				None	< 1 Year	1-1.99 Years	2-4.99 Years	>= 5 Years
Men	46.7	1.5	0.7	53.3	18.4	7.4	11.1	9.8
Women	57.5	2.5	1.3	42.5	19.4	8.1	12.3	17.8
Income Quintiles								
Lowest	55.3	2.7	1.2	44.7	17.6	7.1	11.7	18.9
Second	53.2	2.3	1.2	46.8	16.8	7.0	12.7	16.7
Middle	53.9	2.2	1.1	46.1	18.7	8.1	12.4	14.7
Fourth	49.7	1.8	0.9	50.3	19.5	7.4	10.6	12.2
Highest	51.1	1.5	0.8	48.9	20.7	8.7	11.6	10.1
Total	52.3	2.0	1.0	47.7	18.9	7.8	11.7	13.9

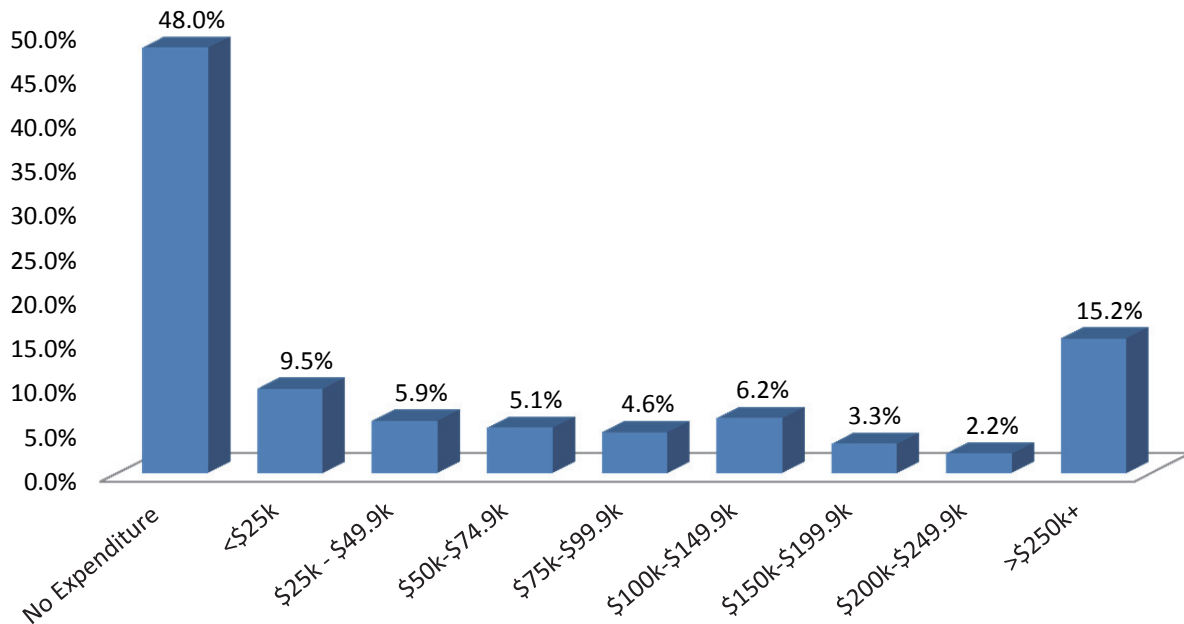
As shown in Figure 11, roughly 20% will have lifetime expenditures in excess of \$150,000 and three-quarters of them—roughly 15% of all individuals—will have expenditures exceeding \$250,000.⁵⁶ The average lifetime expenditure before death for all individuals turning 65 over

⁵⁶ ASPE, 2015. “Long-Term Services and Supports for Older Americans: Risks and Financing,” Issue Brief, Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy, Washington, DC., <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research->

the next three years (2016 to 2019) is \$138,000. This extremely skewed distribution lends itself to risk pooling, and the benefits of doing so are presented in the following section.

Figure 11: Expected LTC Costs From Age 65 to Death for Those Turning 65 in 2015—2019 (Thousands)

Source: U.S. Department of Health and Human Services



The Benefits of Insuring⁵⁷

One way to evaluate the value of insurance for LTC is by comparing the premiums a policyholder could expect to pay over his/her lifetime with the maximum benefits they might receive if care were needed. Data for this analysis was based on actual policyholder purchase patterns and privately insured claimant information.^{58,59} Figure 12 shows that a person buying a policy at age 60 will have paid approximately \$52,000 in premiums by the time he/she is age 82,

brief, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>

⁵⁷ Note: Many of the subsequent findings are based on a study conducted for AHIP in 2014 and entitled: The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing (2014) Washington, DC.

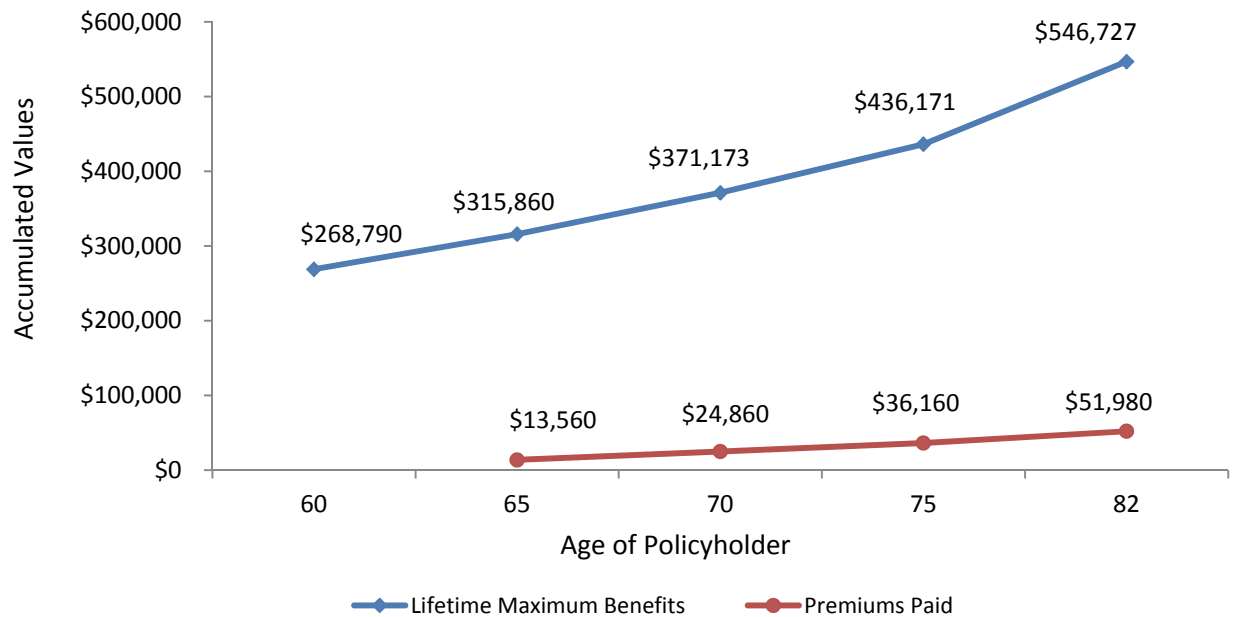
⁵⁸ U.S. Department of Health and Human Services, (2006 “Service Use and Transitions: Decisions, Choices, and Care Management among an Admissions Cohort of Privately Insured Disabled Elders,” Draft Baseline Interview Report, Washington, DC., <https://aspe.hhs.gov/pdf-report/service-use-and-transitions-decisions-choices-and-care-management-among-admissions-cohort-privately-insured-disabled-elders>

⁵⁹ Cohen, M., J. Gordon, and J. Miller, 2011. “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers,” America’s Health Insurance Plans, Washington, DC.

at which time he/she would be entitled to a maximum monthly benefit of \$9,492 for 4.8 years, or roughly \$547,000 of total benefits. This premium/benefit relationship could also be expressed in these terms: Roughly 22 years of premium payments (\$52,000) would be returned to a policyholder as claims payments after only about five months of service-related payments at the level of the full daily insurance benefit.

Figure 12: Expected Total Premiums Paid and Policy Benefit Value over Time (60-year-old Buyer)

Source: U.S. Department of Health and Human Services



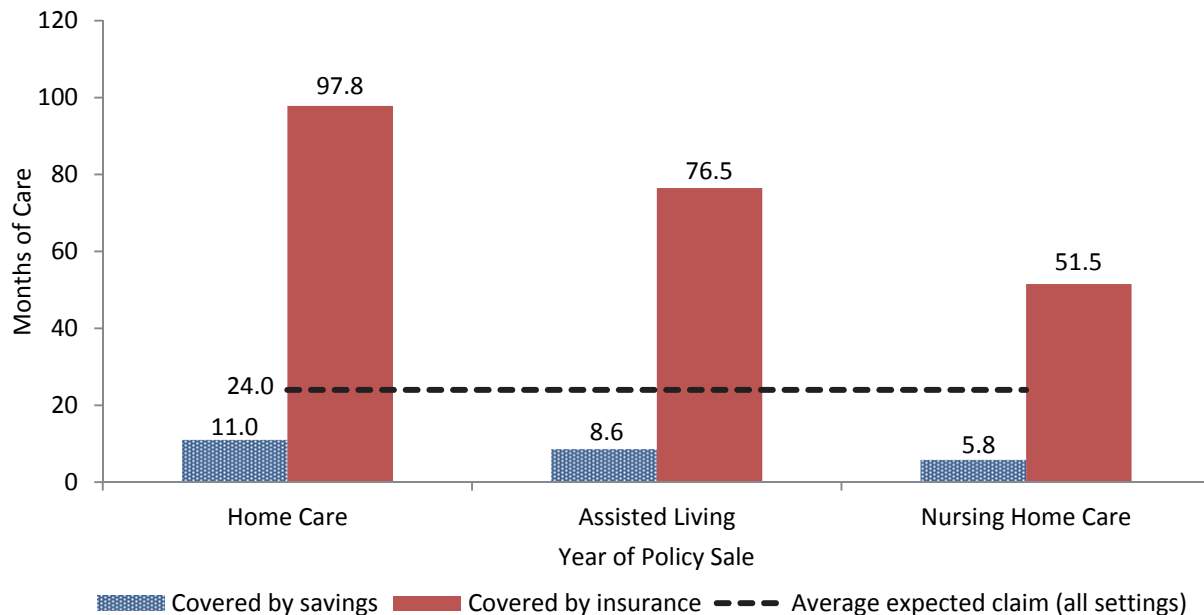
Another way to look at this issue is to ask how much money one would have to save in order to self-fund the amount available from a policy at claim time. To accumulate the average lifetime benefit amount of \$547,000 by the age of 82 (starting at age 60), one would have to set aside a little more than \$1,666 each month for the 22-year period (assuming 2% interest compounded annually). Compare this to the average monthly insurance premium of \$188 for a similar level of benefit. For most Americans, setting aside \$1,666 a month is not an affordable option. However, for many individuals in the top three income quintiles, paying a premium of less than \$200 is achievable.

There is also an underlying aspect to LTCI which “leverages” the impact of risk pooling to enable a much higher level of benefit payout compared to a savings approach. To illustrate the point the amount of care available to an individual is simulated under two scenarios: 1) paying

premiums for an LTCI policy; and 2) taking the premiums and investing them in the market.⁶⁰ Figure 13 shows the number of months of care that would be covered by policies sold in 2010 compared to the alternative of setting aside the savings to pay for care in different settings. As shown, individuals saving an amount equal to the insurance premium do not accumulate enough to pay even average LTC costs—in fact, their savings fall far short—by as much as 20 months or more. Insurance benefits, on the other hand, far exceed average costs, in most cases by a few years or more. In other words, while savings do not cover even average costs, insurance covers some but not all catastrophic situations, when much more than the average duration of care is needed.

Figure 13: Expected Months of LTC Costs Covered by Savings vs LTCI by Setting

Source: LifePlans, Inc.



The Benefits of Insurance for Policyholders

Clearly, given the distribution of need, some individuals who insure will pay premiums for many years and receive no benefits—because they will not have LTC needs—and others will pay premiums and receive benefits far in excess of the premiums they paid. This is the nature of all

⁶⁰ Note: For the savings approach, we assumed that, starting at age 60, the individual places the money she would have spent on the LTC premium in an investment that earns 3% interest annually, and we calculated the amount accumulated by age 82. We then projected care costs for each setting and calculated the amount of care covered by the insurance benefits and by the savings.

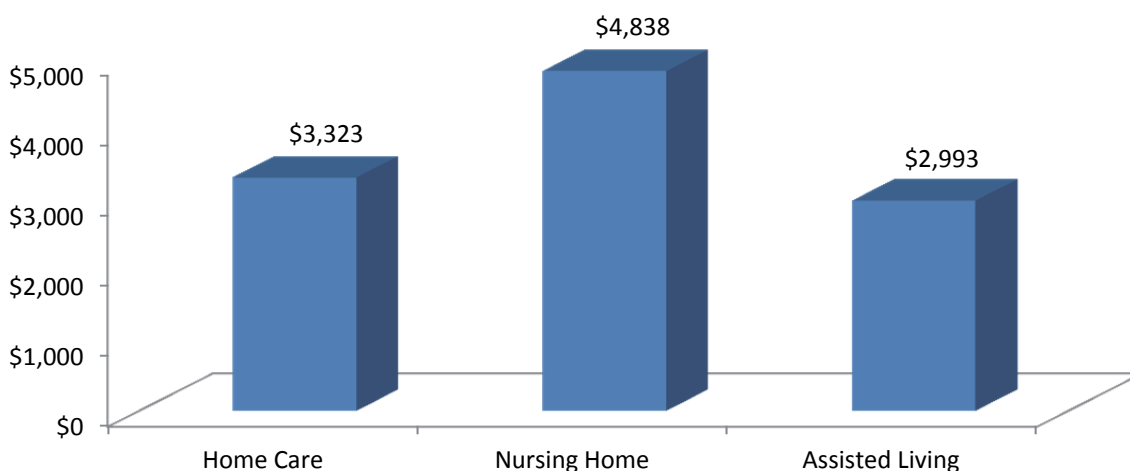
insurance, and in particular, those coverages designed to protect individuals against catastrophic risk, such as is the case with LTC.

People receive the peace of mind or psychological benefits associated with knowing that should the unpredictable event occur, they are protected. By removing the volatility associated with future potential LTC expenses, consumers can better plan for other more predictable expenses during retirement.

A major benefit of insurance is to reduce out-of-pocket costs, so people can continue to live at an economic standard roughly in line with pre-disability levels. Figure 14 shows the average amount of money an insured person would receive in benefits and, therefore, have to spend their own resources. Depending on the care setting, this amount ranges from \$3,000—\$5,000 a month (in 2014 dollars).^{61,62}

Figure 14: Reduction in Monthly Out-of-Pocket LTC Expenditures by Individuals with LTCI

Sources: U.S. Department of Health and Human Services, MetLife Mature Market Institute



In addition to the financial benefits provided by insuring for LTC, there are also care and quality of life benefits. For example, insureds may be better able to obtain care in the setting of their choice, including their own homes. In a study of LTCI claimants, interviewees were asked if they had wanted to receive care at home, and if so were able to do so. They were also asked if their

⁶¹ U.S. Department of Health and Human Services, 2006. "Decisions, Choices, and Care Management among an Admissions Cohort of Privately Insured Disabled Elders," <https://aspe.hhs.gov/basic-report/service-use-and-transitions-decisions-choices-and-care-management-among-admissions-cohort-privately-insured-disabled-elders>

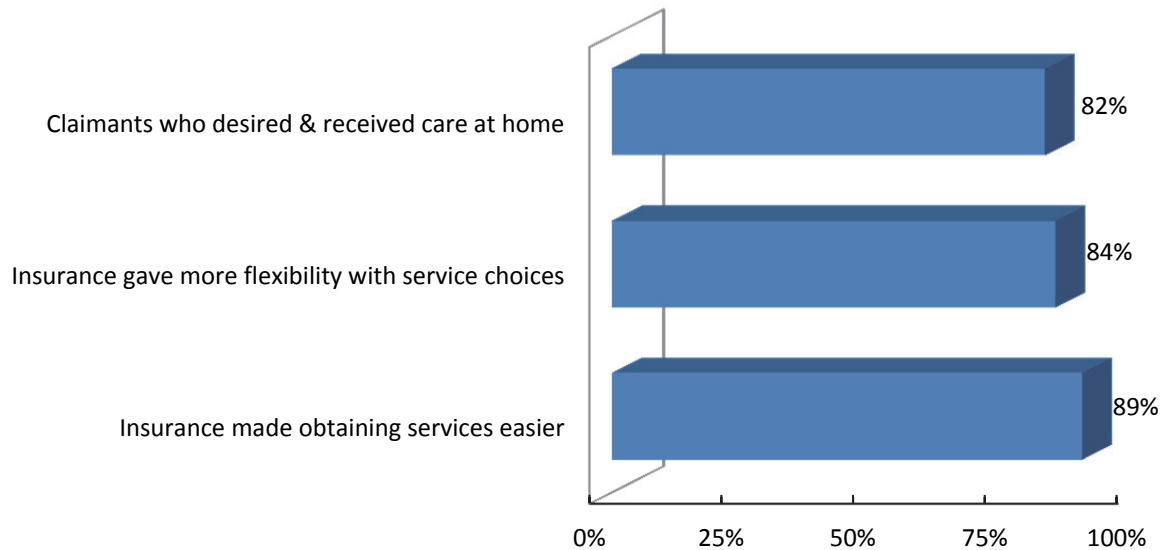
⁶² Note: Data were adjusted to 2014 costs with assumptions of 1%, 3.5%, and 4% increases in the costs of home care, nursing home, and assisted living care, respectively.

insurance had made it easier for them to obtain the services they wanted and whether it gave them flexibility in choosing their services.

As shown in Figure 15, a high percentage of insureds were able to receive home care, and large majorities agreed LTCI enhanced service access and flexibility.⁶³

Figure 15: Nonfinancial Benefits of LTCI Two Years After Initial Service Use

Sources: U.S. Department of Health and Human Services, MetLife Mature Market Institute



With LTCI benefits, policyholders can afford more care while those without insurance may be forced to rely more on family caregivers or simply make do with less care than they really need. To ascertain whether those with insurance receive more hours of care than those without, we compared similarly disabled persons with and without LTCI.⁶⁴ Figure 16 compares the total hours of paid and unpaid care received by insured and uninsured individuals. As shown, insured individuals receive substantially more hours of care (35% more) than the uninsured. The insured receive almost twice as much paid care, but only 10% less unpaid care. This suggests there is not a significant diminishment in the level of family care provided in the presence of paid insurance-financed services, but rather, in the nature of the care provided. Families devote

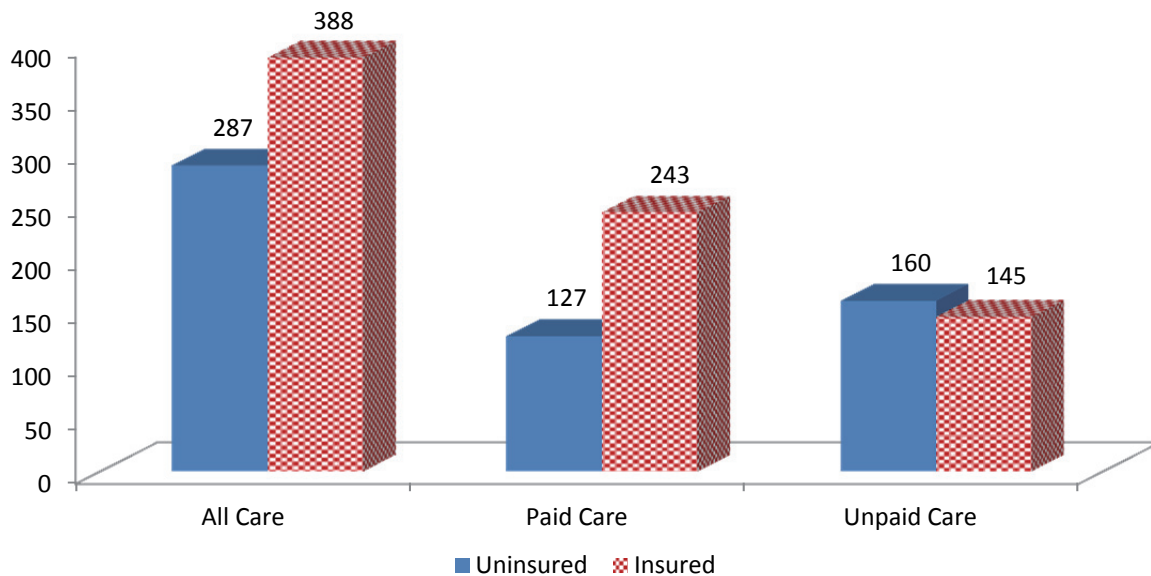
⁶³ U.S. Department of Health and Human Services, 2006. "Decisions, Choices, and Care Management among an Admissions Cohort of Privately Insured Disabled Elders," and MetLife Mature Market Institute, 2012. "Market Survey of Long-Term Care Costs."

⁶⁴ Information on the non-insured was derived from the National Health and Aging Trends Study (NHATS) which is a new resource for the scientific study of functioning in later life. The NHATS gathers information on a nationally representative sample of Medicare beneficiaries ages 65 and older. In-person interviews collect information on activities of daily life, living arrangements, economic status and well-being, aspects of early life, and quality of life.

fewer hours to helping with daily living limitations and spend more time simply being with the person and providing companionship.

Figure 16: Monthly Hours of Care for Impaired Home Care Recipients by Insurance Status

Source: National Health and Aging Trends Study



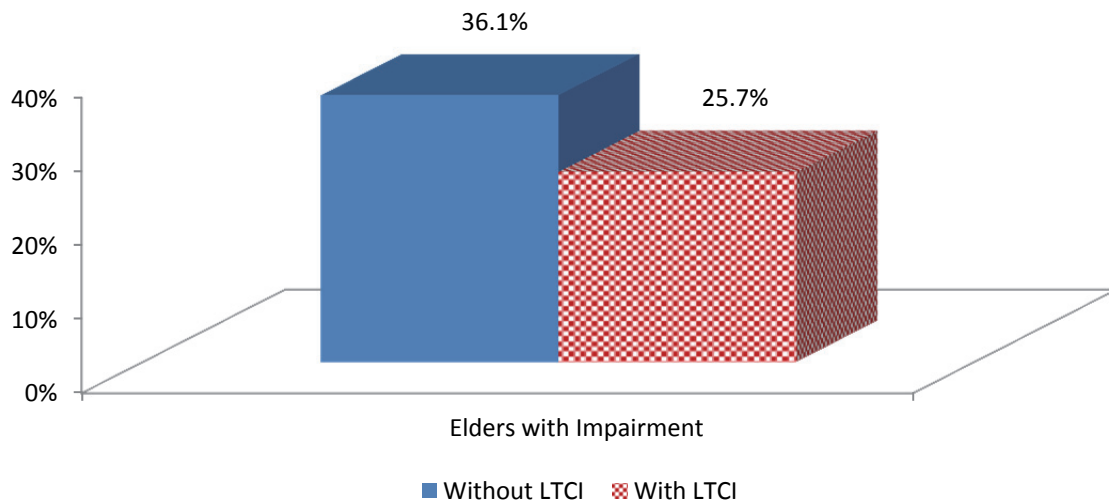
An issue closely related to the number of hours of care received is the level of LTC need which is or is not being adequately met and the relationship to insurance status. As shown in Figure 17, those with LTCI are less likely to report unmet or undermet needs. In fact, holding disability status constant, there is a 29% reduction in reported unmet/undermet needs among those with private LTCI. The fact that one-quarter of claimants report their needs are not being met, suggests that while the insurance can help, there do remain significant deficiencies in the service delivery system for LTC. Long-term care insurance largely eliminates the financial barrier to receiving care, but it cannot solve all provider issues.⁶⁵ Some such deficiencies include mismatches between preferences and service schedules, not enough help actually performing ADLs, poor communication, lack of provider reliability, and others.^{66,67, 68}

⁶⁵ U.S. Department of Health and Human Services, 1999. "A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community," (Final Report to the Office of Disability, Aging, and Long-Term Care Policy and the Robert Wood Johnson Foundation Home Care Research Initiative). Washington, DC.

⁶⁶ Deficiencies in the delivery and quality of services refer to insufficiency of the help received from outside personnel in performing ADLs and IADLs. Some examples given: the individual was bathed but not completely dried, the water was not at the right temperature, the caregiver did not show up when needed or on time.

Figure 17: Reported Levels of Undermet/Unmet Needs by Insurance Status

Sources: U.S. Department of Health and Human Services, MetLife Mature Market Institute



The Benefits of Insurance for Caregivers

As mentioned above, family caregivers continue to play an integral role in the care of elders and an estimated 39.8 million adults in the U.S. have provided unpaid care to an adult, which represents an estimated prevalence of 16.6%.⁶⁹ On average, caregivers spend about 24 hours per week providing care and about 25% provide care for 41 hours or more each week. Another 30% provide between nine and 40 hours of care. For the most part, the care provided is to compensate for ADL deficiencies or to help with instrumental activities of daily living (IADLs) such as grocery shopping, light housekeeping, laundry, medications management, etc. All of this takes a great deal of effort and there is a growing body of research showing how caregiving can take a toll on caregivers.^{70,71,72} Caring for someone with LTCI should alleviate the burden on

⁶⁷ The SCAN Foundation, 2013. "Understanding Satisfaction among Older Adults Using Long-Term Services and Supports," http://www.thescanfoundation.org/sites/default/files/lifepans_understanding_satisfaction_among_older_adults_using_ltss-9-18-13.pdf

⁶⁸ U.S. Department of Health and Human Services, 1999. "A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community," Washington, DC. <https://aspe.hhs.gov/basic-report/descriptive-analysis-patterns-informal-and-formal-caregiving-among-privately-insured-and-non-privately-insured-disabled-elders-living-community>

⁶⁹ American Association of Retired Persons, 2015. "Caregiving in the U.S.," 2015 Research Report. Washington, DC. <http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf>

⁷⁰ Genworth Financial, 2015. "The Expanding Circle of Care: Beyond the Dollars," Richmond, Virginia, September 2015, <https://pro.genworth.com/riiproweb/productinfo/pdf/157453C.pdf>

family caregivers and make it easier for caregivers to work (and to avoid disruption in work) and maintain social interactions. Research shows individuals caring for people with private LTCI are nearly twice as likely to be able to work as are those caring for people without such insurance. This research also indicates a working caregiver of someone with LTCI is less likely to experience severe social stress than a caregiver of a non-insured person.^{73,74}

Additional research suggests because many policies provide the help of a care coordinator free-of-charge, this can reduce caregiver stress; a survey of claimants showed care coordination is a highly valued service by them and their families.⁷⁵ Finally, paid services enable family caregivers to focus on companionship and social interaction with their loved one, rather than hands-on care. This helps restore a greater sense of normality to the relations between adult children and their parents, or between spouses. Insured claimants are generally satisfied with the services they receive because insurance makes it easier to receive care in the setting of their choice.⁷⁶

Insurance and Medicaid Expenditures

As mentioned, the primary public payer for LTC is the Medicaid program. Roughly one-third of all Medicaid spending is for LTC, of which 52% is for nursing facility care and care in intermediate care facilities and about 48% is for a wide range of home—and community—based services (HCBS), primarily section 1915(c) waiver programs, as well as personal care and home health service.⁷⁷ While an institutional bias still exists in the program, Medicaid spending

⁷¹ American Association of Retired Persons, 2013. “Caregivers in Crisis: Why New York Must Act,” Washington, DC., <http://states.aarp.org/wp-content/uploads/2013/11/Caregivers-in-Crisis-FINAL.pdf>

⁷² National Alliance for Caregiving (NAC) and AARP, 2009. “Caregiving in the U.S. 2009” Bethesda, MD and Washington, DC., http://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf

⁷³ MetLife Mature Market Institute, 2011. “The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents, 2011,” <http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf>.

⁷⁴ America’s Health Insurance Plans, 2002. “Benefits of Long-Term Care Insurance: Enhanced Care for Disabled Elders, Improved Quality of Life for Caregivers, and Savings to Medicare and Medicaid,” Washington, DC.

⁷⁵ U.S. Department of Health and Human Services, 2008. “Following an Admissions Cohort: Care Management, Claim Experience, and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Twenty-Eight Month Period,” Final Report, Washington, DC.

⁷⁶ The SCAN Foundation, 2015. Satisfaction with Long-Term Services and Supports across the Continuum of Care,” <http://www.thescanfoundation.org/lifepans-inc-satisfaction-long-term-services-and-supports-across-continuum-care-0>.

⁷⁷ Thompson Reuters, Aug. 17, 2010, available at www.hcbs.org/files/193/9639/2009LTCExpenditures.pdf and in Steve Eiken et al., “Medicaid Expenditures for Long-Term Services and Supports in 2011,” revised October 2013, Mathematica Policy Research, Inc., and Truven Analytics, for the Centers for Medicare & Medicaid Services, www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Downloads/LTSS-Expenditure-Narr-2011.pdf.

for HCBS has grown considerably, as has the number of people served. Between 2000 and 2010 alone, the number of people being served by the Medicaid HCBS program grew by 50% to 3.2 million.⁷⁸ The growth in Medicaid-financed LTC is causing strains on state budgets across the country and crowding out other policy-objectives.

Thus, there is a strong desire on the part of states to encourage those individuals who can afford to do so to plan ahead and pay for LTC should the need arise.

There is a presumption a meaningful proportion of middle-income people without insurance would spend most, if not all, of their savings on costly LTC. A key purported benefit of LTCI is that it would enable most people to avoid having to spend down their assets and rely on Medicaid if they have a catastrophic need. Public policy support for the private insurance market is built in part on the belief as more people become insured fewer will require public financing for their LTC needs. The argument is growth in the private insurance market will help ensure scarce public dollars are targeted only to those who do not have available private alternatives to fund care, and consequently, market growth will strengthen the social safety net.

Recent data collected by America's Health Insurance Plans (AHIP) show over the past decade, the share of LTCI buyers who are in the middle-income range has declined.⁷⁹ In 1995, 41% of buyers were considered middle-income, but by 2010 that number had declined to 36%.⁸⁰ This suggests, everything else held constant, the pool of policyholders who, in the absence of insurance would spend down their assets to reach Medicaid eligibility thresholds has declined. This raises the question of whether the potential impact of LTCI on Medicaid spend-down rates might be minimal.

Using a simulation model based on industry buyer and claimant data, and as reported in a recent study published by AHIP, between 28% and 31% of insured nursing home claimants

⁷⁸ Prepared by the National Health Policy Forum based on FY 1997 data in Steve Eiken et al., "Medicaid Long-Term Care Expenditures in FY 2009," figure 1, Thompson Reuters, Aug. 17, 2010, www.hcbs.org/files/193/9639/2009LTCExpenditures.pdf and in Steve Eiken et al., "Medicaid Expenditures for Long-Term Services and Supports in 2011," revised October 2013, Mathematica Policy Research, Inc., and Truven Analytics, for the federal Centers for Medicare & Medicaid Services, www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/

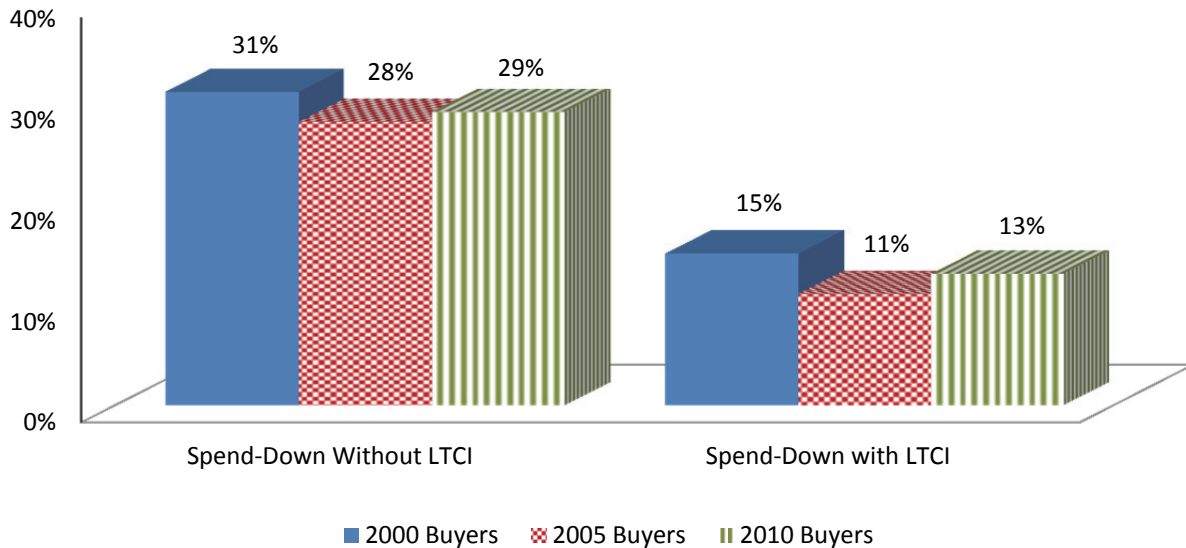
⁷⁹ America's Health Insurance Plans, 2012. "Who Buys Long-Term Care Insurance in 2010-2011? A Twenty-Year Study of Buyers and Non-Buyers (In the Individual Market)," Washington, DC. "Middle-income" is defined as the middle third of income distributions according to the census data for each year studied.

⁸⁰ LifePlans, Inc., 2014. "The Current State of the Private Long-Term Care Insurance Market," (Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference, Orlando, Florida, March 16 – 19.)

would have spent down to Medicaid in the absence of their LTCI policy (Figure 18).⁸¹ This theoretical claimant spend-down rate is lower than among the general population, which is not surprising given LTCI purchasers are generally better off financially.^{82,83}

Figure 18: Impact of Long-Term Care Insurance on Medicaid Spend-Down Rates Among Nursing Home Claimants by Buyer Cohort: Longitudinal Analysis of Service Use

Sources: AHIP



However, when we take into account the amount of LTCI benefits available to these claimants (that is, in the presence of LTCI), the spend-down rates decline significantly to between 13% and 15%.⁸⁴ Thus, LTCI reduces Medicaid spend-down rates significantly for those policyholders entering nursing homes. If we translate this from a “claimant rate” to a “policyholder rate,” then insurance is projected to reduce the spend-down rate among policyholders from 6% to 9% (no LTCI) down to 2% to 4% (with LTCI). Not shown in the graph is that Medicaid spend-down in the community is virtually eliminated in the presence of LTCI.

⁸¹AHIP, 2014. “The Benefits of Long-Term Care Insurance and What they Mean for Long-Term Care Financing,” Washington, DC.

⁸² Wiener, J.M. et al., 2013. “Medicaid Spend-Down: Implications for Long-Term Services and Supports and Aging Policy,” The Scan Foundation, http://www.thescanfoundation.org/sites/default/files/tsf_ltc-financing_medicaid-spend-down-implications_wiener-tumlinson_3-20-13.pdf

⁸³ Note “Middle-income” is defined as the middle third of income distributions according to the census data for each year studied.

⁸⁴ Some policyholders eventually qualify for Medicaid because they exhaust their insurance benefits.

While the spend-down rate among this population is relatively small, given the very skewed distribution of LTC risk and the high costs of care across the entire policyholder base, the projected Medicaid savings per policyholder in 2014 dollars is about \$10,000. Because the insurance people have purchased covers most of an insured's LTC expenses, there is protection against spending down to Medicaid eligibility thresholds.

While the focus of the discussion has thus far been on private insurance, similar conclusions can be drawn when looking at the potential impact of new public insurance programs on Medicaid expenditures. New work by Favreault et al., (2015) shows how the imposition of various public insurance programs for LTC would influence Medicaid expenditures.⁸⁵ They demonstrate mandatory programs would lead to the greatest savings in Medicaid expenditures compared to voluntary schemes. This is true regardless of whether the program was for front-end coverage (i.e. begins paying after a 90-day spell of disability and pays benefits for up to two years), back-end catastrophic coverage (i.e. begins paying after a two-year period of disability and provides a lifetime benefit), or a comprehensive benefit. They also show a back-end mandatory insurance program for LTC yields almost as much in Medicaid savings (32%) as does a comprehensive public insurance benefit (37%). Thus, similar to private coverage, public insurance would also reduce financial strains on the Medicaid program by reducing the proportion of individuals who must use up all of their assets paying for care and then qualify for Medicaid coverage.

Concluding Thoughts on the Economics and Benefits of Private LTCI

Clearly, the LTC risk faced by individuals as they age is large, unpredictable and also quite insurable. In this section of the study, the author has tried to demonstrate the benefits of insuring against this risk from a variety of perspectives, including that of the disabled individual and his or her family caregiver. As well, given the competing demands on public dollars, having more people insured for LTC would have a positive impact on the growth of Medicaid expenditures, and this is true both in the context of private and public insurance approaches. Clearly, as the demographic balance shifts over the coming decades toward greater number of elders living longer lives, there will be tremendous demands placed on the service system. A robust insurance market can help support the growth and development of a high-quality service infrastructure to meet growing demands. Such a market can reduce the growing strain felt by caregivers, many of whom have to make workplace accommodations to care for elderly

⁸⁵ Favreault, M., H. Gleckman, and R. Johnson, 2015. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans And Federal Spending," *Health Affairs*, 34:12.

family members. Both the public and private sectors should continue to explore and work together to develop and support a reinvigorated private market and new insurance models to assure a much greater share of the middle class can be insured for LTC, and, hence, protected from the potentially catastrophic costs of this risk.

The Long-Term Care Insurance Puzzle



The Long-Term Care Insurance Puzzle: The Lack of Private Insurance Penetration

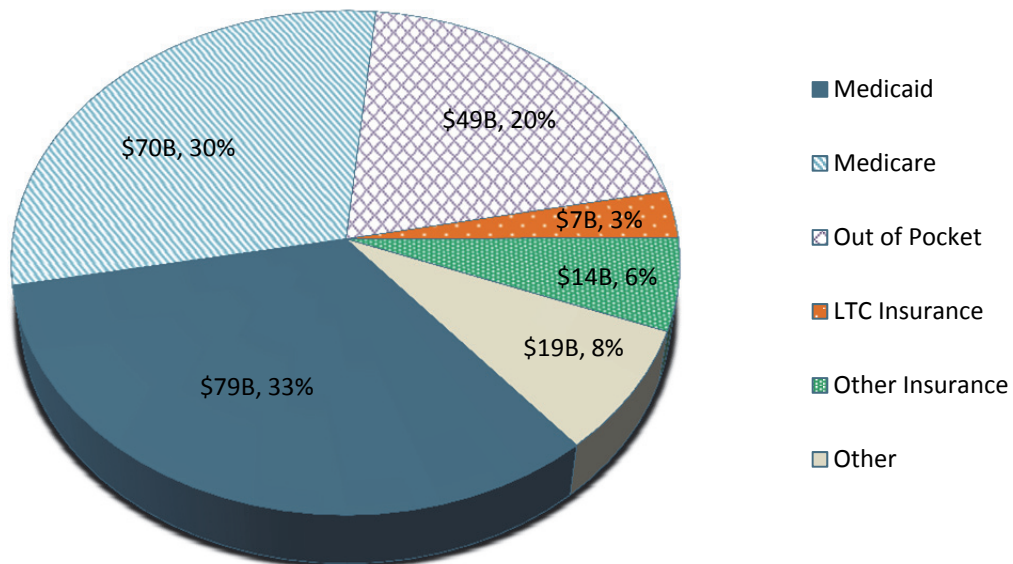
By Vincent Bodnar, Chief Actuary, LTCG

Current Financing of Long-Term Care

According to the National Health Expenditures Survey compiled by the Centers for Medicare & Medicaid Services (CMS), the U.S. spent \$239 billion on long-term care (LTC) expenses in 2014. The source of funding for these expenses is shown in Figure 19.

Figure 19: Funding of 2014 Long-Term Care Expenditures

Sources: The Centers for Medicare & Medicaid Services



Almost two-thirds of LTC spending was funded by two social programs. Medicare comprises the larger of the two at \$79 billion (33%). Medicare, as it was noted in the previous section, covers limited post-acute home health care expenses and the early days of skilled nursing home care (90 days per episode and 150 days per lifetime), with both subject to co-payments. About 30%, or \$70 billion, is funded by Medicaid programs for persons needing care that have fallen below poverty thresholds (Figure 19.)

About 20% of LTC expenditures are paid for directly out of the pocket of people receiving the care. Much of this was paid by persons who are or were in the process of spending down their

The Long-Term Care Insurance Puzzle

assets on their way to becoming poor enough to qualify for Medicaid. Only 3% of expenditures, or \$7 billion, was funded by private long-term care insurance (LTCI). This percentage is small due to the fact there are currently only about 7 million people with private LTCI out of 86 million people aged 55 and over. The remaining 14% of LTC expenditures was funded by other insurance and social programs or charities (Figure 19.)

Currently, as it was discussed in the previous section, personal asset spend-down followed by Medicaid qualification is the most common funding scheme for LTC expenses. This typically occurs when a person has not sufficiently planned for financing his/her LTC expenses privately. Long-term care expenses typically exceed income, which means without private insurance, a person's assets will need to be accessed to finance care. If his/her assets are exhausted by LTC expenditures (or are transferred to other persons via loopholes), the person becomes eligible for public welfare programs, including Medicaid, which then becomes obligated to finance the person's LTC expenses.

This common approach to financing LTC expenses puts an incredible strain on the funding of Medicaid via public sources. Medicaid's mission is to provide a safety net for the poor. It was not meant to be a primary source of funding LTC expenditures for the middle class, which is what is predominantly happening today. Unless an alternative financing scheme emerges as the dominate source of funding, the aging demographics of the U.S. will result in an unsustainable burden on public resources in the future.

Consumer Attitudes

The biggest fear Americans have about retirement is high medical expenses. This fear can be isolated to a critical concern about LTC expenses. Many of today's younger retirees have witnessed their parents or grandparents enter into nursing homes and exhaust their assets. They have seen this financing scheme at work and have become concerned for themselves. Most Americans are aware Medicaid is available as a safety net, but they are worried it will not allow or provide for an acceptable lifestyle if they ever need LTC.

The option of privately financing LTC is strongly preferred by the American public. About 59% agree individuals should be responsible for financing their own LTC expenses, while 66% agree

owning a private LTCI policy would give them peace of mind. Also, 51% do not trust the government to run an LTCI plan.⁸⁶

In spite of these views, private LTCI has had very limited success in penetrating its target market. This is driven by a general lack of awareness of the level of risk and costs involved. The same survey cited above also found knowledge of the cost of LTC and the risk of LTC is relatively low. Most survey participants greatly underestimated the chance of needing LTC services in their lifetime. Only 20% correctly estimated the cost of LTC in their state.

Another factor is the cost of private insurance, which is generally expensive. Once the survey participants were provided with such information, 44% stated they would rather not purchase coverage because they have other priorities for their money other than LTCI.

Unique Distribution Challenges

Consumer awareness and attitudes present unique challenges to the distribution of LTCI products. Consumers must first be educated on the risks and costs of LTC expenses. They then need to be walked through a complicated insurance product design to select appropriate coverage. After that, agents must help the consumer overcome the sticker shock of the premiums for an LTCI product and demonstrate it is still a valuable purchase.

This makes LTCI a difficult product to sell through a broad distribution system. Most insurers that entered the market found they could not simply roll the product out to their existing life insurance or health insurance agents and expect meaningful volumes of sales. Many of these agents have the same low levels of awareness of LTC risks and costs as consumers have and were uncomfortable selling the product. As a result, the vast majority of insurers that entered the market quickly left after disappointing sales volumes.

Early Distribution Success

The industry addressed this unique challenge by forming specialty distribution. Early on, a few insurers experimented with the concept of training small groups of agents to effectively sell LTCI and to sell it almost exclusively. In general, these agents were trained to provide education-based sales presentations to consumers who responded to lead generation programs. Such sales sessions would often take several hours, and would possibly span more

⁸⁶ RTI International, 2015. "Long-Term Care Awareness and Planning: What Do Americans Want?" ASPE Policy Forum, <https://aspe.hhs.gov/report/long-term-care-awareness-and-planning-what-do-americans-want>

than one visit. The agents were trained to first educate the consumer about the risks and cost of LTC. They would then explain the very complex nature of LTCI products. Finally, they would provide rational responses to the high premium rates which were presented to the customer. This approach became very effective for those insurers that developed and adopted it.

At first, such distribution was limited to small pockets of captive agents. These pockets enlarged as the success of specialists proved out. Later, independent marketing organizations recruited and trained specialists who would sell for multiple insurers in the brokerage market. Specialist agents often worked with agents in broader distribution who were uncomfortable selling LTCI to customers who inquired about such coverage.

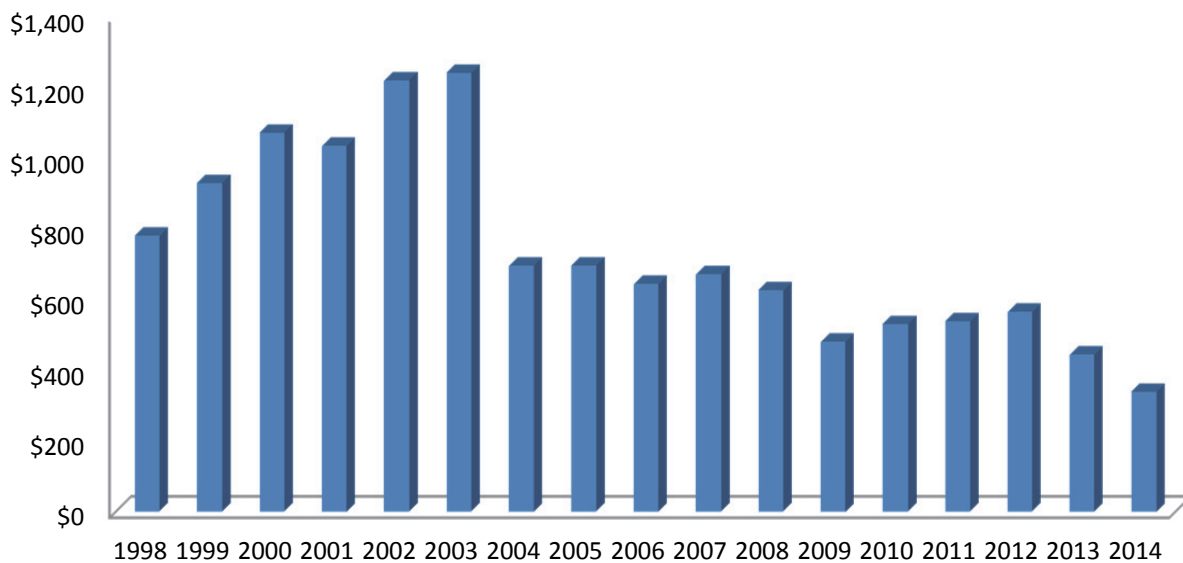
Of the 177 insurers entering the LTCI market in the 1990s, only 56 of them sold 10,000 or more policies, and 74 of them sold less than 1,000 policies. In general, those insurers that did not train agents to be specialists or access independent specialist distribution had dismal sales volumes and quickly exited the market. Those insurers using specialty distribution were generally successful with larger sales volumes.

Early Successes Soon Faced Challenges

The industry's early success with sales of LTCI soon faced challenges. Figure 20 shows sales collapsed in 2004 and have not recovered.

Figure 20: New Premium Issued (Millions)

Source: 1999-2015 Broker World Surveys

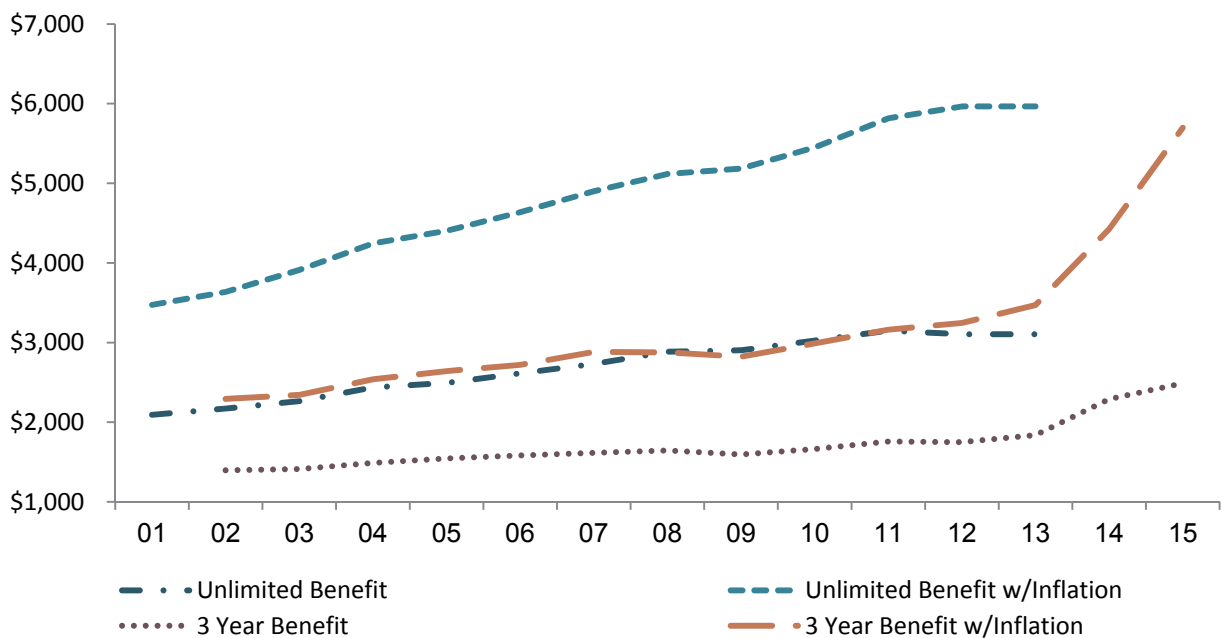


There are several reasons for this collapse. First, as it has already been noted in the earlier sections, some insurers began to recognize premium rate increases on their older business were necessary as interest rates fell and lapse and mortality rates emerged much lower than expected. Some of these insurers became uncomfortable with these risks and began to exit the market. These insurer exits affected distributors' confidence in the commitment of insurers in the market, which resulted in contraction in the number of agents selling LTCI.

Second, decreasing interest rates and emerging regulatory requirements resulted in increased new business premium rates. These increased premium rates greatly affected consumer buying power for the same comprehensive benefits purchased by customers in earlier years. This trend is captured in Figure 21, which illustrates the average annual premium available in the market for four different benefit configurations.

Figure 21: Average Annual Premiums for New Business

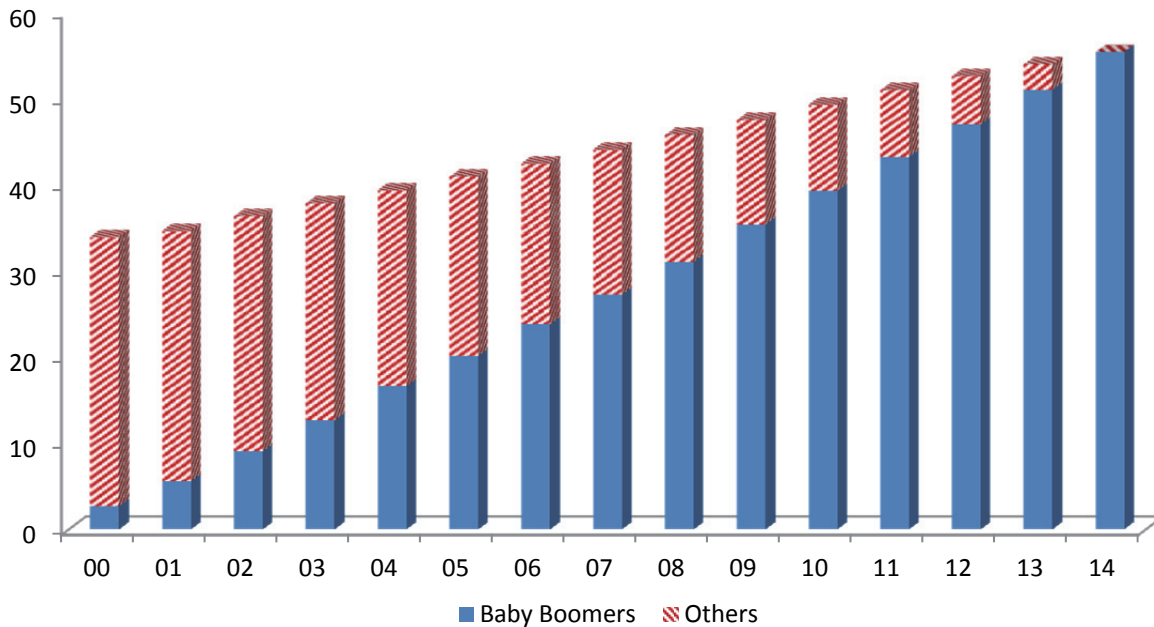
Source: 1999-2015 Broker World Surveys



Third, the target market for LTCI, persons aged 55 to 69, has transformed over the past 20 years. Although the target market grew tremendously during this period, from 25 million persons in 1995 to 55 million in 2014, its composition changed dramatically as illustrated in Figure 22. The average age of a person who purchased an LTCI policy in 1995 is about 70 years old. Such a person was born in 1925 and is a member of the GI generation. However, the average age of a person who purchased a policy in 2015 is about 58 years old. Such a person was born in 1957 and is in the baby-boom generation.

Figure 22: Persons Aged 55 to 69 (Millions)

Source: U.S. Census Bureau



The baby-boom generation of today’s market has drastically different financial and consumer attitudes than the GI generation which purchased LTCI during the product’s high-growth period. Unlike the prior generation, baby boomers want the ability to have immediate value from their purchases. Traditional LTCI does not provide anything tangible immediately after it is purchased. Such products do not provide the ability to “cash out” of the product if liquidity is desired or if their benefits are never used.

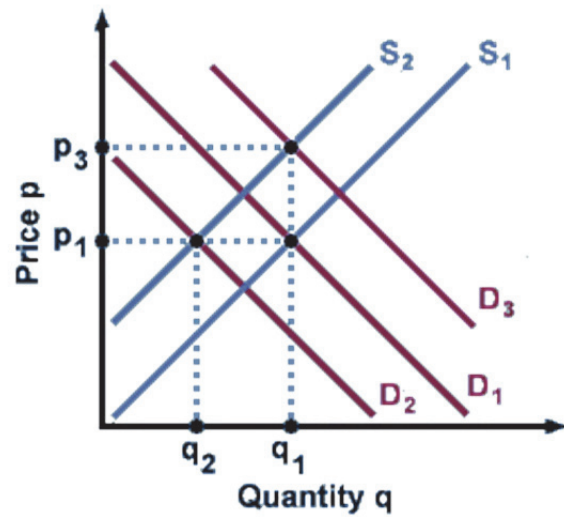
Baby boomers tend to have less patience, making certain elements of specialist distribution difficult. It is more difficult for agents to sit at a kitchen table with a baby boomer for the time needed to educate them about the risks and costs of LTC. The GI generation is very interested in protecting assets for the sake of transferring them to their children or grandchildren, which was a key motivator for them in purchasing LTC coverage. On the other hand, baby boomers tend to be more self-centered than the prior generation and are much less interested in protecting assets for the purpose of transferring them to their adult children. They are much more motivated in using assets to sustain a lifestyle with which they are comfortable.

Finally, most insurers have implemented large rate increases on in-force business, which has affected consumer confidence in the product. It has become more difficult to sell new policies

The Long-Term Care Insurance Puzzle

to consumers given what they have heard or read about such rate increases. They simply do not want to have the same events happen to them.

Estimating Demand for Improved Long-Term Care Insurance



Estimating Demand for Improved Long-Term Care Insurance⁸⁷

By Andrew Caplin, New York University & National Bureau of Economic Research (NBER); John Ameriks, Vanguard; Joseph Briggs, New York University; Mathew D. Shapiro, University of Michigan and NBER, and Christopher Tonetti, Stanford GSB and NBER

Introduction

As demonstrated in the previous sections, many people ultimately will require help performing activities of daily living (ADLs) they now generally handle independently. The government says if people make it to age 65, 70% of them will need long-term care (LTC) at some stage.⁸⁸ So, why then do only 10% of older Americans purchase LTCI?

Academics and policy makers have studied the low use of private LTCI for years without finding satisfactory explanations. Research has been vital in helping us understand critically important issues related to the demand for LTCI, such as the impact of adverse selection and the importance of public alternatives to private care and insurance. Yet this work has failed to answer basic questions regarding why people make the choices they do, and given the choices they do make, what types of financial products or services could enhance their well-being.

Our work takes retirement oriented research back to its foundations and then in fundamentally different directions.^{89,90} We use the same building blocks as most mainstream economists do, starting with a rigorously specified model built around the notion observed behavior and decisions are the result of efforts to achieve preferred outcomes subject to constraints. However, in our work, we ask a bit more of this model and framework. In addition to explaining observed choices, can such a model explain the choices people tell us they would make in hypothetical situations we did not observe or have not happened yet, or possibly will not ever happen? Our work is unique in that we include responses to hypothetical survey questions as

⁸⁷ In this section of the study, the authors present their work on consumers' behavior, both observed and in hypothetical situations, to understand how people feel about long-term care insurance (LTCI) and how they actually make decisions regarding the purchase of LTCI products. The use of the words "we" and "our" in this section of the study refer only to the work, opinions and conclusions of the authors and does not in any way imply agreement and/or endorsement of these statements by the NAIC and state insurance regulators.

⁸⁸ U.S. Department of Health and Human Services, <http://longtermcare.gov/the-basics/who-needs-care>

⁸⁹ Ameriks, J., J. Briggs, A. Caplin, M. D. Shapiro, and C. Tonetti, 2015a. "Long Term Care Insurance, Annuities, and the Under-Insurance Puzzle," Vanguard Research Initiative Working Paper, <http://ebp-projects.isr.umich.edu/VRI/papers/VRI-LTC-I.pdf>

⁹⁰ Ameriks, J., J. Briggs, A. Caplin, M. D. Shapiro, and C. Tonetti, 2015b. "Long Term Care Utility and Late in Life Saving," Vanguard Research Initiative Working Paper.

part of the data we use to constrain our model of decisions. We call these questions strategic survey questions (SSQs).

There is only one better way to assess interest. This would be to introduce and market better designed LTCI products. But in classic chicken-and-egg mode, this would require changes in regulations and in the competitive landscape and strong political will. This will happen only if there is evidence of high demand. It is for this reason that estimating hypothetical demand forms such a vital link in the reform chain, and it is exactly why it is the centerpiece of our work.

Not only our approach, but also our sample is unique. We use information collected directly from a large number (thousands) of older, generally well-educated and upper-middle class Americans who have accounts at The Vanguard Group, Inc. These respondents constitute the newly developed Vanguard Research Initiative (VRI) panel. Respondents are Vanguard clients aged 55 and older who agreed to participate in up to three surveys. The sample runs across two of Vanguard's major lines of business—individual accounts and retirement accounts through employers. Panel members not only answered our hypothetical questions, but the vast majority of them passed tests which checked their understanding of the various details of the hypothetical situations before answering critical questions.

We use the information collected from the survey participants to calibrate a new model of how people make decisions in retirement. We then use the model to try to estimate how useful new/atypical designs for LTCI products might be in meeting their needs. We focus our attention on a product concept we call ADL insurance. This is essentially a disability-style insurance policy paying a pre-specified dollar amount if a trusted third party determines the policyholder is in need of assistance with the tasks of daily living. It pays out precisely when individuals have difficulties with ADLs and may therefore need care. Unlike many current products, it is not subject to default risk, premium risk, inflation risk, or the uncertain claims process based on expense reimbursement characterizing existing products.

Based on the model we have built, using the responses people provide in our survey questions, we estimate the demand for ADL insurance far exceeds current LTCI holdings. The gap between estimated demand and actual holdings is present across the wealth and income distribution, survives in more representative subsamples, and is robust to reasonable loads. The basic reason for this is that most panel members would choose to spend money on private LTC to achieve high-quality care even at the expense of leaving a smaller bequest. Reliance on government provision of LTC via Medicaid is not seen as an attractive alternative to private procurement, and bequests are something of a luxury. The ADL insurance is valued because it

provides additional resources when in need of LTC, while also allowing for flexible spending in normal times or planning for a bequest.

While some would be satisfied with building a new, extended model of retiree behavior with some interesting predictions, we use our unique data and methods to attempt to learn more. In particular, we want to know how model-predicted demand compares to model-free measures of demand. There may be factors at work in terms of motivations and constraints standard models miss. Hence, our second estimate of demand is less model-bound. We pose stated demand questions in the VRI, and we find a significant proportion of those who do not hold LTCI, but are predicted to have positive demand, also have positive stated demand for ADL insurance. Hence, it seems imperfections in the products on offer do indeed limit interest.

Both of our demand measures thus indicate a large, latent demand for insuring the ADL state. There are many whose motivations suggest they should be interested, yet in reality may not purchase such insurance. Similarly, stated demand for the ideal product would seem to be of lower interest than our model implies.

We found the overall level of stated demand for ADL insurance is significantly lower than the level suggested by the calibrated model estimates. We also found similar patterns (even more intensely) when it came to comparing the model-based estimates of demand for annuities to model-free estimates of stated demand.⁹¹

In our 2015 article we considered several potential explanations for the difference between the model predicted and stated demand and found three important correlates.⁹² Specifically, the gap between modeled demand and model-free demand is lower for three types of individuals:

1. Those who have made past transfers to descendants or heirs.
2. Those who performed better in recalling the details of our hypothetical survey questions.
3. Those who expect LTC will be more expensive or lengthy.

The first correlation is particularly interesting. It provides unique direct evidence arrangements between family members (in particular wealth transfers) may have an important influence on planning and insurance decisions among retirees. While this makes strong intuitive sense, the

⁹¹ Ameriks, J., J. Briggs, A. Caplin, M. D. Shapiro, and C. Tonetti, 2015a. "Long Term Care Insurance, Annuities, and the Under-Insurance Puzzle," Vanguard Research Initiative Working Paper.

⁹² Ibid.

importance of family interactions around wealth, LTC and insurance decisions are understudied and deserve more attention in future research.

Background

The research outlined herein draws from the first three VRI surveys and analysis in previous work as presented by the authors and which can be consulted for more detailed analysis.^{93,94,95}

The Sample

VRI Survey 1 introduces novel methods for measuring household portfolios of assets and debts (see Ameriks, Caplin, Lee, Shapiro, and Tonetti (2014) for detailed analysis).⁹⁶ Survey 2 has at its center the key SSQs and stated preference questions. Survey 3 gathers information on family structure, as well as family transfers. The sample for which we estimate interest in ADL insurance completed all three surveys and provided answers to all necessary survey questions.

Knowing ahead of time singles would be better suited for research that does not directly model family interaction, singles were over-sampled when constructing the VRI and will be the subsample used in the research discussed here. A key take-away is that the VRI sample is wealthier, more educated, more often married and healthier on average than the U.S. population through comparison to the U.S. Health and Retirement Study (HRS).⁹⁷ However, the employer-based VRI panel members have wealth and demographic profiles aligning reasonably with the correspondingly conditioned HRS. Summary statistics are included in Table 5.

⁹³ Ameriks, J., A. Caplin, M. Lee, M. D. Shapiro, and C. Tonetti, 2014. "The Wealth of Wealth-holders," Vanguard Research Initiative Working Paper.

⁹⁴ Ameriks, J., J. Briggs, A. Caplin, M. D. Shapiro, and C. Tonetti, 2015a. "Long Term Care Insurance, Annuities, and the Under-Insurance Puzzle," Vanguard Research Initiative Working Paper.

⁹⁵ Ameriks, J., J. Briggs, A. Caplin, M. D. Shapiro, and C. Tonetti, 2015b. "Long Term Care Utility and Late in Life Saving," Vanguard Research Initiative Working Paper.

⁹⁶ Ameriks, J., A. Caplin, M. Lee, M. D. Shapiro, and C. Tonetti, 2014. "The Wealth of Wealth-holders," Vanguard Research Initiative Working Paper.

⁹⁷ National Institute of Aging, 2015. "Growing Older in America: The Health and Retirement Study." U.S. Department of Health and Human Services, <https://www.nia.nih.gov/health/publication/growing-older-america-health-and-retirement-study/preface>

Table 5: VRI Survey Sample Characteristics

Source: The Vanguard Group, Inc.

WEALTH							
Full Sample	Number of Observations	Mean	10p	25p	50p	75p	90p
		1087	\$745,274	\$115,000	\$271,720	\$543,191	\$1,012,263

DEMOGRAPHICS							
Full Sample	Education		Health			Gender	
	< College	≥ College	Poor/Fair	Good	Excellent	Male	Female
		25.7%	74.3%	5.2%	22.5%	72.2%	44.3%

The Model

The consumer choice model as detailed in Ameriks, Briggs, Caplin, Shapiro, and Tonetti (2015b) allows consumers to differ in terms of wealth, income, health status and preferences, as well as age and gender. The treatment of health is particularly important. Individuals are modeled as being either in good health, in poor health, or needing help with ADLs, such as eating, dressing, bathing, walking across a room, and getting in or out of bed.

Health status evolves randomly, conditional on age, gender and prior health status. For those in need of help with ADLs, we allow for a means-tested government-provided care program. The cost of using government care for a consumer is forfeiting all wealth, as it was noted in previous sections. This aligns with public welfare only being accessible to individuals with sufficiently low financial resources. To capture the fact alternative private LTC provision is expensive there is a certain level of expenditure needed to obtain it.

Whether consumers are in good or poor health, they value consumption according to a standard constant relative risk aversion utility function,⁹⁸ which motivates their efforts to smooth consumption spending over the life cycle. While poor health is associated with additional health costs, it is assumed otherwise to operate just like good health, involving the

⁹⁸ In economics, utility function is a numerical representation of how consumers feel about a set of goods and services by measuring their preferences.

same utility function over non-health-related spending. Needing help with ADLs is different, and is associated with a possibly heightened need for resources.

We allow individuals to differ in viewing such expenditure as a luxury or as a necessity, and in terms of its importance relative to spending when healthy.⁹⁹ We allow for this by introducing additional parameters whose value is estimated to reflect individualized choices in various hypothetical choice scenarios as outlined below. If an individual needs help with ADLs and uses government care, the government provides care which may be regarded by different consumers as of relatively high or low quality. If there is money available at the end of life to leave as a bequest, this also is of value to the consumer. As with expenditure on LTC, we allow bequests to be viewed either as an economic necessity or as a luxury, and we allow the priority assigned to bequests to differ across individuals, precisely as presented earlier by De Nardi.¹⁰⁰

Strategic Survey Questions

As the model description makes clear, behavior depends on richly described preferences. Estimating all required parameters from standard observed behaviors is difficult. Even in simpler models, bequest and LTC motives are not separately identifiable since wealth is fungible.¹⁰¹ Hence, we follow the work of Ameriks, Caplin, Laufer, and Van Nieuwerburgh in using SSQs to elicit key model parameters.¹⁰² These questions place respondents in hypothetical choice scenarios significantly more detailed than those in standard stated preference questions.

Because SSQs require respondents to comprehend and imagine complex scenarios, their design involved rich interaction with early respondents, who were subjected to cognitive interviews and various respondents to a pilot survey, who were themselves subjected to iModerate pop-up interviews structured by the psychologists on the research team. As a result of this process, we broke questions up and presented them in four parts. We illustrate this four-part process in the context of a particular SSQ (SSQ 3) related to the tradeoff between expenditure when in need of help with ADLs and leaving a bequest, starting with the introduction of the subject of interest and the scenario itself. We opened the question by clarifying it referred to a

⁹⁹ De Nardi, M., 2004. "Wealth Inequality and Intergenerational Links," *Review of Economic Studies*, 7, 743–768.

¹⁰⁰ Ibid.

¹⁰¹ Hubbard, R. G., J. Skinner, and S. P. Zeldes, 1995. "Precautionary Saving and Social Insurance," *The Journal of Political Economy*, 103(2), 360–3999.

¹⁰² Ameriks, J., A. Caplin, S. Laufer, and S. Van Nieuwerburgh, 2011. "The Joy of Giving or Assisted Living? Using Strategic Surveys to Separate Public Care Aversion from Bequest Motives," *Journal of Finance*, 66(2), 519–561.

hypothetical scenario involving a definite need for help with ADLs, and that respondents were being asked to make tradeoffs between spending on LTC and leaving a bequest.

Compared to the previous hypothetical choice literature, these questions describe a more complete scenario, with additional details on the environment, choice and other confounding factors. The benefit is that the question is more precisely aligned with the quantitative model and we can be more confident the respondents are answering the exact question we want them to answer. The cost of the extra detail, however, is that it may be harder for the respondent to fully understand the question. We take steps in the survey design to both bolster and measure comprehension.

To reinforce the definition of needing help with ADLs, respondents were given a comprehension test on the definition prior to this SSQ. Furthermore, the definition was available in a hover button whenever *ADL appeared in the survey to make it easy for respondents. The scenario and choice were as follows:

“Suppose you are 85 years old, live alone, rent your home, and pay all your own bills. You know with certainty you will live for only 12 more months and you will need help with *ADLs for the entire 12 months. You have \$100,000 you need to split into Plan E and Plan F.

- Plan E is reserved for your spending. From Plan E, you will need to pay all of your expenses, including LTC and any other wants, needs, and discretionary purchases.
- Plan F is an irrevocable bequest.”

Immediately after the scenario is presented, respondents are provided with a summary of the rules governing their choice in a bulleted, easy-to-read format. In addition, some features hinted at in the first screen—e.g., there is no public care option and that determination of which plan pays out is made by an impartial third party—are stated explicitly.

To further reinforce details of the scenario and obtain a quantitative measure of understanding, we ask the respondents to answer a sequence of comprehension questions. When answering these questions the respondents do not have access to the screens describing the scenario, but they have a chance to review the information before retrying any missed questions a second time. If they fail to answer questions correctly a second time, they are presented with the correct answers. The questions asked for this and the other SSQs verified: 1) the understanding of the ADL state; 2) what were the exact tradeoffs in that question; 3) which plan allocated resources to which state; 4) what restrictions there are on the use of funds; and 5) the nature of the claims process. Because respondents who make errors review the scenario between their

first and second attempt, they get to reinforce those aspects they failed to understand the first time through before reporting their demand.

Having measured and reinforced understanding, we asked respondents to split their wealth between the two plans after again presenting them with the original scenario and including a link to the description of the full scenario in the top right corner of the screen. Recording the respondents' desired division of money involved a custom-designed interface which presents the trade-off as clearly as possible. Specifically, we use an interactive slider presenting the payoffs in different states of the world (Figure 23). These payoffs change as the slider is moved, allowing respondents to observe how their choice is affected by moving the slider. Text is included instructing the respondent how to allocate money by moving the slider, as well as what their allocation implies about resources available for different uses. A static representation of the slider can be seen in Figure 23.

Figure 23: SSQ Response Slider

Source: The Vanguard Group, Inc.



When the slider first appears, it does not have an allocation selected. It is only when respondents themselves click on the slider that any allocation is shown. To further dampen possible anchoring and status quo bias, we ask respondents to move the slider at least once, which helps also to clarify the connection to the chosen allocation.

Having spent such a long time setting up the scenario and aiding comprehension, we stayed within the scenario and asked respondents to make new choices with different scenario

parameters. In the above question, answers were gathered not only concerning the division of \$100,000, but also of \$150,000 and \$200,000.

In addition to this SSQ, we posed three other SSQs. SSQ 1 asks about willingness to take a risky bet over income, using an analogous survey question and identification strategy to those developed in the 1997 paper by Barsky, Juster, Kimball, and Shapiro, and in the 2008 paper by Kimball, Sahm, and Shapiro.^{103,104} SSQ2 asks individuals facing uncertain future health to allocate wealth either to the state of the world when healthy or the state of the world when in need of help with ADLs. SSQ 4 asks individuals how much wealth they would need to have in order to purchase private LTC instead of using government provided care.

Several forms of evidence support the credibility of the responses. For example,

1. Respondents generally performed well on the comprehension tests. For SSQ3, more than 50% of respondents answered all questions correctly on their first attempt, 75% doing so after their second attempt, and more than 90% making one or fewer errors after the second attempt. Analogous tests were presented for the other SSQs, with similar performance.
2. Responses were internally coherent. As expected by design, correlations of answers within each SSQ were high, yet they were low for distinct SSQs.
3. Individual responses to SSQs are predicted by behaviors or characteristics outside the model in expected ways. In SSQ 3, regressions of these responses on standard demographic variables and other variables of particular relevance show that: 1) having transferred wealth to children predicts lower allocations to the ADL state; 2) the expectation of receiving care from a family member predicts lower allocations to the ADL state; and 3) higher expected ADL costs predicts higher allocations to the ADL state. Similar external consistencies are found in other SSQs as well.
4. A subset of the iModerate questions posed to participants in the Pilot survey, were posed to the full production sample at the end of the survey in relation to the SSQs as a whole. Answers reveal nearly 90% of respondents found the tradeoffs either very clear or somewhat clear. Furthermore, more than 80% indicated they were able to place themselves in the hypothetical scenario either moderately or very well. Finally, more

¹⁰³ Barsky, R. B., F. T. Juster, M. S. Kimball, and M. D. Shapiro, 1997. "Preference Parameters and Behavioral Heterogeneity: An Experimental Approach in the Health and Retirement Study," *Quarterly Journal of Economics*, 112, 537–579

¹⁰⁴ Kimball, M. S., C. R. Sahm, and M. D. Shapiro, 2008. "Imputing Risk Tolerance from Survey Responses," *Journal of the American Statistical Association*, 103, 1028–1038.

than 80% had given the underlying issues at least a little thought before taking the survey.

These measurements permit high confidence in the quality of responses and suggest responses reveal valid information about preferences and motives. The end result of recording responses to these SSQs is that we have the information required to estimate a rich set of preference parameters describing an individual's desires to: 1) consume in ordinary times; 2) have money when in need of help with ADLs; and 3) to leave an end-of-life bequest.

Model-Implied Demand

We use responses to the SSQs to estimate a distinct parameter set for each individual that, together with the risks they face, determines optimal saving and insurance decisions in our model. In brief, the SSQs broadly indicate more concern with LTC than with bequests, and this is reflected in the utility parameters we identify. For each individual we then identify demand for ADL insurance. This is modeled as a security paying out whenever an individual is in the ADL health state. The cost of the insurance is an up-front lump sum paid at the current age to receive the purchased amount of income in each year an individual needs assistance with ADLs for the remainder of life. The pricing function is determined so the product is actuarially fair given an individual's gender, age, health state, and access to a risk-free outside asset promising 1% annual return.

Using this approach, we estimate approximately two-thirds of respondents have positive demand for ADL insurance. This indicates most individuals assign a high valuation to having wealth when in need of help with ADLs and, if offered suitable insurance products, would like to insure they have enough wealth in this contingency. While many have potential interest, there is a substantial minority for whom purchasing does not appear to make sense. Such individuals answered SSQs in a manner indicating low preference for wealth in the ADL state relative to other spending motives. It is, therefore, clear survey responses could have produced completely different estimates. Furthermore, the distribution of other attributes like income, age, wealth and gender look very similar across those estimated to have positive or no demand for ADL insurance, so the heterogeneity driving the different interest in insurance is in preferences and not observable individual characteristics. Majority interest was not predestined, but rather a result of desires as inferred from the responses to SSQs.

In strong contrast to their high levels of predicted interest in ADL insurance, only 22% own private LTCI. Moreover we do not know the extent to which this private ownership is due to deliberate purchase as opposed to being a job benefit, making this an upper bound on the

fraction of individuals in the sample who have actively purchased private LTCI. The large difference between modeled and observed holdings is significant at all wealth and income levels in the VRI. Observed insurance holdings among older wealth-holders are well below the levels suggested by the model across the board. Moreover this finding is robust to reasonable increases in the risk free interest rate on savings, which corresponds to higher loads on ADL insurance.

Stated Demand

As indicated at the outset, a key question is whether the gap between estimated interest in ADL insurance and actual holdings of LTCI is more due to product flaws or flaws in the estimates of interest. To assess this, we posed stated preference questions on the demand for improved insurance products in VRI Survey 2.

A challenge in gathering this demand is, by definition, it concerns a form of insurance not available in the market place. For that reason, the stated demand questions were preceded by the definition of the ADL state, defined as “needing significant help with activities such as eating, dressing, bathing, walking across a room, and getting in or out of bed.” Moreover, when gathering demand information, we explicitly ask respondents to “make choices in hypothetical financial scenarios.” In the specific case of the ideal LTCI, the product is presented in the following frame.

Please suppose you are offered a hypothetical new form of insurance called ADL insurance with the following features:

- You pay a one-time, nonrefundable lump sum to purchase this insurance.
- If you need help with ADLs, you will immediately receive a monthly cash benefit indexed for inflation.
- For each \$10,000 you pay for this insurance, you will receive \$Y per month indexed for inflation in any month in which you need help with ADLs.
- The monthly cash benefit is set at the time of purchase and is not dependent on your actual expenses.
- There is no restriction on the use of the insurance benefits. You are free to use benefits in any way you wish: to pay for a nursing home; a nurse to help at home; for some other form of help; or in literally any other way you would like.
- An impartial third party who you trust will verify whether you need help with ADLs immediately, impartially, and with complete accuracy.
- The insurance is priced fairly based on your gender, age and current health.

- There is no risk the insurance company will default or change the terms of the policy.

Note that when gathering stated demand information, we price the product for each individual at the expected value of payouts conditional on age, gender and current health based on the estimated health transition probabilities. This is reinforced by the qualitative statement the pricing is actuarially fair. We price the product at monthly intervals because many nursing home stays and LTC provisions are short term.

After all information is provided, demand is collected in two steps. We first ask respondents whether they would have any interest in purchasing ADL insurance were it available. If the answer is affirmative, we ask how large a monthly benefit they would purchase, while simultaneously reporting how much their purchase of any such benefit would cost up front. In the top right corner of the answer screen we present a link to a hover screen which presents the full specification of the product in case the respondent would like to review any features prior to reporting their demand.

Stated demands are correlated in meaningful ways with observed behaviors. Individuals who have high expectation of needing help with ADLs at some point report being more likely to purchase the offered ADL insurance, and are more likely to demand more insurance conditional on purchasing. In addition, individuals with more positive opinions of public care facilities report lower demand for insurance conditional on purchasing. These patterns suggest again respondents considered relevant expectations and preferences when reporting stated demands.

Twenty-nine percent of respondents indicate they would purchase a strictly positive amount of the offered ADL insurance. Because preexisting LTCI holdings may have caused individuals who would otherwise desire ADL insurance not to demand any more, it is perhaps more meaningful to consider respondents who either report already owning LTCI or having a positive demand for the offered ADL insurance. Forty-four percent of such respondents fall in either or both of these categories, suggesting twice as many individuals would like to insure the ADL state than do in practice. This suggests there is substantial room for expansion in LTC insurance ownership if products were improved. Additionally, many respondents indicating a desire to purchase the offered ADL insurance stated they would purchase significant amounts, with 40% indicating they would purchase more than \$20,000 in annual coverage.

Concluding Remarks Regarding Demand for LTCI

Using two different measurements, we show if ADL insurance products were improved, there would be increased demand for insurance for the ADL state. Specifically, when using a model-driven demand measure, we find ADL insurance ownership would be at least three times as large as actual LTCI ownership, and when using a model-independent demand measure we find ADL insurance ownership would be twice as large.

These results suggest policies designed to improve the current products available in the LTCI market would result in higher rates of insurance. This would reduce reliance on public provision of LTC and potentially result in large improvements in people's well-being.

Insurer In-Force Long-Term Care Insurance Management



Insurer In-Force Long-Term Care Insurance Management

By Vincent Bodnar, Chief Actuary, LTCG

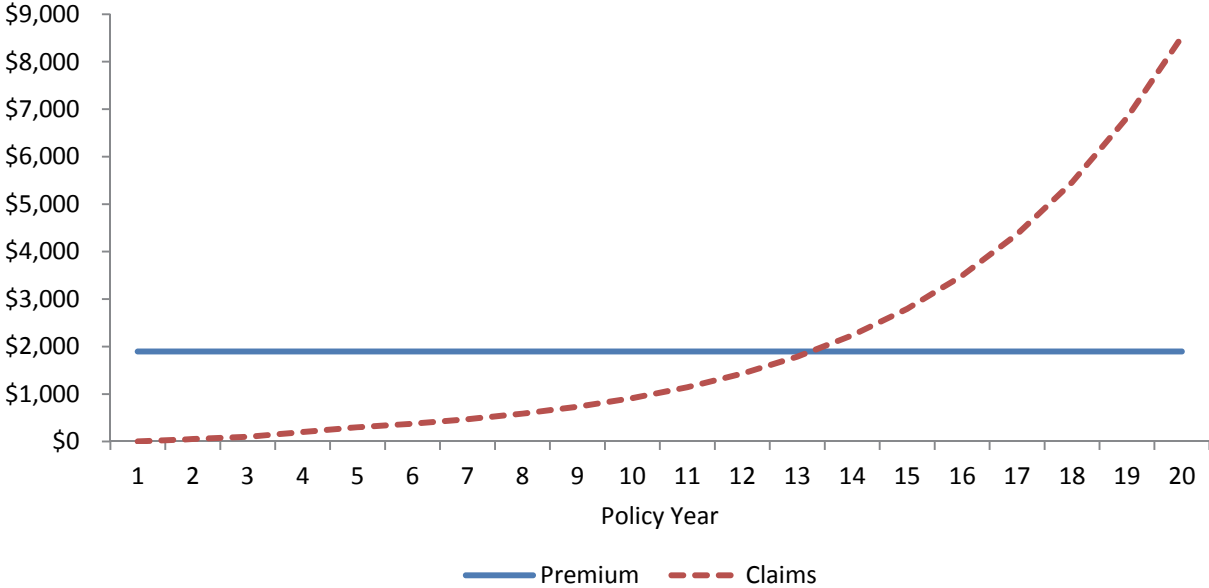
Basics of Long-Term Care Insurance Financial Mechanics

Level Premium vs Increasing Claim Costs

State insurance laws require long-term care insurance (LTCI) contracts to be guaranteed renewable for a policyholder’s lifetime. This means, as long as a policyholder continues to pay his or her premium, the policy cannot be cancelled by the insurer. The same laws and regulations require initial premiums be determined in such a way they are expected to remain level for life. Non-level premium schedules are permitted below attained age 65. Insurers are permitted to adjust premium rates for entire classes of policies if experience emerges adversely to pricing assumptions, but such adjustments are subject to regulatory approval.

Contrary to this requirement for level premium rating, per-capita LTCI benefits (also referred to as claim costs) are not expected to be level over the lifespan of a policy. Graphically, this pattern for claim costs and premium looks as shown in Figure 24 for an illustrative policy.

Figure 24: Illustration of Claim Cost and Premium for a Single Policy

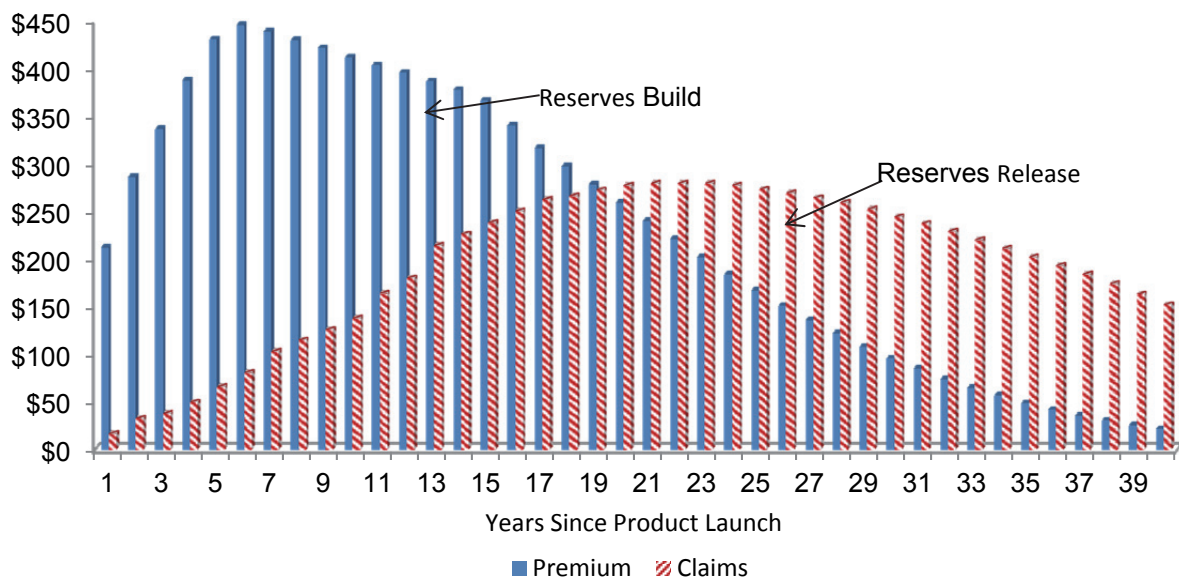


Expected claim costs increase dramatically each year after issue for four general reasons:

1. Aging. The incidence of becoming disabled or cognitively impaired (and triggering LTC benefits) increases by attained age.
2. Underwriting selection wear-off. Most LTCI policies are underwritten at issue based on health conditions. Claim costs will increase as the effect of this initial risk selection wears off over several years after a policy is issued.
3. Marital status changes. Long-term care claim costs are much higher for people who live alone than for married couples. This generally occurs because healthy spouses will tend to provide informal care for disabled spouses. Policies issued to married couples have lower initial claim costs. When one spouse dies, however, claim costs for the surviving spouse will occur at the same rate as persons who live alone.
4. Inflation protection benefits. Many LTCI policies contain inflation protection benefits. State laws and regulations require an option to purchase a benefit that automatically increases benefits by 5% upon each policy anniversary (with a level premium rate) be offered at the time of issue.

Due to this mismatch of level premium rates and steeply increasing claim costs, every cohort of LTCI policies will have a mismatch of cash flows. Premiums will greatly exceed benefit payments in early durations. However, the opposite will occur in later durations and large net cash out-flow will occur. Figure 25 illustrates this for a sample cohort of LTCI policies issued over a 5-year period.

Figure 25: Illustration of Cash Flows Over Time (Millions)



Because of this, insurers must set aside the majority of the net cash in-flow during the early durations of policies into what is commonly referred to as an active life reserve. This reserve will earn investment income and will grow up to a certain point in time. Once the cash flows become negative, this reserve is drawn down to fund benefit payments and expenses exceeding premium collections and investment income.

Unforeseen Developments and Trends

A report prepared for the U.S. Department of Health and Human Services (HHS) in 2013 titled “Exiting the Market: Understanding the Factors Behind Carriers’ Decision to Leave the Long-Term Care Insurance Market” (HHS Report) discusses the experience that has occurred in the LTCI industry since the 1990s in general.¹⁰⁵ Virtually all insurers issuing LTCI policies prior to the mid-2000s have observed adverse experience on these policies when compared to pricing assumptions. The HHS Report documents key historical assumptions commonly used in the industry and how they have developed adversely over time. These are as follows:

- *Low lapse and mortality rates.* Long-term care insurance is a lapse supported product. If voluntary lapse and mortality rates are lower than expected (i.e., fewer policies lapse), there will be more policies in-force at later policy durations than were expected when the policies were priced. Because of the mismatch of level premium rates and claim costs that increase steeply by policy duration, the additional premium collected from the greater number of in-force policies will not be enough to fund the additional claims occurring at later years.

According to the HHS Report, pricing lapse assumptions in the 1990s were 8% in the first policy year grading down to 4%, while industry experience has generally been about 4% in the first year grading down to 0.5% in later durations. This difference by itself can potentially have a severe impact on the adequacy of an insurer’s active life reserves.

Although not explicitly described in the HHS Report, most insurers have observed mortality rates well below what was expected when older products were priced. As with lapse rates, even small deviations from expected tables can cause severe financial results for an insurer.

¹⁰⁵ U.S. Department of Health and Human Services, 2013. “Exiting the Market: Understanding the Factors behind Carriers’ Decision to Leave the Long-Term Care Insurance Market,” Washington, DC. <https://aspe.hhs.gov/basic-report/exiting-market-understanding-factors-behind-carriers-decision-leave-long-term-care-insurance-market>

- *Interest rates.* The assets held in reserve to fund future cash out-flows in later durations of LTCI policies are expected to generate investment income. If this investment income is less than expected, the assets, together with premium collected, will not be sufficient to fund these future benefits and expenses.

According to the HHS Report, in the 1990s, insurers generally assumed assets held to fund future LTCI policy out-flows would earn investment income at rates between 5% and 8%. Due to unforeseen economic conditions, such investment earnings rates have not been realized for many years. Current earnings rates are between 2% and 4%. This difference by itself potentially can have a severe impact on the adequacy of an insurance company's active life reserves.

- *Morbidity.* Morbidity is made up of three factors: 1) claim incidence rates, or the rate that policies go on claim; 2) length of claim; and 3) benefit utilization. While the HHS Report does not directly list specific assumptions used in earlier pricing efforts, it does state that publicly available data sources generally were used to develop assumptions. In general, these sources did not include experience for assisted living facilities, which have become a highly utilized care setting, and which have much longer length of claim than claims that begin in nursing homes. Although this trend by itself generally is not enough to have a severe impact on reserve adequacy, it can compound the level of reserve deficiency when combined with lower lapse, mortality and investment earnings rates.

Corrective Actions

Nearly all insurers in the LTCI industry have pursued corrective action after realizing the adverse experience of their legacy blocks. In general, these actions fall into the following three categories:

- *Premium rate increases.* The ability to correct reserve deficiencies completely with premium rate increases diminishes quickly in the later policy durations. This is because the amount of premium collected in later years is much less than benefit payments and there are fewer policyholders paying premium, which causes the level of rate increase needed to restore reserve adequacy to be very large. This phenomenon is illustrated in Table 6, which is developed from the same example block of business that was used to prepare Figure 25.

Table 6: Rate Increase Required to Offset Future Losses

Deviation	Yr. 10	Yr. 13	Yr. 16	Yr. 19	Yr. 22
+10% Claims	11%	13%	16%	20%	25%
-1% Lapse	8%	13%	21%	31%	46%
-1% Interest	7%	9%	11%	14%	17%
All Three	28%	38%	50%	67%	90%

As shown, rate increases required to merely offset future losses (which is generally less than what is required to restore reserve adequacy) become large for even small deviations. Many insurers have experienced multiples of all three of the deviations shown, resulting in large actuarially justified rate increases. Many insurers and regulators view such levels of rate increases to be unfair to remaining policyholders and accordingly seek or approve premium rate increases that do not completely restore reserve adequacy by themselves.

- *Benefit reductions.* An approach becoming more common in recent years among insurers is to offer policyholders the option to reduce benefits in lieu of premium rate increases (after rate increases have been approved by the regulator). As an example, a policyholder may reduce his or her daily benefit, benefit period or inflation benefit option to offset the effect of a premium rate increase.
- *Recognize losses.* In many cases, premium rate increase requests and benefit reduction offers have not been sufficient to restore reserve adequacy and fund future benefits. In such cases, insurers were required to recognize reserve deficiencies and post additional reserves, typically at the expense of insurer surplus or profits from other products. If the insurer has inadequate surplus, or is a mono-line LTC insurer, options for subsidizing losses may not exist.

Nontraditional Funding for Long-Term Care

Although traditional LTCI sales have declined dramatically and have fallen into a state of stagnation, sales of hybrid products are growing, and a recent push for innovation appears promising.

Long-Term Care Hybrid Products

Product Features

Life insurance hybrid products are the most popular types of hybrids. Often, such products are comprised of a base life insurance policy with a rider providing LTC benefit elements. Such riders can be attached to any type of permanent life insurance product, such as whole life or universal life policies. These riders allow the insured to accelerate all or a portion of the base policy's life insurance face amount to access LTC benefits in the event the LTC eligibility requirement is met. This requirement is often the inability to perform two or more activities of daily living or a cognitive impairment requiring supervision. A small percentage (2% to 4%) of face amount is paid monthly while eligibility continues until the face is exhausted. Often, there is an optional feature to extend LTC benefits beyond the depletion of the face amount. This extension is typically for a multiple of two or three times the face amount. The rider's LTC benefits are typically financed by an additional premium or an account value charge.

Deferred annuity hybrid products are less popular than life insurance hybrids. The most common types are made up of a base deferred annuity contract with a rider providing LTC benefits. Typically, the rider allows the annuity's account value to become available with a reduced or without a surrender charge if the contract holder meets LTC benefit eligibility requirements. As with life insurance hybrids, a small percentage of the account value can be withdrawn monthly until the account value is depleted. An extension of benefits feature is also common, which allows for monthly LTC benefits after account value depletion, up to a multiple of two to three times the account value in place when LTC benefits were first triggered. The LTC benefits of the rider are financed through an additional premium payment at the issuance of the rider or through monthly charges to the annuity's account value.

Appeal of Hybrids

Hybrid products are appealing to customers, with particularly good alignment with consumer attitudes of the baby-boom generation, which now entirely comprises the target market for LTCI products. The products are fairly simple and can be easily explained to consumers. Generally, the customer has already made a decision to purchase life insurance or an annuity contract, and the step of making it a hybrid product is as simple as a choice to add a rider with LTC features. The customer is simply being advised of an optional feature which allows the ability to access his/her death benefit or account value in the event LTC is needed.

Also, there is equity in the based product’s cash or account value. If the customer decides to terminate the policy without using the LTC benefits, he/she will at least receive the surrender value of the base product. Finally, hybrid products are cost-effective. The add-on premiums for the LTC benefit riders are generally much less costly than their standalone counterparts.

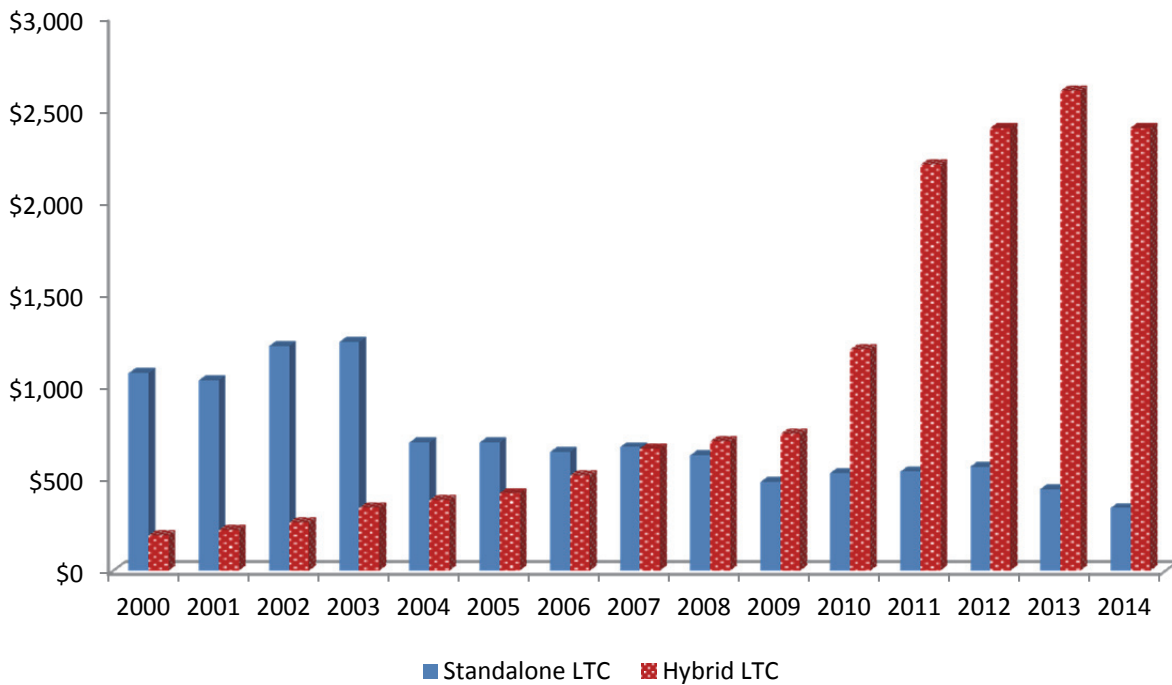
Hybrid products are also appealing to insurers. The risks typically found in standalone products are much more mitigated for hybrid products. For life hybrids, the majority of the exposure is limited to the base policy’s net amount at risk. The low mortality rates are often observed with LTCI products acts as an offset to the life insurance risk. Hybrid products are also very easy to distribute and can be sold through an insurer’s broader distribution system if its producers are properly licensed. As previously noted, the sale is typically made as an add-on feature to a base-product already in the process of being sold.

Size of Hybrid Market

The hybrid product market has experienced substantial growth at the same time that standalone LTCI sales have collapsed and stagnated. This is illustrated in Figure 26.

Figure 26: Traditional vs. Hybrid New Premiums Issued (Millions)

Sources: 2001–2013 Broker World Surveys, LIMRA



Products with hybrid features currently comprise 12% of new life insurance premium issued in 2014. It is estimated 100,000 hybrid policies were sold with \$2.4 billion of premium issued in 2014. This compares to 130,000 policies and \$330 million of new premium issued in the standalone LTCI market. It is important to note the majority of hybrid products are single premium whole life insurance policies, so the premium volumes are not directly comparable to the annualized premiums of standalone LTCI. It is also worth noting, while standalone LTCI insurers continue to exit the market, new insurers are entering the hybrid product market every year.

Underwriting and Private Long-Term Care Insurance Options

The vast majority of LTCI products sold today must go through a rigorous underwriting process which allows only the best risks to be issued coverage. As a result, a large portion of persons attempting to purchase insurance are not issued policies. Although there are some options, which are described below, most people in this situation must deal with financing their care if and when they are faced with a need for LTC.

Some life insurance products sold through the workplace are on a guaranteed, simplified issue basis, and LTC benefit riders on such products are becoming more common. However, the availability of such an option is still limited, and it generally has a small face amount, which means minimum LTC benefits.

Not long ago, however, standalone substandard LTCI products were available to people who could not meet stringent underwriting criteria. These products disappeared at just about the same time new sales in the traditional market collapsed in the mid-2000s.

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

- Short benefit periods (12 to 36 months)
- Long elimination periods (120 to 180 days)
- Low daily benefit maximums (\$70 to \$120)
- A limitation of covered services to nursing home care
- No waiver of premium
- No restoration of benefits
- Low first-year commissions and no renewal commissions

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

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

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

The potential market for such a product is large. According to some leading producers, approximately 15% to 25% of all applications submitted are declined coverage due to today's strict underwriting standards, and another 10% to 15% of applications are never submitted. Distribution could be greatly streamlined through automatic referral agreements with insurers issuing standard products.

Underwriting Point-of-Care and Point-of Need Funding Solutions

Viable financing options are beginning to emerge for persons who have not had the opportunity to purchase LTCI prior to the point of needing care. This is a good development given the low penetration such insurance products have experienced.

To understand better how these options might fit into the future of LTC financing, it is important to first know some basic statistics about the financial situation of the average person over the age of 80. The average age of first incurring LTC expenses is currently between 80 and 85. On average, his/her net worth is \$275,000 (of which \$135,000 is home equity), and his/her

average annual income is \$22,000. When a person in this average situation enters a nursing home, he/she is faced with an average annual nursing home expenditure of \$81,000, which results in an average income shortfall of approximately \$60,000. The fear of outliving assets becomes very real at this point, as it will take only four years for this to happen for the average person. This fear is often shared with the adult children of the person needing care, who commonly make or heavily influence the tough financial decisions in these cases. Many people panic and initiate Medicaid planning.

In this average situation, the incidence risk has been decoupled from the longevity risk. The person is now faced with a care episode. The time for insuring against the chance of a care episode occurring has now passed. If we look closely, however, the person has the means to pay for an average stay in a nursing home (which is just under two years), but surely cannot afford to pay for a stay lasting more than four years, which is a real risk. So, this leaves a need to protect against the longevity risk, which can be accomplished by a new breed of immediate annuities.

Traditional immediate annuities are priced assuming the annuitant is anti-selecting; in other words, the person is very healthy and expects to live longer than others the same age. For example, let us assume the premium for healthy people buying an annuity at age 82 is 10 times the annual payment they will receive. So, a \$120,000 single premium will purchase an annual income stream of \$12,000. However, people beginning a stay at a nursing home typically have health conditions which will shorten their life expectancy to, let us assume, 20 months. This makes the purchase of a traditional immediate annuity to protect against longevity uneconomical.

Such a situation is ideal for an underwritten immediate annuity, particularly one aimed at people entering a nursing home. Here, underwriting is counter to what we think of in life and health insurance because the more health conditions people have shortening their life expectancy, the more leverage they have. For example, an underwriter could discern, based on health conditions, a particular person is expected to live approximately 20 months. Allowing for profit margin, the insurer might assume a two-year life expectancy for pricing purposes. In this case, the \$120,000 could purchase an annual income stream of \$60,000 for the life of the annuitant, which is enough to fill the average income gap during a nursing home stay while the annuitant lives. This could be purchased from just a portion of the average person's net worth at over age 80—and it would eliminate the fear of outliving assets and the panic which leads to the initiation of Medicaid planning.

As of this writing, there is at least one such product available in the U.S. There are examples of proven success elsewhere. This is the predominant form of LTCI in the U.K., where the traditional product as we know it in the U.S. is not sold.

The target market for such a product comprises people entering or currently in care episodes with income shortfalls, but who have enough net worth to fund the income shortfall for an average remaining impaired life expectancy. This is the case for about half of the U.S. population over age 80.

Other point-of-need funding solutions have emerged for those who did not previously purchase LTCI. There is a budding financial advisory space focusing on these cases, and these advisors do not push a Medicaid solution.

The approach of such financial advisors is to first determine whether there is an income shortage for persons who need LTC and, if so, to quantify it. Then they take steps to convert net worth into income streams help fill this gap. The most common ways of doing so are:

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

At least one “financial concierge” company has emerged in this market, which receives referrals from nursing home and assisted living facility admissions offices. It acts as an advocate for new entrants in finding ways to finance care, and it can provide bridge loans as solutions are put into place, which can take months in many cases. The company also receives real estate brokerage or referral fees in cases where a home is sold, as well as referral fees for other transition services (such as moving and storage services).

Financing Options for Long-Term Care



Financing Options for Long-Term Care

By Robert L. Kane, Professor and Minnesota Chair in Long-Term Care and Aging,
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of Aging Transformation, Minnesota Department of Human Services

Introduction

There is strong interest from many quarters in maximizing the likelihood older persons have the ability to pay for long-term care (LTC). Efforts to promote some form of savings or insurance are presented as increasing consumer autonomy and flexibility, but the often unstated sub goal is to do this without increasing the burden on Medicaid. States that have mounted campaigns to increase citizens' ability to pay for LTC, do so because they envision increasing demands on Medicaid as the aging population increases.

Converging forces make continuing use of current LTC financing practices less feasible. In addition to the growing numbers of older people, the relative dearth of working age people means a lower tax base and fewer workers to provide services. Family composition has also been changing. Fewer people are marrying, while divorce rates are high. In addition, couples have fewer children. Thus, the pool of informal caregivers is shrinking. At the same time, smaller families may mean more disposable income, some of which could go towards investment in some form of LTC financing.

The economic situation has also changed. Two-income families are the norm. Unemployment and under-employment are still problems and wage rates for the majority are still low. The costs of formal LTC are high. Too much of it is still provided in institutions, although the nature of the care in these settings has broadened from a focus on activities of daily living (ADLs) to managing complex medical care for very sick people and a whole new role in providing rehab/post-acute care after a hospitalization.

Medicaid policy is strongly affected by Medicare policy, since both compete for public dollars, and costs in both programs are continuing to rise. Especially in response to rising costs, Medicare has tried hard to remain responsible for only acute care.

This section of the study examines the role of long-term care insurance (LTCI) and the ways the basic design could be changed to achieve greater take-up or address the problem inherent in the traditional design. It also examines a range of other financing options which could be candidates for future use to pay for LTC, and it analyzes the extent to which any of these LTCI

and other options meet relevant criteria for addressing the need for such financing in the future.

Who Would Benefit Most from LTCI?

Long-term care insurance has two major goals: 1) to provide funds to cover LTC costs for those with modest resources; and 2) to protect the assets of those with more substantial resources who want to leave an inheritance for their family. Those at the very top and bottom of the income distribution are least likely to benefit from LTCI. The very wealthy do not need the protection. The very poor are already in Medicaid. The large group in the middle face trade-offs. The lower their income, the less disposable income they have available to pay premiums (especially for term insurance which they are not likely to use). The younger they are, the cheaper the premium but the less immediately useful it is and the greater the risk of losing all they have paid in if they stop before they need the benefits.

There is an incentive to purchase insurance early in order to obtain a lower premium, but that premium rate is calculated on the assumption of very low risk. In essence, one is prepaying, but doing so at great risk because it is term insurance. The coverage is only available so long as you are paying a regular premium. The second motivation for early purchase is eligibility. The longer the delay, the greater the risk of contracting a chronic health condition, which will eliminate eligibility entirely or raise premium costs.

How Could the Basic Design of LTCI Change to Meet Greater Needs?

There are multiple insurance formats and alternatives for accruing resources to address LTC costs. Within the realm of LTCI, programs can be designed in various ways to address current limitations. The insurance could offer more modest benefits at a lower cost. Such coverage would provide a modest cushion, which would protect a few with modest needs and offer the rest some limited protection. Universal public coverage could be designed to start after a person has expended some amount. This design would provide a private insurance market much like Medigap insurance for Medicare, with definable predictable, limited risk. If the public product includes cost-sharing for the more affluent, the private insurance market is even stronger. The alternative design would be public coverage for the initial costs, leaving continuing costs (after a defined limit) to the consumer. This offers a less predictable insurance market. Such a situation would resemble what exists now with a smaller risk pool.

Alternatively, the current term insurance approach might be altered to create new products, such as life stage, which combines LTCI with life insurance, or modify the environment for LTCI.

These are described in Table 7. Experts report that LTCI policyholders use only about one-half of their available benefits and argue that many are over-insured.¹⁰⁶ One could argue the average policy could be reduced, thereby reducing the average premium, and making this new lower level of protection more affordable to middle income households.

Table 7: Alternative Designs for LTCI and Other LTC Products

Option	Description
Insurance Options	
Current typical LTCI policy	This type of insurance product pays for the costs of LTC you need. You pay a premium and when benefits are triggered, the policy pays a selected dollar amount per day for a set period of time for the type of LTC outlined in your policy. In most policies, benefits are payable based on your inability to perform two or three specific ADLs, such as eating, dressing, bathing, continence, toileting and transferring. Some of the common features a purchaser will need to decide on include: elimination period, duration of benefits, daily benefit, inflation protection, range of care options covered, pre-existing conditions, premium increases, guaranteed renewability, grace period, return of premium, prior hospitalization and non-forfeiture. Average cost of premiums for single, age 55 is \$2,007 per year. This assumes lifetime benefit maximum of \$164,000, based on daily benefit of \$150 and a three-year benefit period.
LTCI with more limited benefits (short-term care insurance)	This variation offers benefits for up to one year and uses looser underwriting standards and lower premiums, which make them more accessible to people with health problems. They typically do not cover all levels of care. The average cost of annual premium for single, age 64, is \$312 for a daily benefit of \$120 for 100 days.
LTCI that offers front-end public coverage	This variation provides an LTCI policy offering coverage of the front-end expenses paid for with public funds for a set time period (1-2 years), and policy providing back-end coverage paid by the individual to cover the remainder of his/her LTC need. This would be more affordable than current policy design because public funds would cover the upfront part of the LTC all individuals need, and insurers would cover the longer period of time fewer individuals need.

¹⁰⁶ Gleckman, Howard, 2015. “Consumers are Buying Less Long-Term Care Insurance coverage,” Forbes Personal Finance, www.forbes.com/sites/howardgleckman/2015/02/20/1469/

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<p>LTCI that offers back-end public coverage (high-deductible catastrophic)</p>	<p>This variation provides an LTCI offering coverage of the front-end expense paid through premiums for a set period of time (1-2 years) and back-end coverage paid with public funds for the remainder of the LTC needed. It would function as high deductible catastrophic and the individual would buy a policy to pay for a short and fat benefit and a publicly funded benefit would cover the long and lean remainder.</p>
<p>Treat LTCI premiums like a 401 (k) contribution</p>	<p>This option is currently not available, but it would provide tax-deferral on the income used to pay LTCI premiums just like individuals are allowed to defer taxes on the income put into a 401 (k) plan.</p>
<p>Life insurance and annuity options with an LTC rider or link (combo or hybrid policies)</p>	<p>These financing options are increasingly popular in light of the uncertainty and carrier withdrawal from the traditional LTCI market. Called combo or hybrid products, sales of these policies grew 79% in 2010, 56% in 2011 and 10% in 2012.¹⁰⁷ If your main focus for use of a life insurance policy is the LTC insurance payout, a linked benefit policy would be your choice. It will allow your LTC benefits to be paid out in excess of the life insurance payout. A \$100,000 deposit will provide you with a paid-up life insurance policy of \$137,419 or \$413,257 for LTC. You will receive \$5726 a month for six years if you need care. An annuity option essentially works the same way; it provides an LTC rider on the annuity that makes those funds available to pay for LTC.</p>
<p>Life stage protection insurance (specific combo product)</p>	<p>This new product concept would provide a term life insurance benefit up to age 65 or retirement, when consumers need family protection most. Then, for approximately the same premium and same level of coverage, the product would provide LTC benefits from age 65/retirement on, when consumers are most likely to need that type of protection.</p>
<p>LTC benefit add-on in Medicare supplemental plans</p>	<p>This option would embed a nonmedical home care benefit in all Medicare supplemental plans sold in a state. It would be a mandated offering, with an opt-out for consumers who already had equivalent or better LTC protection. It would pay for qualifying home and community services but not assisted living or nursing home care. The benefit pool would be approximately \$50,000 over the lifetime.</p>

¹⁰⁷ <http://longtermcareinsurancepartner.com/blog/life-insurance-combined-with-long-term-care-insurance-a-plus-with-buyers>

Option	Description
Savings Options	
Savings and Investments	<p>This is the most common source individuals use to pay their LTC costs. It provides the most flexible option for paying for LTC products or services. There are countless ways to save and they include tax-free, tax-deferred and tax-deductible vehicles. Being able to amass enough savings to pay for LTC requires early and regular diligent savings. Even with this, savings generally do not provide the same level of benefit one can obtain through purchase of an insurance policy.</p>
Health Savings Account (HSA)	<p>An HSA is paired with a high-deductible health insurance policy. It is the vehicle for saving money used to pay the deductibles and co-pays required by a high-deductible policy. If a policy has a deductible of at least \$1,300 for individuals and \$2,600 for family coverage in 2015, you may be eligible to contribute to an HSA. You may contribute up to \$3,350 to an individual account or \$6,650 to a family account, plus up to an additional \$1,000 if you are 55 or older anytime in the year. The contributions are pre-tax and tax-free for eligible medical expenses. For the biggest tax benefit, you want to keep the money in the HSA growing and use other cash for current bills. There is no time limit for use of the money, although once you sign up for Medicare you are no longer able to contribute. However, you can use the money for LTC expenses, including LTCI premiums.¹⁰⁸</p>
Borrowing Options	
Asset Conversion (Reverse Mortgage)	<p>A reverse mortgage is a special type of mortgage available to homeowners age 62 and older. You can access cash from the value of the home without selling it. You choose whether you want to receive a lump-sum payment, a monthly payment, a line of credit, or a combination. There are no restrictions on how you use the money from a reverse mortgage. Unlike a traditional mortgage, a reverse mortgage does not currently require an income or credit requirements. You make no monthly mortgage payments. You do not have to repay the loan as long as you continue to live in the home. The total amount you can borrow is based primarily on the age of the youngest homeowner, the home value, the type of reverse mortgage you select and the current interest rates.</p>

¹⁰⁸Kimberly Lankford, 2014. "FAQs About Health Savings Accounts" *Kiplinger*, Dec. 1, 2014. www.kiplinger.com/article/insurance/T027-C000-S002-health-savings-accounts.html

Criteria for Solutions

To assess the potential for each of these possible approaches we propose a set of criteria:

- Affordable for most people (What segments of the population could afford to buy such care?)
- Politically feasible (Who would support such a strategy? Who would actively oppose it?)
- Actuarially feasible
- Are there features which could be added to the option that protect the consumer?
- Is the option marketable? Is it flexible, and does it provide for multipurpose use?

Table 8 summarizes how each strategy in Table 7 fares against these criteria.

Table 8: Assessment of LTCI and Other Financing Options

	Affordable	Politically Feasible	Actuarially Feasible	Marketability	Consumer Protection
Current traditional LTCI policy	Less affordable Seen as too expensive by most middle income households.	More feasible Lawmakers are familiar with traditional LTCI	Less feasible Premium increases have been significant over the past 10 years because of actuarial issues in previous years	Less marketable The Premium increases, and companies exiting the LTCI market have made consumers apprehensive about the product	More protection Protections have been added to the product over time, but consumers hear stories of cost increases and repeated claims denials
LTCI with more limited benefits (Short-term care insurance)	More affordable A short and fat policy would be more affordable for the middle income households	Somewhat feasible	More feasible Less costly to administer Exposure to less risk for the carrier	More marketable The lower price and looser underwriting would bring younger, sicker and middle income households into the market	Less protection May not have the same level of safeguards larger policies have been required to provide

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	Affordable	Politically Feasible	Actuarially Feasible	Marketability	Consumer Protection
LTCI that provides public front-end coverage	<p>More affordable</p> <p>This option would be more affordable because the risk to the insurer is reduced</p>	<p>Less feasible</p> <p>Private front end coverage would need to be paired with public catastrophic and this may be difficult to get through the political process</p>	<p>Feasible</p> <p>Makes private LTCI more attractive to insurers</p>	<p>More marketable</p> <p>A sizable proportion of individuals who need LTC need it for relatively small amounts of time, so this option would be attractive to those who believe they will not need extensive LTC</p>	<p>More protection</p> <p>More protections would be added because of the public funding role that is part of this option</p>
LTCI that provides back-end public coverage (high deductible catastrophic)	<p>More affordable</p> <p>Cheaper than current products because the risk for extensive care for years is taken by the public sector</p>	<p>Less feasible</p> <p>This design was proposed on CLASS Act and was repealed by Congress because it was unworkable</p>	<p>Less feasible</p> <p>Actuarial issues arise if this option is voluntary</p> <p>If mandated, the actuarial model works</p>	<p>More marketable</p> <p>Individuals tend to worry about risk of needing extended periods of care so this option would appeal</p>	<p>More protection</p> <p>More protections would be added because of the public funding role that is part of this option</p>
Treatment of LTCI premiums like a 401 (k) contribution (non-term design)	<p>Affordable</p> <p>Tax favors are seen as a reward for purchasing a policy, not a real incentive to make purchase</p>	<p>More feasible</p> <p>Tax favors are popular with lawmakers at both federal and state levels</p>	<p>Feasible</p> <p>Not an issue</p> <p>Fiscal analysis would be needed to see the effect on take-up</p>	<p>More marketable</p> <p>Tax favored treatment of income is popular with taxpayers</p>	<p>More protection</p> <p>401 (k) plans are regulated both at the federal and state levels</p>

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	Affordable	Politically Feasible	Actuarially Feasible	Marketability	Consumer Protection
Life insurance and annuity options with an LTC rider or link	<p>Less affordable</p> <p>Current policies require \$100,000 investment</p>	<p>Feasible</p> <p>Because of the expense to use these options, there is no large political role in expansion</p>	<p>More feasible</p> <p>Actuarial analysis of these options would look positive for the carrier</p>	<p>More marketable</p> <p>There has been significant growth in hybrid products. Consumers expect to get benefits if they die or if they need LTC</p>	<p>More protection</p> <p>More protections have been added as these products have grown in the market</p>
Life stage protection insurance (specific combo product)	<p>More affordable</p> <p>Compared to traditional LTCI, Combo product is cheaper to buy than each of the two</p>	<p>More feasible</p> <p>Lawmakers are interested in supporting new affordable products for their constituents</p>	<p>More feasible</p> <p>Actuarial analysis indicates very affordable costs for this product</p>	<p>More marketable</p> <p>This product is relatively easy to understand and use, since it manages two risks we all face</p>	<p>More protection</p> <p>Some additional consumer protections may be needed because this is a new product</p>
LTC benefit add-on in Medicare supplemental plans	<p>More affordable</p> <p>A very modest increase in the premium can provide significant benefit for Medicare beneficiaries</p>	<p>Less feasible</p> <p>Accomplishing this plan requires support and approval from both federal and state level government</p>	<p>More feasible</p> <p>Actuarial analysis shows the large risk pool offers larger benefit for smaller premium</p>	<p>More marketable</p> <p>Medicare is very popular with seniors</p> <p>Over 75% purchase a supplemental plan</p>	<p>More protection</p> <p>Any part of Medicare is already highly regulated but there may be additional requirements for this new concept</p>
Savings	<p>Affordable</p> <p>Even for lower income households, the message to save for retirement and old age is important. Most have limited disposable income</p>	<p>More feasible</p> <p>There are many (too many?) options for saving including tax advantaged options, all attractive to politicians</p>	<p>Feasible</p> <p>Actuaries point out an individual cannot save the amount of money they can access through insurance products unless they are extremely diligent and save significant amounts regularly</p>	<p>Less marketable</p> <p>Savings is hard to sell</p> <p>However, many more individuals expect to use their savings and investments to pay for LTC than use insurance or government programs</p>	<p>Some protection</p> <p>Basic regulations that apply to savings up to FDIC limits are in place</p> <p>Consumer protections when investing are less robust</p>

	Affordable	Politically Feasible	Actuarially Feasible	Marketability	Consumer Protection
Conversion of home equity for LTC coverage (reverse mortgages)	Affordable The fees to apply for and obtain a reverse mortgage are relatively high but it provides immediate cash to use for any purpose the homeowner wishes	Less feasible Because of previous problems with reverse mortgages, state and local officials have not dealt with remaining ongoing issues No one wants to foreclose on seniors	Feasible Using housing asset is seen as last resort but for individuals with no other resource it allows them to remain in their home and use the proceeds to pay for needed care	Marketable People do not want to give up homes; most want to remain in their homes as long as possible and a reverse mortgage can help make that a reality	More Protection Reverse mortgages have had problems with credibility in the past, but new HUD regulations have set new standards meant to eliminate the problems
HSA variation (tax-free premiums and non-taxed benefits)	More affordable Individuals can put in as much as they are able up to limit set at federal level each year	More feasible No cost to state There are tax costs to changing provisions in the HSA but small compared to paying total cost of LTC	More feasible Provides flexible money to individuals to use any way they wish for LTC (and medical) expenses	More marketable HSAs are increasingly available to employees	Some Protection What are the tax consequences from early vs. late use?

Next Steps

The current LTC financing marketplace consists of insurance products, home equity options such as reverse mortgages, and health and retirement savings plans. None of these products has seen widespread use recently due to a number of factors, including the perception of their stability, their safety and their uncertain benefit levels.

Long-term care insurance has seen dramatic across-the-board rate hikes on both prospective and retrospective business, tightened underwriting practices and a reduction in consumer demand. On the supply side, nationally approximately 90% of insurance companies that once offered LTCI no longer do so. Annual sales are only about one-third of what they were a decade ago. Those who are buying are purchasing less coverage; at the same time, LTC costs are rising. There are increasing sales of policies with shorter duration (three years or less), policies with lower daily rates (\$100 per day), and policies with lower inflation protection levels (from 5%

down to 3%).¹⁰⁹ These all have one feature in common: They reduce the price the consumer must pay.

There also seems to be greater interest in options besides private insurance for paying for LTC. In the past, most consumers thought the only available option to pay for LTC (besides Medicaid) was private insurance. This belief seems to be changing as consumers look for new ideas and products.

Several observations seem evident:

1. Individually marketed products will be hard to sell.
2. Moral hazard is a major concern.
3. Consumers are unlikely to buy more than modest coverage.
4. Informal care will remain the backbone of LTC.

Given this situation, Professor Kane proposes a set of features which seem essential for any LTC financing option to be considered in the future. These features include:

1. A product serving a large risk pool of individuals with LTC services and supports, which are designed to mitigate adverse selection and make the option as universal as possible.
2. A product offering flexible benefit structures, to accommodate the wide range of services and supports individuals may need and want to meet their LTC needs.
3. Cash payments are better than service coverage.
4. A product offering a combination of savings and insurance, often called a hybrid or combo product, so the buyer gets the advantage of savings (total flexibility) along with the risk mitigation insurance offers.
5. A product as affordable as possible to attract and serve middle income households, those with annual incomes of \$50,000 - \$125,000.
6. A product offering an option to individuals who would otherwise turn to Medicaid to pay for their LTC. Perhaps these products could offer an incentive to use private funds before MA public funds. The experience with the RWJF Partnership program suggests such programs typically break even.
7. A product whose design could include a mandated offering, but with specific opt-outs for certain groups or conditions.

¹⁰⁹ Howard Gleckman, 2015. "Consumers are Buying Less Long-Term Care Insurance coverage," *Forbes Personal Finance*, www.forbes.com/sites/howardgleckman/2015/02/20/1469

8. A product ensuring the consumer has long-term protection for their investment and the legal agreement for benefits to be provided as specified in the legal contract.
9. A product melding public and private options together to maximize the use of private funds for one type of risk management (short and fat) and the public sector to manage the other type of risk (long and catastrophic).

We are in the midst of a sea change in how we view LTC financing. We are moving away from the world of either the traditional LTCI or Medicaid and into a world of more flexible options to meet the varied situations of our population. As new or refreshed products are developed, they represent a kind of disruptive innovation of our thinking about LTC financing that can lead to an exploration of new ways of approaching the basic issue of how to pay for our LTC at both the individual and governmental level.

As we move deeper into the developing societal aging, a larger national (or state level) governmental role may be necessary to stabilize the LTC financing system and ensure an equitable system across all states. While many are working to avoid a crisis, there may still be a point when state Medicaid programs are overwhelmed with unsustainable increases because of the number of elderly turning to this program, and the federal government will need to act. The work many are doing now to identify the most important features of that system and how to meld individual responsibility with governmental responsibility will provide useful guide posts.

Long-Term Care Reform Proposals



Long-Term Care Reform Proposals

By John Cutler, Esq., Senior Fellow, National Academy of Social Insurance ¹¹⁰

Introduction

To respond to the largest unmet risks facing aging Americans, two national policy experiments in long-term care (LTC)¹¹¹ financing were passed by Congress and signed into law by the president in recent years.

The first was the federal Long-Term Care Security Act signed by President Bill Clinton on September 19, 2000. This Act created an employer sponsored long-term care insurance (LTCI) program for federal employees and retirees, and their spouses.¹¹² While offered by the federal government, it is essentially an employer offering similar to what other large employers have.

The other effort was signed into law by President Barack Obama March 23, 2010. It was Title VIII, Community Living Assistance Services and Supports (CLASS) Act of the federal Affordable Care Act (ACA).¹¹³ Its sponsors and supporters viewed it as a new option for Americans to finance LTC. The way it was structured, it would have actually operated as both an LTCI program as well as a disability insurance program. The CLASS Act was voluntary and self-

¹¹⁰ The author was the architect of the Federal Long-Term Care Insurance Program. He retired from the federal government in 2015 and is now a Senior Fellow at the National Academy of Social Insurance as well as a special advisor to the Women’s Institute for a Secure Retirement (WISER). Disclosure: The author has a consulting contract with the state of Minnesota pertaining to its Medicare long-term care option. Opinions stated here are entirely his own.

¹¹¹ A word on nomenclature. Advocates and policymakers have been shifting to the use of long-term services and supports (LTSS), viewing long-term care (LTC) as too passive a term. “Long-term services and supports (LTSS) are defined as the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

¹¹² Public Law 106-265. The Federal Long Term Care Insurance Program (FLTCIP) launched in 2002 and now is the largest group long-term care insurance program (with over 270,000 enrollees). Unlike the health insurance program where there is a substantial subsidy (in line with employer practices in general), the FLTCIP is employee pay all. As a consequence, the expected take up was not likely to be robust enough to overcome the concern about adverse selection. That led to the decision to have underwriting (though it was short form underwriting during new product offerings or for new hires). While the federal program can certainly be viewed as a programmatic success, it did not achieve the unstated aim of policymakers to substantially increase the number of Americans insuring against the risk of needing long-term care.

¹¹³ Public Law 111-148

funded, and meant to be offered through the workplace. In the end, certain design flaws could not be fixed, and the law was repealed.¹¹⁴

Let us fast forward to today. These proposals were nowhere near enough. Indeed, in the case of the CLASS Act, the failure to implement it arguably set policy back by years. But given the problem is not going away and instead remains mostly unresolved, it would be surprising if efforts did not continue to “fix” LTC. This section of the study addresses organizations and initiatives which will shape the debate during the next several years.

As an aside, while a potential solution could be a major proposal that passes like health care reform, most likely it will be in incremental steps.¹¹⁵ Reform efforts may be about better using existing products and services—enhancing and strengthening them—both in the private and public sphere.

It is not within the scope of this section to look in-depth at private products but the shift from standalone LTCI to combo products is a perfect example of this trend. By better using existing products like life insurance (and to some extent annuities) which consumers find valuable, the LTCI industry is attempting to overcome the hesitancy of the buying public to stand-alone insurance as the way to fund LTC risk. Thus, it would not be odd to find efforts to do the same with other products, for instance combining insurance with 401(k) and individual retirement account (IRA) plans, or with health insurance or Medicare. We will explore this later in the section.

Likewise, on the public side, there may be interest in shoring up existing systems. While not an insurance issue per se, the amount of uncompensated caregiving—estimated now at \$470 billion a year¹¹⁶—makes this an obvious area for political interest. If the support system for this informal caregiving collapses, then people will be forced to tap insurance (public or private) earlier than might otherwise be the case. The same is true for employers who already see their employees taking off more time from work or having to quit altogether.

¹¹⁴ Public Law 112-240 (as part of the American Taxpayers Relief Act to avoid the so-called “fiscal cliff” because no budget had been passed). The bill also created the Long-Term Care Commission to look into matters and make legislative recommendations to Congress.

¹¹⁵ Cutler, J. 2014. “How American Society will Address Long-Term Care Risk, Financing and Retirement,” Society of Actuaries <https://www.soa.org/Library/Monographs/Retirement-Systems/managing-impact-ltc/2014/mono-2014-managing-ltc.aspx>

¹¹⁶ Reinhard, S. C., Feinberg L.F., Choula R., and Houser, A., 2015. “Valuing the Invaluable: 2015 Update Undeniable Progress, but Big Gaps Remain,” AARP, <http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf>

For purposes of making some organizational sense out of all the activity, this section divides the LTC universe into: 1) states; 2) other current efforts; and 3) a number of other initiatives right around the corner. Most of these other initiatives are proposals by organizations and even individuals. Very few bills have been filed in Congress to deal with LTC financing and the Obama administration post-CLASS has not accomplished much either. At the same time, into the vacuum are a new band of policymakers and advocates whose proposals may lay the groundwork for action in 2016 and beyond.

The States

Minnesota¹¹⁷

Minnesota has been focusing on LTC financing reform since 2012. A State Advisory Panel has been working to implement a number of recommendations made in 2014 for the last several years, focusing on options which would bring in more private financing to the LTC financing ledger.

The recommendations have included:

- Stimulating the LTCI market by identifying new and enhanced product concepts which will better meet the needs of Minnesota middle-income consumers.
- Modifying legislation and regulations, to make innovative new product approaches viable and existing products more effective and attractive. This category includes an option called a life stage product that would provide different benefits at different points in consumers' lives. The leading example of this approach is a term life insurance product that converts into LTCI at retirement. An early review of this approach showed strong consumer interest and it looks actuarially affordable. Given take up of term life insurance is fairly large this has the potential to be a game changer.
- Explore incorporating LTC services into Medicare supplement plans. One very promising proposal would add a home care benefit to all Medicare Advantage and Medigap plans sold in Minnesota. The actuarial estimate priced a home care benefit between \$30 and \$50/month. Medigap policies could also have these LTC services added. (Minnesota is one of three waiver states that do not have to follow the NAIC standard Medigap model.)

¹¹⁷ For more on Minnesota see the following section by LaRhae Knatterud in this study.

- Various proposals recommended by the Advisory Panel or by individual legislators were considered in the 2015 legislative session, but little action occurred. A reduction in the required minimum level of inflation protection (to a minimum of 1%) within the Partnership provisions in the state did pass. The 2016 session begins in March and a number of proposals and suggestions could be discussed, including: 1) developing a Minnesota-specific LTC financing model; 2) creating a consumer-friendly call center for LTC financing and services; 3) creating a high-level task force to look at the impact of aging on the state budget, including the impact of LTC financing, and making recommendations to the state on action needed; and 4) completing more detailed analysis of the new life stage product and the home care benefit to be embedded in the supplemental plans.
- The work Minnesota is doing on LTC financing reform involves a number of state agencies including the Departments of Human Services, Health, Revenue and Commerce, as well as the state unit on aging—the Minnesota Board on Aging (MBA). In order to determine the current status of the LTCI market, the commissioner of the Minnesota Department of Commerce, Mike Rothman held a public hearing in August 2015 to hear the perspectives of consumers, the LTCI industry, insurance and actuarial experts and regulators. Representatives from several Midwest states attended the hearing, and the testimony collected could result in legislative proposals in Minnesota. In addition, Commissioner Mike Rothman (MN) serves as the vice chair on the NAIC Long-Term Care Innovation (B) Subgroup and this Subgroup will work towards developing proposals that would be useful and of interest in the state.

California

California has an active regulatory presence involving LTCI, particularly in efforts to extend consumer protections to its population. In terms of product and policy reforms that are the focus of this section it is likely we will see more from various parties in the state later in 2016.

However, as it has already been noted in the previous section, LTCI is not the only way to address LTC needs. California is one of the leading states using existing government programs to do so. One of the unexpected outcomes of the federal Affordable Care Act (ACA) is the expansion of Medicaid and its impact on the LTC population. While the ACA was primarily focused on Medicaid expansion for those not able to afford even unsubsidized health insurance, it has forced states to pay more attention to the entire program. What California is doing around the duals program—those dually eligible for both Medicare and Medicaid—may be a model for improving Medicaid effectiveness and generating program savings.

California is among a dozen states participating in the national demonstration to improve care for people with serious chronic illnesses and functional limitations who qualify for both Medicaid and Medicare. This is called Cal MediConnect in the state's demonstration.¹¹⁸

The Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at the federal Centers for Medicare and Medicaid Services (CMS) have created the Financial Alignment Initiative to test integrated care models for beneficiaries who are dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees). The goal of the Financial Alignment Initiative is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and LTC for Medicare-Medicaid enrollees.¹¹⁹

The Dual Eligible Integration Demonstration Senate Bill in 2010 authorized a pilot project which would integrate the full range of Medicare and Medi-Cal (California's Medicaid program) services, including LTC and behavioral health services. In 2011, California was one of 15 states awarded a \$1 million planning contract from the CMS to develop a demonstration.¹²⁰ The main components of the Coordinated Care Initiative (CCI) include mandatory enrollment of dual eligibles into Medi-Cal's managed care program, as well as integration of Medi-Cal-funded LTC into managed care.

The CCI began operation April 1, 2014, originally in eight counties. For 2015–2016, one key improvement includes the development and pilot-testing of a universal assessment tool. The initiative was to have a General Fund savings of \$176.1 million from 2015 to 2016, primarily attributed to a Managed Care Organization (MCO) tax. But the CMS provided guidance to California that the MCO tax is not permitted. As a consequence the governor proposed a

¹¹⁸ For the best summary on California's effort see "Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals," RTI Dec. 16, 2013 at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanExecSumm.pdf>

¹¹⁹ Ibid.

¹²⁰ Ibid.

revised and broader based MCO tax that complies with federal law, which should still generate savings like the current MCO tax.^{121 122}

Other State Activity

The state of Washington has passed legislation to fund a study on the feasibility of new LTC financing options that would include studying a public mandatory LTC program, and a public/private approach where the state would assist in funding catastrophic coverage to help stimulate the private insurance market. Assuming positive results from the study the finalized recommendation will be brought forward for a voter referendum in 2017.

Although the referendum would determine the direction the state goes, the current draft is structured to provide an LTC benefit through (and paid for) by the workforce. Funding would be through a payroll deduction that could provide a one-to-three-year, capped-dollar LTCI benefit. The maximum length and amount of that is to be determined by actuarial analysis. In addition, there could be a public-private reinsurance or risk-sharing model. This is both to provide a stable and ongoing source of reimbursement to insurers (for at least a portion of their catastrophic LTC losses) but also to provide additional insurance capacity for the state. It is envisioned the private insurer's role would be as the primary risk bearer.¹²³

Hawaii seriously considered what some would regard as universal LTC coverage. In December 2014 a major report was released with proposals to design and test this program.¹²⁴ The fundamental characteristics of the 2014 program options were: 1) mandatory membership; 2) limited benefit periods; and 3) limited benefit amounts. An additional provision of the commission was to recommend the program initially be restricted to working households.

The design has an initial limited indemnity benefit of \$70 per day with graduated inflation adjustments, a limit of 365 days of coverage (which could be non-consecutive), use of the

¹²¹ The SCAN Foundation, 2015. "California's Coordinated Care Initiative," www.thescanfoundation.org/californias-coordinated-care-initiative-january-2015-update

¹²² See <http://www.calduals.org/> (a website specific to California's duals demonstration where enrollment data, outreach materials, and key documents are posted). Results from the duals demonstration polling and evaluation work commissioned by the Foundation can be found at <http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration>

¹²³ House Bill 1025 (Filed Dec. 8, 2014 for the 2015 session).

¹²⁴ State of Hawaii Department of Health, "The Feasibility of a Long-Term Services and Supports Social Insurance Program for Hawaii," (Dec. 15, 2014) at https://www.hawaiiadrc.org/Portals/AgencySite/LTSS/LTSS_2.pdf See also the supporting materials developed by the state ADRC, at <https://www.hawaiiadrc.org/site/439/reports/publications.aspx>

standard HIPAA trigger of two or more activities of daily living (ADLs) or cognitive impairment, and a 30-day elimination period. Because it was envisioned there would be no underwriting—“providing the individual was not receiving long-term supports or services at the beginning of membership”—there was in essence a 10-year waiting period where the member would incrementally vest in the benefit.

Given the difficulty of introducing and paying for a universal program, in 2015 Hawaii issued a call for proposals around an education campaign. This campaign is to inform the public of the likelihood of needing LTC and how to plan so individuals can maintain their independence. The focus is on potential caregivers.¹²⁵

Nebraska has convened a Task Force for Financial Independence charged with pursuing a 2016 legislative agenda.¹²⁶ Its goals are to:

- Foster financial independence through private market incentives and affordable options helping Nebraskans prepare for their LTC needs, with special emphasis on supporting people in middle income brackets.
- Effectively manage state resources used to pay for LTC by reducing overall reliance on Medicaid as the LTC payer, specifically focusing on extending Medicaid rebalancing efforts to ensure care is provided in lowest cost settings that can delay spend-down.
- Raise awareness of LTC needs and educate Nebraskans about resources and incentives they can use to prepare for their LTC needs.

Indiana is working on a legislatively mandated written report due October 2016 providing a complete study on LTC, including financing.¹²⁷ Early goals of the work are three-fold: 1) raise awareness about LTC need; 2) offer innovative and affordable tools and options for people to prepare and pay for LTC; and 3) protect future Indiana Medicaid budget by shifting funding to private sources where possible and preserving state funds for those most in need.

¹²⁵ A. Bell, 2015, “Hawaii seeks long-term services and support awareness proposals,” *LifeHealthPro*, Jan. 6, 2015, www.lifehealthpro.com/2015/01/06/hawaii-seeks-long-term-services-and-support-awareness

¹²⁶ The latest report came out December 15, 2015. LB801, www.nebraskalegislature.gov/bills/view_bill.php?DocumentID=28406 (for bill language click on “introduced copy” near the top). See “Task force outlines steps to prepare for aging population,” Lexington (Nebraska) Herald Leader, Dec. 16, 2015, www.kentucky.com/living/health-and-medicine/article49924915.html

¹²⁷ Indiana does not yet have draft legislation and plans to propose something for their 2017 session, but might tack on some aspects of their work to this year's bills already in progress. Personal communications with Olivia Mastry (Jan. 31, 2016), consultant to LeadingAge on Pathways.

South Carolina convened a statewide task force of providers, researchers and advocates in 2014 to develop recommendations for improving LTC that could actually be implemented (were actionable). Their 2015 report highlights some 30 recommendations developed by the task force.¹²⁸ By category they would:

- Promote efficiency in the system.
- Strengthen the LTC continuum.
- Ensure an adequate and trained workforce.
- Protect vulnerable adults.
- Support family caregivers
- Promote choice and independence through education.

Other Major Players

The SCAN Foundation

The SCAN Foundation in California has been a key player in the LTC world.¹²⁹ The Foundation, along with AARP and LeadingAge (formerly the American Association for Homes and Services for the Aging) has funded the Urban Institute and Milliman (one of the nation's premier actuarial firms) to undertake major economic modeling effort using Urban's Dynamic Simulation of Income Model (DYNASIM) model to project the future needs, costs and some potential policy options for long-term services and supports. For those following this topic, this is not just a modeling exercise but the opening gun on concrete proposals for reform to follow. How meaningful the modeling will be to actual proposals will still have to be seen. But the impact of the CLASS Act here cannot be overstated. Policymakers and advocates alike realize they cannot be caught short again without design parameters laid out and facts in hand to inform lawmakers as various reform proposals are introduced and debated.

The DYNASIM model was developed by the Urban Institute though the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) has done a lot to add the LTC component. It is a dynamic microsimulation model following representative samples of individuals and families aging the data year by year (going

¹²⁸ Stein, E., Waldrep, S. and Pearson, J.L., 2015. "Creating Direction: A Guide for Improving Long-Term Care in South Carolina," South Carolina Institute of Medicine and Public Health," June 2015

<http://imph.org/wordpress/wp-content/uploads/2015/06/creatinqdirectionbriefpdf.pdf>

¹²⁹ See the materials on "LTC Financing Initiative" at www.thescanfoundation.org/ltc-financing-initiative?utm_source=11-17-15+%28TSF%3A+New+LTSS+Policy+Modeling+Results%29&utm_campaign=11-17-15&utm_medium=email

out 75 years in fact). It is used to simulate various demographic and/or economic events. What has now been added is a component dealing with long-term services and supports.¹³⁰

The Urban Institute owns the model, and has done the most work with ASPE over the years to keep it up to date. Milliman's role relies on its many years working in LTCI, making sure any modeling results meet certain actuarial minimum standards. This includes ensuring any proposed solution (whether it be private insurance or public) will be financially sound and sustainable over time. Any solution must also meet other criteria: Will it be affordable? Will the benefits be comprehensive? Will there be choice? And, important but often not met in proposals to date, how many people will be covered? That last one is difficult given results of other reform efforts so far.¹³¹

From the initial results, it is apparent the mandatory versus voluntary issue will be critical.¹³² Mandatory insurance is not widespread but exists more than one would think: Auto insurance is mandated for all drivers by most states. Homeowners insurance is effectively mandated since lenders will only give people loans if they protect their investment with insurance. Until the ACA came along, it was not a feature in health care as it has become now. One interesting note is the CLASS Act was originally slated to be a mandatory requirement. However, because it was part of the ACA and the health portion already had the insurance mandate, the federal legislators decided against adding a second mandate.

The reason this is critical is the early modeling results suggest apparent take up rates will likely be fairly low in any voluntary offering, hence the need to induce participation. This could include subsidies and/or auto enrollment to get a larger number of people into the program.¹³³

¹³⁰ The study can be found at the SCAN Foundation website, here www.thescanfoundation.org/ltc-financing-initiative?utm_source=11-17-15+%28TSF%3A+New+LTSS+Policy+Modeling+Results%29&utm_campaign=11-17-15&utm_medium=email

¹³¹ Favreault, M.M., Gleckman, H. and Johnson, R.W., 2015. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending," *Health Affairs*, November 2015, <http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full>

¹³² See a presentation by Rich Johnson of the Urban Institute December 2015 at the Long-Term Care Discussion Group <http://www.ltcdiscussiongroup.org/archives.html> and here --

https://www.nasi.org/sites/default/files/events/195/Johnson_Giese_2016_NASI.pdf -- for a presentation by Johnson and Chris Giese of Milliman at the National Academy of Social Insurance (Jan. 27, 2016).

¹³³ Favreault, M.M., Gleckman, H. and Johnson, R.W., 2016. "How Much Might New Insurance Programs Improve Financing for Long-Term Services and Supports?" *Urban Institute*, February 2016, [www.thescanfoundation.org/sites/default/files/how_much_might_new_insurance_programs_improve_financing_f_or_ltss_feb.2016\[1\].pdf](http://www.thescanfoundation.org/sites/default/files/how_much_might_new_insurance_programs_improve_financing_f_or_ltss_feb.2016[1].pdf)

A word here on private insurance; it has become obvious even to those in the LTCI industry there is no way private insurance, by itself, would ever enroll large enough numbers to provide a realistic answer by itself. However, social insurance advocates often fail to consider the value of the industry's decades of experience. Private insurance can help inform the social insurance solutions. In addition, the other obvious point is if a social insurance program does eventually get passed, it would still likely not cover all risk. Hence, the private sector could have an important role to play and/or be a critical gap-filler to any social insurance program.

LeadingAge

Pathways is the brainchild of LeadingAge which represents more than 6,000 non-profit providers of LTC-related services. The LeadingAge Pathways project revolves around national and state efforts to develop solutions to their LTC financing concerns.¹³⁴ State-level reforms may be an area where one can test innovations and drive change more quickly. To this end, the Pathways initiative has been fostering state-level reform by convening, facilitating and/or informing existing state LTC efforts in this arena.¹³⁵

LeadingAge developed a framework identifying numerous policy options (pathways) toward making positive steps around LTC reform. As one of three funders of the economic simulation model it sought to identify some of the opportunities and challenges existing within each pathway. Its report is expected to be released following the writing of this section. However, we know it will build on previous identification of approaches:

- *Status quo*. In the U.S., there is an expectation people will take personal responsibility for their own LTC needs. The U.S. operates a safety net system heavily reliant on Medicaid for those who are impoverished. However, counting Medicare and other public programs, 70% of spending for LTC is publicly financed. The status quo is not fiscally sustainable for Medicaid or Medicare, as neither is structured to meet the increasing demand.

¹³⁴ The Leading Age/Pathways report can be found at <http://viewer.zmags.com/publication/7ebedb28#/7ebedb28/1>, October 2013.

¹³⁵ Personal communications with John O'Leary (Oct. 2, 2015) and Olivia Mastry (Dec. 2, 2015), both consultants to LeadingAge on Pathways. LeadingAge is active in Minnesota, California, Washington State, Nebraska, Indiana and Texas (starting in 2016). Other states, beyond those that may show movement on LTSS include Iowa, Kansas, Massachusetts and Ohio. See "State Innovations for LTC Financing," at the Intercompany Long Term Care Insurance Conference (March 24, 2015), accessed www.iltciconf.org/index.htm/files/35-StateInnovations.pdf (slide 55).

- *Personal responsibility.* This pathway aims to reduce the government role in financing LTC by tightening the public safety net and narrowing eligibility, with the intention of inducing more personal responsibility. Individuals may seek insurance coverage for LTC in the private market. The government would offer no incentives or subsidies for the purchase of LTCI. Under this option, compared to the status quo, the public safety net would shrink slightly. The challenge with this pathway is there would likely be an increase in unmet needs.
- *Private market.* This pathway seeks to activate and strengthen the private market. It would encourage the development of a greater choice and standardization of products, including those offering cash benefits, as well as incentivizing the purchase of those products. Other incentives might include preferential tax treatments, subsidies based on income, and government-sponsored stop loss coverage or reinsurance pools to limit the cost of insurance products and to encourage more private providers to enter the marketplace by reducing their risk. The challenge with this pathway is the increased uptake would likely be limited; analysts estimate uptake might only increase from 10% to 20%.
- *Private catastrophic.* With this pathway, the government would require individuals to purchase catastrophic LTCI made available in the private market. Although persons who could demonstrate they have the means to cover their own expenses would be allowed to opt out. The objective of this scenario would be to avoid the impoverishment which occurs when LTC expenses mount and thereby reduce reliance on Medicaid as a safety net. This type of coverage might prove far more affordable than existing products and has not yet emerged in today's marketplace. The safety net would no longer be needed as currently constructed; instead it would become an alternative insurance pool for high-risk individuals who are unable to secure coverage in the private market.
- *Public catastrophic.* This pathway is similar to the previous scenario, except insurance coverage would be provided through a public program and consumers would be required to purchase coverage by paying premiums to the government. Because this insurance pool would be inclusive of all Americans, this scenario effectively would become the public safety net, replacing Medicaid. While this pathway offers the potential for addressing the LTC problem, the requirement of mandatory participation could be a challenge.
- *Common good.* This pathway would create a public program to meet basic, front-end LTC needs for working and retired Americans, by providing cash and/or services for a defined dollar or time limit. Participation would be either required or strongly incentivized and premiums would be based partially on income. Because coverage would not be comprehensive, the safety net remains for people who have not met

minimum contribution requirements, are outside the program, or are unable to afford LTC expenditures exceeding those covered by the program. The private sector would be encouraged to develop supplemental and catastrophic need products.

- Comprehensive. This pathway combines the public catastrophic coverage and the front-end common good coverage to create a comprehensive program for LTC needs providing a benefit of cash and/or services. Personal responsibility would come in the form of co-payments or deductibles. Participation would be mandatory.

Society of Actuaries

The Long Term Care Section of the Society of Actuaries (SOA) has been very active in looking at potential solutions. The “Land this Plane” Delphi study in 2014¹³⁶ identified five core ideas to explore: 1) a high-deductible plan (basically catastrophic coverage); 2) short-term care (as in short-term LTCL, meaning covering less than a year); 3) an LTC savings program (with deferred taxes as one finds in HSAs); 4) a universal LTCL program; and, 5) strengthening reinsurance so insurers could feel more comfortable with the long tail risk and lower prices.

Of great interest is the fact these leading insurer experts pretty much said the private sector will NOT be the solution and only a public-private arrangement would offer any hope. Many participants suggested reforming Medicaid is the essential first step in the overall LTC system overhaul. There was overwhelming strong support for a national LTC awareness program and for tax incentives to support the purchase of LTCL products as key ways the government should encourage and incent a more effective LTC system.

Of importance to state regulators, many panelists also supported standardizing regulations on a national basis. The NAIC regulations provide much-needed consumer protections. Unfortunately, in so doing many in the group felt they have required or encouraged product designs financially out of reach for middle-income Americans. Panelists indicated a need for regulatory change encouraging simpler policies affordable and accessible to a broader population.

The group met again in October 2015 to brainstorm new solutions to LTC funding quandary. Attendees included representatives of the insurance industry and also the public policy

¹³⁶ Society of Actuaries Long-Term Care Section, 2014. “Land this Plane,” www.soa.org/Research/Research-Projects/Ltc/research-2014-ltp-ltc.aspx

universe.¹³⁷ They generated more than 80 ideas for financial and care delivery reform. A formal report that lists, categorizes and describes the feasibility of the ideas is due to be published in 2016. Many of the ideas were similar, so they were grouped into common themes. This included many around caregiving, with and without insurance; LTC apps and other ways to use modern tools for reaching people; health insurance look-alike products as well as adding to or linking with Medicare; and better use or creation of savings accounts and insurance products combining 401 (k) plans.

A complementary effort by the SOA has also been underway through the organization's Post-Retirement Needs and Risk committee. It held a call for papers in 2013-2014 and a call for essays in 2015-2016, both around (in part) the risk of LTC and retirement.

Bipartisan Policy Center

In December 2013, the Bipartisan Policy Center (BPC) launched a Long-Term Care Initiative under the leadership of the BPC Health Project leaders, former U.S. Senate Majority Leaders Tom Daschle and Bill Frist, as well as former Congressional Budget Office Director Alice Rivlin and former Wisconsin Governor and HHS Secretary Tommy Thompson.¹³⁸

Potential solutions have to be viewed by policymakers in the context of the current political and fiscal environment, which includes concern about the long-term cost of major entitlement programs and long-term public debt. In their view, policymakers seeking to address the challenge of financing and delivering LTC have to look at reforms to reduce the rate of growth in spending and provide greater efficiency in public programs. They also will seek to increase the reliance on privately funded solutions, so there is less need for publicly funded LTC solutions. Since it is unlikely a single solution will adequately address these challenges, BPC's Long-Term Care Initiative has produced a set of recommendations weaving together the approaches of publicly funded programs, such as Medicaid, with private insurance products to control costs, while also improving the efficiency and quality of LTC.

¹³⁷ Society of Actuaries, LTC Think Tank (2015)(unreported). See a presentation by Eileen Tell and John O'Leary, two of the Think tank co-chairs, in November 2015 before the Long-Term Care Discussion Group <http://www.ltcdiscussiongroup.org/archives.html>

¹³⁸ Bipartisan Policy Center, 2014. "America's Long-Term Care Crisis: Challenges in Financing and Delivery," April 7, 2014 <http://bipartisanpolicy.org/library/americas-long-term-care-crisis> and BPC, 2014. "America's Long-Term Care Crisis," April 2014 <http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20Long-Term%20Care%20Initiative.pdf>

Their Long-Term Care Initiative released the first of its series of bipartisan policy options in February 2016,¹³⁹ with the goal of building consensus on how to finance and deliver LTC. This report calls for creating a new type of LTCI policy, which BPC calls retirement LTCI. It would have a limited benefit, so it would be more affordable for individuals than is typically found in the current market. Retirement LTCI benefits would be paid after either a deductible (in dollar amounts, for example, \$25,000 or \$50,000) or a longer-than-typical waiting period (e.g., one year). To reduce complexity, there would be a limited choice of standard plan designs (e.g., \$100/\$150/\$200 per day daily benefit amounts and a two-, three- or four-year benefit period).

To get at one of the difficult issues with current policies, inflation protection, there would be premium adjustments on a regular basis. First, premiums would be updated annually for inflation based on the consumer price index (CPI). Second, insurers would be required to rerate premiums on three-year cycles to incorporate updated assumptions (interest rates, lapse rates, investments, mortality, morbidity, claim severity and claim duration). These updates would be mandatory, including in cases in which they result in a premium decrease.

Since many of these ideas require changes in law, the report recommends Congress charge the NAIC with developing proposed changes to the LTCI model. At the federal level, the BPC report recommends federal law be changed to allow participants in employer-sponsored retirement plans, such as 401(k) plans (and IRAs), to make withdrawals beginning as early as age 45 without the early-distribution penalties.

The report also includes a proposal offering incentives to employers auto-enrolling employees, into a default retirement LTCI policy. Participants could change coverage parameters or opt out entirely. Employers would be covered by a safe harbor which would limit legal risk. For those who do not have access to LTCI through an employer, BPC proposes state and federal health insurance exchanges would offer this option.

In addition to the private-market LTCI proposals, the BPC report includes specific recommendations to encourage state Medicaid programs to offer LTC in the home and community, as well as a proposal for an LTC-only Medicaid buy-in for working Americans with disabilities.

Going forward in the coming year, the BPC will focus on the possible creation of a catastrophic insurance program, addition of a limited LTC benefit to Medigap and Medicare Advantage plans

¹³⁹ Bipartisan Policy Center, 2016. "Initial Recommendations to Improve the Financing of Long-Term Care," Feb. 1, 2016 <http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/>

Long-Term Care Reform Proposals

(similar to what Minnesota is interested in doing), changes in federal tax law to provide credit for caregivers with their expenses, and analysis of the possibility of a respite-care benefit or other direct-service benefit in Medicare.

LTC Financing Collaborative

The Long-Term Care Financing Collaborative (Collaborative) seeks to shift LTC financing in the U.S. from the current welfare-based model to an insurance-based system.

The Collaborative released in July 2015 principles for financing LTC to allow older and younger Americans with functional and/or cognitive impairments to live as independently as possible, and with maximum autonomy and choice in the services they receive and the setting in which they receive them.

The Collaborative is looking to improve financing to better support family caregivers, integrate health care with person- and family-centered services and supports, increase access to insurance while improving safety net programs and assure any programs are fiscally sustainable. It aims to improve mechanisms for people with sufficient assets and income to save for and insure against LTC needs and risks, and it recognizes the need to increase public awareness about the need to prepare for the costs of LTC.

The group released, also in July 2015, recommendations for improving integration of LTC and medical care, support for paid caregivers and families, and reforming supports for communities and employers of caregivers.¹⁴⁰ The Collaborative's final consensus recommendations were released February 2016.¹⁴¹

Center for American Progress

The Center for American Progress (CAP) recommends two reforms to help make LTC more affordable and allow more individuals to live independently in their homes for longer periods of time. While the need for LTC can arise at any age, the doubling of the elderly population over

¹⁴⁰ Personal communications with Caryn Hederman of the Convergence Policy Center and consultant to the Collaborative, Dec. 18, 2015. Also see "LTCFC Principles and Vision Papers," Convergence Center for Policy Resolution 2015, www.convergencepolicy.org/ltcfc-interim-reports/

¹⁴¹ See www.convergencepolicy.org/ltcfc-final-report-release-222/

the coming decades means a substantial increase in the number of people who will need LTC. CAP believes policymakers will need to develop a broad-based approach which melds public insurance, private insurance and private caregiving. They also recommend creating a new service-corps program to increase the number of caregivers. However, while those efforts for larger reform are underway it does not mean action could not occur more immediately to address the affordability of private insurance. Its current proposal recommends refundable tax credits to help individuals pay for LTC needs. Policies purchased using these credits would include a number of consumer protections though it is unclear whether these would be developed at the federal level or through the NAIC as is done now.¹⁴²

National Association of Health Underwriters

The National Association of Health Underwriters (NAHU) recommends the following to respond to these LTC financing challenges noted above:

- Protect Medicaid for the truly needy by encouraging the use of LTC Partnership Programs, closing loopholes to access Medicaid and encouraging the use of reverse mortgages.
- Allow tax-free withdrawals from 401(k), 403(b) and IRA accounts for the purposes of purchasing LTCI. Currently, early withdrawals come with a 10% excise tax, which discourages individuals from using these funds to purchase insurance. Implementing a change so withdrawals to buy LTCI are tax-exempt and eliminating the early withdrawal penalties will help.
- Add LTCI to the types of benefits that can be purchased through IRS Section 125 plans, which is currently prohibited under federal law. Doing this will send a signal to employees about the importance of the benefit, while the pre-tax treatment makes the product more affordable.¹⁴³

Unfortunately, while there is still a call from the insurance industry for tax breaks such as adding LTCI to Section 125 plans, there currently is no interest in Congress in going this route (at least so it appears to this author). Other ideas like the “top of the line” tax deduction for LTCI are not even advanced by the insurance industry any more. Having said that, tying an LTC

¹⁴² Center for American Progress, 2014. “CAP Issue Brief Calls for Tax Credits for Long-Term Care Insurance; Expanding Service-Corps Programs to Aid in Providing Long-Term Care,” www.americanprogress.org/press/release/2014/10/31/100116/release-cap-issue-brief-calls-for-tax-credits-for-long-term-care-insurance-expanding-service-corps-programs-to-aid-in-providing-long-term-care/

¹⁴³ National Association of Health Underwriters, 2016. “Long-Term Care White Paper Executive Summary,” released at its annual conference Feb. 22, 2016.

tax break to a caregiver proposal was tried in the late 1980s/early 1990s. We will look at caregiver proposals later, but this might be an area where linkage DOES offer the opportunity to move NAHU kinds of proposals forward.

Other Interesting Proposals

The American Long-Term Care Insurance Program (ALTCIP) builds on the model of the federal Long-Term Care Insurance Program, of which Paul Forte is CEO of the vendor for that program.¹⁴⁴ The ALTCIP is based on the premise current fiscal reality prohibits the introduction of another taxpayer-financed entitlement, and a voluntary LTCI program offering basic benefits and administered equitably, could conceivably be implemented within the next five years and could attract potentially millions of people in the middle market, reducing the number of people who rely on Medicaid. The ALTCIP features an exchange-like structure which would encourage insurers to compete for enrollees within a federally regulated framework.¹⁴⁵ Special segregated reserve accounts, reinsurance, and expense and profit caps would increase value for both consumers and insurers. Powerful Internet sites with interactive calculators and decision tools, supported by highly trained customer service representatives, would allow direct-to-consumer transactions at lower costs.

Wesley Lin (UCLA LTC Advantage proposal) would create a voluntary LTC program he calls LTC Advantage.¹⁴⁶ He envisions a progressive subsidy that would be paid directly to the insurer, effectively lowering premium costs. (And, as an aside, this would likely have a positive impact on take up rates because of the implied endorsement of the government of private insurance.) He would impose some constraints on insurers though; for instance, they would not be able to game the system if they misprice the product or mishandle claims.

¹⁴⁴ Forte, P., 2014. "The American Long-Term Care Insurance Program," Society of Actuaries, www.soa.org/Library/Monographs/Retirement-Systems/managing-impact-ltc/2014/mono-2014-managing-ltc.aspx

¹⁴⁵ It is beyond the scope of this section to get into this in detail but once the Exchanges (Marketplace) are more stable it is logical to view them as a means of one-stop shopping for insurance needs. At this point one can get to dental coverage because of the way the ACA was structured but no other products. It would be a nice feature to allow consumers to click on other products, including long term care insurance, if they were so interested.

¹⁴⁶ Lin, W., 2015. "Strengthening Risk Protection through Private Long-Term Care Insurance," *The Hamilton Project*, www.hamiltonproject.org/assets/files/brief_yin_private_long_term_care_insurance.pdf

Karl Polzer, an LTC policy consultant in Washington, DC, proposes changing 401(k) and IRA rules.^{147,148} He would address the two major risks facing participants in defined-contribution (DC) retirement accounts: 1) the risk of outliving one's savings; and 2) the risk of having to pay substantial costs for LTC. The proposal would allow retirees to invest a portion of their retirement savings for longer than under current tax rules and could also provide tax incentives for money withdrawn to pay for LTC expenses or LTCI. The proposed policy change addresses issues in both the retirement and LTC financing policy arenas. He believes as policymakers seek ways to develop a more comprehensive, efficient and socially equitable system of financing the cost of future LTC, increased flexibility to use retirement accounts for this purpose could play a key role.

It should be noted there are other efforts in the retirement space and it is not impossible to see LTC provisions added or bootstrapped along with these. Frankly, the impetus behind retirement proposals and changes is (to this author at least) much greater than what we see with LTC alone.¹⁴⁹

The other arena to watch for its impact on LTC reform is efforts around caregiving. Senator Amy Klobuchar (MN), for instance, introduced the Americans Giving Care to Elders (AGE) Act of 2015

¹⁴⁷ Polzer, K., 2014. "Financing Future LTSS and Long Life through More Flexible 401(k)s and IRAs," Society of Actuaries, www.soa.org/Library/Monographs/Retirement-Systems/managing-impact-ltc/2014/mono-2014-managing-ltc.aspx

¹⁴⁸ The Long Term Care Commission also viewed this approach favorably in its 2013 report. The commission's final report suggested providing "a tax preference for long-term care policies through retirement and health accounts." The report went on to say: "Allowing withdrawals from existing 401k, IRA, or Section 125 accounts to pay LTCI (long term care insurance) premiums or distributions would have minimal tax implications. The tax costs of incentivizing broader participation would be more than offset over time as those with private coverage draw on private rather than public resources to finance their care," <https://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>

¹⁴⁹ On July 9, 2013, Senator Orrin Hatch of Utah introduced the SAFE Retirement Act of 2013 (S. 1270), which would expand the use of annuities by public pension plans. Senator Hatch explained in his statement introducing the bill, which would create "SAFE Retirement Plans" for state and local governments. The bill creates a new voluntary pension plan, "with stable, predictable costs that state and local governments may use to deliver secure pension benefits." Under the SAFE Retirement Plan, public employers would purchase fixed annuities from state-regulated insurance companies. Hatch's suggested changes build on efforts already made into final regulation by the Treasury Department in 2014. This rule affects longevity annuities and Minimum Distribution Rules (MDRs). The final Treasury regulations changed MRD regulations so that longevity annuity payments will not need to begin prematurely. Retirees may use up to 25% of their account balance or (if less) \$125,000 to purchase a qualifying longevity annuity contract without concerns about the age 70 1/2 minimum distribution requirements. "Treasury Issues Final Rules Regarding Longevity Annuities," Department of Treasury, Washington, DC, at <https://www.treasury.gov/press-center/press-releases/Pages/jl2448.aspx> (July 1, 2014). See also Diane Oakley, "Brief Retirement Security Risks: What Role Can Annuities Play in Easing Risks in Public Pension Plans?" National Institute on Retirement Security (August 2015), at pages 20-24, at http://www.nirsonline.org/storage/nirs/documents/Annuities/annuities_aug_2015.pdf

(S. 879). This bill would allow caregivers, among other things, up to \$6,000 in a tax credit for expenses for caregiving provided to their parents. It also expands on grant programs for caregivers.¹⁵⁰ This proposal has already inserted itself into the presidential campaign. In November 2015, Presidential candidate Hillary Clinton released a very similar proposal.¹⁵¹ As mentioned earlier, tying caregiving to LTCI has been an attractive option for many policymakers trying to broaden coalitions seeking legislative changes.

Concluding Thoughts on Reform Proposals

The inability of Congress to correct design concerns in the CLASS Act led, first, the Obama administration to hold off on implementation, and second, to congressional repeal. This essentially stymied much action at the federal level (though to be fair the Obama administration and Congress had ACA implementation and Medicaid expansion to keep them busy). This inaction however, has led to the opportunity for critical players, especially states to work and develop ideas of their own.

¹⁵⁰ Another is the RAISE Family Caregivers Act (S. 1719/H.R. 3099). Sponsors are Rep. Greg Harper of Mississippi and Senator Susan Collins of Maine. It passed the Senate December 8, 2015. It would charge HHS with creating a National Family Caregiving Strategy. Also see the AARP report “Valuing the Invaluable” mentioned earlier, pages 14-16.

¹⁵¹ The new Clinton proposal includes a tax credit to offset up to \$6,000 in home caregiving expenses and an expansion of Social Security benefits to those who take time off to care for a family member. Clinton would also seek to invest \$100 million in a grant program to give caregivers relief from their duties by giving their ailing relative temporary care in a facility outside their home – a program she also championed while she was in the Senate. See <http://static.politico.com/54/24/77b932744dbe80c0b496dec2eedb/hillary-clinton-caregiver-tax-plan.pdf>

Minnesota Efforts to Develop Long-Term Care Financing Option for Middle Income Households



Minnesota Efforts to Develop Long-Term Care Financing Options for Middle-Income Households

By LaRhae Grindal Knatterud, Director of Aging Transformation, Minnesota
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Introduction

One of the biggest challenges our country faces in the elder care area is how individuals and the government will pay for growing amounts of long-term care (LTC) as our population ages. Because the costs of LTC are not covered as part of our health insurance (including Medicare and other health insurance), individuals are responsible for paying for this type of care.

While families provide the vast majority of care for their older relatives, there is evidence the level of family caregiving is declining as the labor force participation of women continues to increase, families are smaller, and families have growing numbers of older relatives living much longer than previous generations. If family is not available or becomes unavailable, individuals must pay for formal care, and this care—whether in the home, in assisted living facilities or nursing facilities—is very expensive. The average household cannot afford this care for very long, and many quickly exhaust their resources and look to the government in the form of Medicaid to pay for this care. As the underlying trends accelerate, dependence on Medicaid could grow substantially and become an unsustainable budgetary burden for states and the federal government. Given the current political stalemate in Washington, it appears unlikely the Congress and President Obama will be able to arrive at a solution to this problem in the near future.

It is against this backdrop Minnesota has been working to reform LTC financing system for its residents, with the hope its efforts might contribute to the national dialogue on new ways to finance LTC costs for elderly people. This section of the study describes the process and the findings of work on this topic Minnesota has been doing since 2012.

Own Your Future

Minnesota launched its work on LTC financing by initiating an Own Your Future (OYF) campaign, a joint federal/state initiative of the administration of Governor Mark Dayton. Its purpose was to encourage and enable Minnesotans to create a plan for their care, including how to pay for this care. In this context, LTC is defined as the assistance with personal care and household tasks people need as they grow older or if they experience an injury or illness earlier in their lives.

Minnesota Efforts to Develop LTC Financing Options for Middle-Income Households

Between 2005 and 2009, 26 states sponsored an OYF campaign in their state to educate individuals about their risk for LTC and encourage them to plan for this part of their lives. Minnesota was the last state to initiate this effort, and one of a handful of states to continue and expand the campaign.

Minnesota launched the public awareness component of OYF in October 2012, with financial assistance from the federal government. The key feature of this campaign was mailing a letter from the Governor and Lieutenant Governor to 1 million Minnesota households ages 40 to 65, urging them to create a plan for their LTC.

Minnesota added two additional components to the public awareness campaign, in order to enhance the desired outcome of increasing the number of Minnesotans using private resources to pay for their LTC. It was felt that if more affordable and suitable options were available, more households would be able to use these products to pay for their LTC. And if Medical Assistance (MA) provided more incentives for individuals to use private financing, this could also increase the interest in using these private options. Thus, the three components of Minnesota's Own Your Future initiative include:

- Implementation of an ongoing public awareness campaign throughout the state.
- Efforts to make more affordable and suitable LTC products available to Minnesota's middle-income households.
- Evaluation of possible changes to Medical Assistance (MA) to better align with and encourage private payment for LTC.

Subgroup Charge

In early 2013, a subgroup with members from the OYF initiative's overall advisory panel together with several additional external experts was appointed and began work on phase two of OYF, called the product availability component. Staff from the Minnesota Department of Commerce were also members of the subgroup. This subgroup met monthly between March and December 2013. The Own Your Future Advisory Panel gave the subgroup the following charge:

"Make recommendations on insurance, financial, or related products that should be available to middle-income households to help pay for LTC costs. These recommendations should include ways to remove barriers to the greater use of existing products as well as strategies to encourage new approaches to the financing of LTC."

In addition to reviewing the demographic realities associated with the issue of LTC—including the growth in the elderly population, the changes in the family size and structure—the subgroup also articulated the critical importance of this issue to the economic realities within the state.

Economic Realities

The aging of Minnesota’s population will bring about a transformation of the state’s economy. A new set of economic rules will apply.

Labor force growth will slow as retirements increase and the number of young people will decline, meaning the number of young people entering the workforce will also decline. Slower labor force growth means slower economic growth. This will reduce growth in government revenue at a time when demand for publicly funded health and LTC services for the aging will be escalating. For example, MA expenditures for the elderly, which include basic health and LTC, are projected to increase by 8.5% per year during the 2010s and 9% per year during the 2020s.

Thus, education and health/LTC will compete for a smaller pool of state revenues in the future. If health care costs continue to increase, state spending on other services will stagnate, making the state’s financial situation unsustainable. (These projections assume the current level of taxation.)

Long-Term Care Financing Reform is Important to Minnesota’s Future Economic Growth

- By increasing the use of private LTC financing options, Minnesota can potentially reduce its public expenditures for LTC.
- To increase the use of private resources for LTC, the available insurance and financial products need to be more understandable, attractive and affordable to consumers.
- If successful, OYF can reduce the fiscal pressure of LTC expenditures on the state budget and help free up funds for other state priorities including education, job training and expenditures on infrastructure needed for the state’s economic growth.

The Current Long-Term Care Financing Marketplace

The current LTC financing marketplace consists of insurance products, home equity options such as reverse mortgages, and health and retirement savings plans. None of these products

has seen widespread use recently due to a number of factors, including a growing concern about their stability, safety and their benefit levels.

[Long-term care insurance \(LTCI\)](#) has seen dramatic across-the-board rate hikes on both prospective and retrospective business, tightened underwriting practices, and a reduction in consumer demand. On the supply side, approximately 90% of insurance companies nationally that once offered LTCI no longer do so. If current practices continue without fundamental change, LTCI will become increasingly limited to a high-end niche product, with few or no options for the middle-income market.

[Life insurance policies](#) that can be used to pay for LTC costs (called hybrid products) are currently more attractive than LTCI to some individuals because they offer a multi-purpose benefit. If you need LTC, the hybrid product pays for LTC costs, but if you do not, your heirs still receive your death benefit.

[Health insurance products including Medicare and other health insurance products](#) for younger individuals have maintained a strict separation between health care coverage and custodial LTC and do not fund LTC. While Medicare provides LTC after a hospital stay, most Medicare beneficiaries do not receive the full benefit to which they are entitled because of changes in care practices which have occurred since Medicare was created in 1965. Similarly, the Medicare supplemental market has restricted its benefits to wraparounds for Medicare benefits only, and neither the Medigap nor Advantage markets have incorporated any LTC services. Federal regulations have restricted the addition of certain services, but changes in LTC since 1965 and the growing need for LTC require a review of these restrictions and creative rethinking of the current design.

[The market for reverse mortgages \(RMs\)](#) is likewise in a difficult position. Recently, state and federal agencies have changed regulations governing the program to address consumer issues with the program, but the perception persists that RMs, as currently constituted, do not have adequate consumer protections.

[Retirement savings in general and savings to cover LTC costs specifically](#) are not high priorities for households. About 25% of households nationally have no retirement savings at all, and the median savings for those who do is less than \$75,000 (*EBRI, Retirement Confidence Survey, 2013*). From an economic perspective, middle-income households are still financially stressed from the effects of the financial crisis. They have less disposable income available for purchasing discretionary products and are weighing these decisions carefully.

These problems signal the need for new approaches to LTC product development and marketing. Individuals need simpler, more understandable, more affordable products easy to access. Insurers need products with acceptable risk profiles and predictable economics. The rise of the Internet and its commercial marketplace, along with the growing use of social marketing, means consumers expect new kinds of information, better decision-making tools, and peer and consumer product reviews to help them make purchasing decisions about LTC products.

The current LTC marketplace requires innovation and creativity to enable new, more acceptable LTC products and options to be developed, marketed and embraced by a broad cross section of Minnesotans.

The Work of the Subgroup on Product Availability

With these issues in mind, the subgroup developed a work plan which provided the members with a base of information to meet their charge. The subgroup first heard a presentation on demographics to determine how to define the middle income levels in Minnesota, received a briefing on current MA LTC expenditures and the interaction between various LTC products and MA eligibility criteria, and developed a list of data its members thought would be helpful during their discussions.

With this basic information, the subgroup then spent a majority of its remaining time identifying and analyzing existing products and new concepts to form the basis of fundamental reforms to the LTC financing market in Minnesota. It heard presentations on a wide variety of insurance and financial products to assess the potential of the products to play a larger role in helping the middle income pay for LTC. The subgroup also considered new concepts which might have potential to meet this need once they were piloted and they proved successful.

The products and new concepts fall into five broad categories:

1. Stimulating the LTCI market by identifying new and enhanced product concepts that will better meet the needs of Minnesota middle-income consumers.
2. Modifying legislation and regulations, particularly related to the Minnesota LTC partnership programs, to make existing or refreshed products more effective and attractive.
3. Developing closer linkages with the Minnesota Medicare supplementary options to explore the viability of incorporating LTC funding options into these Medicare plan options, and making needed reforms in the national Medicare LTC benefits.

4. Making it easier and safer for consumers to access the existing equity in their homes to help fund LTC services.
5. Making it easier and safer for consumers to use tax-favored savings plans to help fund their LTC services.

As the subgroup learned more about the existing products and new concepts, it also developed assumptions and criteria to guide its discussions.

Assumptions

The following assumptions were developed by the subgroup to guide its work.

The subgroup defined the middle-income market as Minnesota households with annual incomes between \$50,000 and \$125,000. However, the subgroup sees the results of its work benefiting households of all income levels in Minnesota.

The state has experienced successes in its state employee LTCL plan and its high take-up rate for Partnership LTCL policies. These successes can be traced to:

- Simplified and streamlined plan designs.
- Affordable premiums.
- Strong education and support by the state.
- Effective public/private program coordination.
- Importance of a financial reward for an LTCL purchase, e.g., tax credit.
- Importance of flexibility in product design.

The subgroup is applying these lessons to changes needed in LTC financing to better serve the middle income market, as well as all Minnesotans.

Medicaid and other public programs will be under increasing fiscal pressure in the future. As such, any viable and suitable private products with reasonable take-up rates have the potential to reduce public expenditures and book savings for the state.

Product complexity, accessibility and perception of high costs are key barriers to both insurance and other financial product utilization. To address these barriers, proposed solutions need to simplify products, standardize benefits and make their features easy to understand and access.

Criteria for Reviewing Products and Concepts

The subgroup also developed criteria for use when identifying and reviewing various concepts to determine if they would meet the needs of the middle-income market (not listed in order of priority). The identified criteria are:

1. Products stimulating competition in the marketplace for the purchase or use of the products.
2. Products providing high levels of consumer protection.
3. Products offering flexibility and multi-purpose use of benefits.
4. Products easier to understand and require fewer complex decisions than current products.
5. Products addressing income sensitivities, i.e., consumer can purchase lower or higher cost products.
6. Products with positive interactions with MA, and encourage use of the product under current MA rules.
7. Insurance and other products providing “short and fat” coverage. This type of coverage gives higher levels of benefits for a shorter period of time. These products tend to be less expensive and offer coverage during transitions to a more permanent situation or for end-of-life needs.
8. Insurance products attractive to younger ages either because the cost of purchase is lower or because eligibility is easier to meet.
9. Products actuarially sound, would generally be considered a value for the price by the middle-income market, and involve reasonably predictable and manageable cost increases after purchase, if increases are necessary.
10. Products that can be marketed and sold through the workplace, as part of a package of benefits to employees.

Recommendations of the Subgroup

The subgroup reviewed and discussed a total of 16 proposals/concepts during its meetings. After much discussion, the subgroup voted on 16 proposals, voting to include them in one of three categories:

Green Vote

“Based on our work to date, this proposal and its possible implementation steps should be recommended to the Own Your Future Advisory Panel.”

Yellow Vote

“Based on our work to date, I support the strategic direction of this proposal but recommend to the OYF Advisory Panel that future work be done to clarify or improve the concept.”

Red Vote

“Based on our work to date, I recommend to the OYF Advisory Panel that no further work be done on this proposal at this time.”

Using the results of this voting, the subgroup recommended 11 proposals as priorities for action. These 11 recommendations received a green vote from a majority of the subgroup. Three proposals (the life settlements, the public option and creation of a reinsurance fund) were recommended to be tabled for the time being, and one proposal, a new approach to home equity is not recommended for action beyond monitoring the work being done to establish a possible pilot project in Minnesota. (The 16th proposal was about creating a clearinghouse for information, and because this was not a product, it was moved to the section that includes overarching recommendations.)

Table 9 contains the subgroup recommendations on the 15 existing and new proposals/concepts identified and analyzed by the group. During the implementation phase, two concepts were deemed as having the most potential to offer a current product with a refreshed design and also provide affordable premiums/costs for the middle income, as well as addressing the other criteria the subgroup developed. These included a life stage protection product, a hybrid insurance product providing term life insurance protection during the working years, and then converting to LTCI protection in later years or upon retirement. The other product with great potential was the inclusion of a home care benefit in all Medicare supplemental plans sold in Minnesota to new Medicare beneficiaries.

The subgroup also developed several overarching recommendations describing broader action steps supporting the changes needed to increase the use of new or redesigned products as they are brought to market.

Overarching Recommendations

Minnesota needs to continue and intensify its efforts to educate Minnesota consumers about all aspects of LTC. Part of this effort should be the development of a Minnesota Long-Term Care

Financing Call Center to provide a virtual, single point of contact where consumers can access objective information about LTC risks, needs, funding and other potential solutions.

One of the biggest challenges in changing behavior in LTC is the lack of understanding and confusion about what LTC is, why consumers need to plan for it, the associated risks, what potential solutions exist and how they can be funded. Central to the success of any LTC financing program is a program like Minnesota's OYF campaign helping educate consumers about LTC costs, risk and options.

Beyond awareness, individuals and families need methods and tools to help them understand, in an objective and personalized way, what their options are, which ones are right for their unique situations, and how they can best access them.

The subgroup recognizes varying consumer needs require a range of financing options. No one option will fit all individual situations or necessarily provide a total solution for any particular situation. To that end, the subgroup is recommending the development of an LTC clearinghouse that would contain information and decision-making tools related to:

- LTCI products and option.
- Savings and investment options.
- Reverse mortgage and other home equity products.
- State and federal government programs including Medicare, Medicaid and Minnesota programs for older adults and those with disabilities.
- Caregiving services and supports.
- Health and wellness programs.

Some implementation steps would include:

- Seeking out potential partners at the national and local level, such as the National Council on Aging (NCOA), AARP, University of Minnesota Extension resources and the Minnesota Board on Aging Senior LinkAge Line.
- Determining organizational structure and potential funding options.
- Defining needed capabilities, including potential interactive tools for consumers.
- Developing design concepts for Web and other support specifications.
- Developing schedule and budget and identifying potential development resources.
- Increasing the expertise and resources dedicated to LTC-related insurance and financial product issues within state agencies, such as the Department of Commerce, overseeing these products.

The state should take a lead role in championing needed changes to state and national legislation and regulations to encourage more innovative and creative LTC financing options for the middle income market. Minnesota should consider critical changes needed at all levels of government.

Minnesota is already recognized as a national leader in the design of LTC services and therefore, is in an ideal position to significantly influence the national discussion and advocate for meaningful changes at both the state and national levels. This includes advocacy at the federal level in cases where the options recommended by the subgroup call for a change in federal programs or regulations. This can also include changes necessary in Minnesota's laws and regulations in order to move ahead with implementation of the high-priority products or concepts.

Recognizing available public financial resources are, and will likely continue to be limited, the Minnesota LTC financing system should include both private and public sector elements as well as incentives encouraging individuals and families to take personal responsibility for a portion of their care, wherever feasible. The state should continue to provide the incentives now available, including the Partnership program and the state LTCI tax credit, and identify similar incentives that could be offered.

There is an emerging consensus among LTC policy experts LTC financial solutions need to include both private and public elements, as well as individual and family responsibility. Increasing the amount of LTC costs financed privately has the potential to reduce public expenditures for LTC and lessen future pressure on the state Medicaid budget resulting from the aging baby-boom generation.

The primary product focus for the subgroup was on changes in private financing options; however, the group also considered ways to use the public role to encourage more creative and effective public/private collaboration. The state needs to work closely with the private and public stakeholders to encourage needed changes in the LTC market. Working together, the state and the private sector will have more ability to get things done than they would separately.

The third component of OYF will focus on how the current major funder of LTC (MA) could be changed to provide more incentives and support for the use of private LTC financing. We need to keep the current incentives in place (the Partnership program and the state tax credit for LTCI). At the same time, we need to explore ways in which public and private financing could be even more effectively linked together in order to create a comprehensive financing program.

For example, there might be a way to maximize private financing at the front end and use public financing to pick up where private dollars end or wrap around private financing in other creative ways.

The state should proactively develop partnerships with Minnesota employers, including worksite outreach programs to educate employees about the need to plan for LTC and what viable solutions exist to fund it. The programs should emphasize the cost advantages of taking action at younger ages, and should build on and expand OYF support for these activities.

Minnesota employers can and should play a major role in educating their employees about planning for LTC as a part of their retirement plans. This role should include offering access to an array of viable financing solutions. Employers are seen by their employees as a credible source of information about LTC and other retirement planning. Moreover, outreach through employers is an effective and efficient way to provide LTC planning tools and a sense of the importance of planning early to younger adults.

In an effort to further refine and gain statewide acceptance of these recommendations, the state should develop a governance steering process that will provide the needed input and advice from the various stakeholders to the OYF staff and consultants on the implementation of the recommendations in this report. As part of this process, the state should establish an LTC consumer research panel consisting of demographically representative members of the various Minnesota target consumer segments. The panel would be available to provide periodic and ongoing consumer feedback on key LTC issues, including concept and product understanding, acceptance, affordability and interest levels.

As one of the most critical issues the state must address, it is important to continue to move forward on actions that make a difference in LTC financing. Since action is needed from the private and public sectors, a process involving interdisciplinary and diverse stakeholders is best suited to address this complex and dynamic challenge.

The same is true regarding the need for a vehicle to test consumer preferences and possible behavior/decisions on the various proposals we will be working on over the next year. It is critical to obtain genuine feedback from consumers on the specific features and other factors within the proposals under development.

Table 9: Potential Product Concepts for Middle-Income Households

Stimulate the LTCI market	Modify laws or regulations to allow changes in products	Modernize Medicare and related products	Improve access to and safety of home equity options	Increase use of tax- favored savings plans
Encourage marketing of starter or transition LTCI plan	Work on state reciprocity for group and hybrid Partnership products	Study feasibility of including LTC in Medicare supplemental plans*	Make reforms in MN reverse mortgage laws to improve market and consumer protections	Create new or modify existing Health Savings Account provisions to allow LTC use
Encourage marketing of streamlined basic LTCI plan	Further the development of a combo term insurance and LTCI product for life stage protection*	Consolidate the Medicare nursing facility, home health and hospice benefit into one LTC benefit	Support new options for accessing home equity for LTC	Modify provisions of tax-deferred savings plans to incent use for LTC expenses
Encourage marketing of high deductible catastrophic LTCI plan	Study pros/cons of establishing life settlement trust funds	Support federal LTC Commission’s recommendations on Medicare		
Study how a public LTCI option might work in MN	Study feasibility of new reinsurance options for LTCI market			

* Products with high potential to meet middle income household needs for coverage

Concluding Thoughts on the Minnesota Efforts

The OYF Advisory Panel is committed to seeing the process to implement its recommendations continue, so that more affordable and suitable products to pay for LTC will become available to Minnesota’s middle income households. The public awareness efforts within OYF are important, but they can only do so much without the availability of financing options affordable and practical for these households to purchase and use to pay for care.

Neither the federal government nor the recent federal Long-Term Care Commission (2013) has been able to agree on real solutions which can address the LTC financing crisis. However, states can take the lead in being innovators in this type of environment and find solutions directly

addressing the LTC financing problems in their state. We believe Minnesota's recommendations can unleash new thinking about how to help Minnesotans pay for their LTC and lessen the pressure on the state's MA LTC dilemma.

Regulation of Long-Term Care Insurance Rates



Regulation of Long-Term Care Insurance Rates

By Eric King, Health Actuary, NAIC

Introduction

This is an overview of U.S. regulation of long-term care insurance (LTCI) rates for both initial rates and rate increases. Further details can be found in the documents referenced below in the Appendix of this section.

LTCI Rating Regulations and Related Resources

The regulation of initial LTCI rates and rate increases varies from state to state, but there is generally a common theme rates must not be excessive, inadequate, or unfairly discriminatory. Additionally, rates must be reasonable in relation to benefits. Most states' regulations are based on the NAIC's *Long-Term Care Insurance Model Regulation (#641)*.¹⁵² The first version of Model # 641 was adopted by the NAIC in December 1987.

Rating Model #641—Pre-Rate Stabilized and Amended Versions

Pre-Rate Stabilized

Prior to the Rate Stabilized 2000 changes to Model #641, state regulators used a minimum loss ratio (ratio of incurred claims to earned premium) projected over the lifetime of the policy standard to determine whether initial LTCI rates and rate increases proposed by LTC insurers were excessive. Two unintended adverse consequences resulted from the minimum loss ratio standard, which are discussed in the following Rate Stabilized 2000 section.

Rate Stabilized 2000

The changes to Model # 641 adopted by the NAIC Executive (EX) Committee/Plenary August 2000 (Rate Stabilized 2000) were in response to state regulators' concerns the minimum loss ratio standard in place resulted in a maximum allowed initial premium, and created a fixed expense margin that would likely over-compensate insurers for administrative expenses and

¹⁵² NAIC, 2014. *Long-Term Care Insurance Model Regulation (Model #641)* www.naic.org/store/free/MDL-641.pdf

profits when rates are increased. A minimum loss ratio standard disallows initial rates producing premiums in excess of the associated maximum, which does not allow an insurer to charge higher rates that may make future rate increases unnecessary or mitigate future rate increases. It may also prohibit charging initial rates sufficient to protect insurer solvency. A fixed expense margin resulting from a minimum loss ratio applied to an increased rate effectively applies the rate increase to the expense component of the rate. Expenses generally do not increase at the same rate as claims costs, and using a minimum loss ratio test for an increased rate can result in an insurer charging an excessive amount for expenses. The following example, taken from the *NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation*, illustrates this concept.

Fixed loss ratios produce a fixed expense margin as a percentage of premium. This is illustrated in Table 10:

**Table 10: Minimum Loss Ratios and Excessive Premiums
(Expense Margin=Premium x Expense Ratio)**

	A=Original Pricing	B=Repricing
Claims Costs	\$600	\$1,200
Loss Ratio	60%	60%
Premium	\$1,000	\$2,000
Expense Ratio	40%	40%
Expense Margin	\$400	\$800

The expected annual claims in Column A are \$600, so with a 60% loss ratio standard, the maximum premium is \$1,000. The portion of the premium available for expenses and profit is 40%, which equals \$400.

In Column B, after a few years of experience have come in, the best estimate of the claims is twice the expected amount in Column A, or \$1,200, so the maximum premium is \$2,000, and the maximum expenses and profit are \$800. Therefore, because some insurer expenses are fixed (such as salaries and rent), the insurer could increase the profit when claims are higher. The portion of the premium available for expenses and profit is increased when claims are higher after issue than was assumed in the original pricing.

Regulation of Long-Term Care Insurance Rates

In an attempt to remedy the issue of insurers not being allowed to charge initial rates in excess of those indicated by the minimum loss ratio when there is a valid reason to do so, Rate Stabilized 2000 removed the minimum loss ratio test for initial rate filings. In its place, an actuarial certification certifying premiums over the life of the contract, even under moderately adverse conditions, are expected to be adequate must accompany all initial rate filings.

A dual minimum loss ratio test was implemented to attempt to address the problems associated with fixed expense margins for rate increases. Rate Stabilized 2000 changes require the insurer to meet a 58% loss ratio for claims over the lifetime of the policy, and an 85% lifetime loss ratio for the expected increase in claims that precipitates a rate increase request (58/85 test).

The Rate Stabilized 2000 changes only apply to policies issued after a state incorporates the changes into its laws and regulations.

Rate Stabilized 2014

The changes to Model #641 adopted by the NAIC Executive (EX) Committee/Plenary at the 2014 Summer National Meeting (Rate Stabilized 2014) are a result of state regulators' concern about frequent and large rate increase requests filed by LTC insurers. The changes are intended to facilitate setting initial rates at a level not requiring future increases to maintain insurer solvency and rate adequacy. The changes also strengthen consumer disclosure requirements at the time of a rate increase, and make contingent non-forfeiture (CNF) benefits more favorable to policyholders. The Rate Stabilized 2014 changes only apply to policies issued after a state incorporates the changes into its laws and regulations.

An actuarial certification attesting premiums over the life of the contract, even under moderately adverse conditions, are expected to be adequate must accompany all initial rate filings. This is similar to the actuarial certification requirement in Rate Stabilized 2000, but Rate Stabilized 2014 adds to this by requiring a minimum 10% margin for adverse experience (MAE) be included in the development of initial rates. Exceptions to the 10% minimum may be granted, such as in the case of combination life/LTC or annuity/LTC products where the LTC component has a lesser effect on the performance of the overall product, or where an insurer can demonstrate its actual experience has developed with little deviation from the experience projected in past filings. An insurer will have to show claims experience is projected to exceed the initially priced MAE before a rate increase will be allowed.

The insurer is required to submit an annual actuarial certification attesting to the sufficiency of current rates. An annual review of experience is intended to alert insurers and regulators to the need for a rate increase sooner, rather than later when a much larger rate increase may be necessary.

Regulators can consider the implementation of a rate increase using a series of smaller increases rather than one large increase. For example, instead of a rate increase of 60% in one year, an insurer could implement an increase of 17% over three years ($[1.17] \times [1.17] \times [1.17] = 1.60$). Many LTCI policyholders who have filed rate increase complaints have said they would prefer several smaller rate increases rather than one large rate increase.

Regulations consistent with Rate Stabilized 2000 provisions require the insurer to meet a 58% loss ratio for claims over the lifetime of the policy, and an 85% lifetime loss ratio for the expected increase in claims that precipitates a rate increase request (58/85 test). Regulators have found some insurers develop rates with initial loss ratios greater than 58%, and if they are allowed to use 58% in the loss ratio test for a rate increase, the resulting rates may result in a higher profit than initially priced for (a lower loss ratio results in a higher rate). Regulations consistent with Rate Stabilized 2014 provisions require the insurer meet the greater of the initially priced loss ratio and 58% to remedy this unintended consequence.

Rate Stabilized 2014 permits the regulator to consider a rate increase lower than required under the rate stabilization certification if, among other requirements, the regulator determines the lower rate increase is in the best interest of the policyholder.

The changes strengthen consumer disclosure requirements at the time of a rate increase by requiring the insurer to offer a reduction in policy benefits (lower daily benefit, shorter benefit period, etc.) to lessen the rate increase the policyholder would experience if current benefits were retained. The changes also require the insurer to inform the policyholder the available benefit reduction options presented may not be of equal value. In the case of partnership policies (LTCI policies that offset the requirement to spend down income and assets to be eligible to receive Medicaid benefits), the insurer must inform the policyholder the election of some benefit reduction options may result in the loss of partnership status, which may reduce protections afforded in the partnership program.

The changes establish contingent non-forfeiture (CNF) benefits of greater benefit to the policyholder. CNF benefits allow the policyholder to maintain LTCI coverage by decreasing the levels of the originally contracted benefits. The policy is considered to be paid up (no further premiums are due) at the time a policyholder elects CNF benefits. The contingency making CNF

benefits available is the cumulative rate increase on a policy meeting or exceeding a given threshold. A maximum rate increase threshold of 100% to trigger eligibility for CNF benefits is established by Rate Stabilized 2014, which is more favorable to the policyholder than the maximum threshold of 200% under Rate Stabilized 2000 (see Table 11 for premium increase triggers for CNF).

Table 11: CNF Premium Increase Triggers

Policy Issue Age	% Increase Over Initial Premium	
	RS 2000	RS 2014
29 and Under	200%	100%
30-34	190%	100%
35-39	170%	100%
40-44	150%	100%
45-49	130%	100%
50-54	110%	100%
55-59	90%	90%
60	70%	70%
61	66%	66%
62	62%	62%
63	58%	58%
64	54%	54%
65	50%	50%
66	48%	48%
67	46%	46%
68	44%	44%
69	72%	72%
70	40%	40%
71	38%	38%
72	36%	36%

Regulation of Long-Term Care Insurance Rates

73	34%	34%
74	32%	32%
75	30%	30%
76	28%	28%
77	26%	26%
78	24%	24%
79	22%	22%
80	20%	20%
81	19%	19%
82	18%	18%
83	17%	17%
84	16%	16%
85	15%	15%
86	14%	14%
87	13%	13%
88	12%	12%
89	11%	11%
90 and Over	10%	10%

Also, policyholders who have held their policy for 20 or more years are automatically eligible for CNF under Rate Stabilized 2014, whether rates have been increased.

NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation

The NAIC *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation*¹⁵³ (Manual) is a resource that can be used by regulators to better understand the Rate Stabilized 2000 revisions to Model # 641. It can also be used by LTC insurers to better understand how state insurance regulators will evaluate initial rate and rate increase filings. A

¹⁵³ NAIC, 2005. *NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation*, www.naic.org/documents/prod_serv_supplementary_ltc_gm.pdf

draft of changes to the Manual to offer guidance on the Rate Stabilized 2014 changes to Model # 641 is being considered for adoption by the NAIC as of this writing.

Model Bulletin

The Announcement of Alternative Filing Requirements for Long-Term Care Premium Rate Increases Model Bulletin (Model Bulletin) was adopted by the NAIC Executive (EX) Committee/Plenary December 2013.¹⁵⁴ It is intended to be used by states as a basis for creating guidelines for LTC insurers to use in developing pre-rate-stability and post-rate-stability premium rate increase filings for LTCI policies currently in force. The Model Bulletin provides suggested requirements for developing actuarial assumptions for rate increase requests, a requirement to offer CNF benefits for policies that did not previously make them available, a dual loss ratio test for pre-rate stability forms similar to the Rate Stabilized 2014 test and new requirements for the insurer's notification to the policyholder of the rate increase. It also disallows any subsequent rate increases for three years after a rate increase is approved.

¹⁵⁴ NAIC, 2013. Model Bulletin, www.naic.org/documents/committees_b_senior_issues_140313_ltc_model_bulletin.pdf

A Consumer Advocate's View on Financing Long-Term Care Insurance: A Tsunami of Another Kind



A Consumer Advocate's View on Financing Long-Term Care Insurance: A Tsunami of Another Kind

By Bonnie Burns, Training and Policy Specialist Consultant, California Health Advocates, NAIC Funded Consumer Liaison Representative

Introduction

The U.S. government as well as state governments will soon face a tsunami of long-term care (LTC) needs as baby boomers enter old age in steadily increasing numbers and live to advanced ages as it has been discussed in earlier sections of the study. More than one-half of everyone living past retirement is expected to require some type of LTC services during their lifetime.¹⁵⁵

The Need for Long-Term Care Insurance and Available Options

Often family members provide care for their family members. But the spouses, daughters and daughters-in-law who most often are the primary caregivers are soon swamped by the combined demands of their families, employment and caregiving. In the future, when the oldest baby boomers are expected to need care, they likely will have fewer potential family caregivers available, due to the higher divorce rate and lower birth rate compared to their parents.

Commercial long-term care insurance (LTCI) has not found a firm footing in the growing national need to finance older Americans' LTC. The principle of insurance depends on: 1) an infrequent risk too large to be assumed by individuals; 2) can be financed through modest pooled payments by individuals subject to that infrequent risk; and 3) under common rules for coverage and payment when that risk occurs. Unfortunately LTC is not an infrequent risk at older ages in a population with increased longevity, and premiums have become unaffordable to large numbers of people subject to the risk of care. Furthermore, current insurance risk is split up into hundreds of insurance pools of various sizes, durations, risk selection, and benefit packages challenging the principle of insurance.

Only 7.4 million LTCI policies sold since 1987 were in-force nationwide as of 2014.¹⁵⁶ The sale of these policies peaked in the late 1990's. In the hypercompetitive market following the passage of the 1996 federal *Health Insurance Portability and Accountability Act (HIPAA)* and the

¹⁵⁵ See <http://longtermcare.gov/the-basics/who-needs-care>

¹⁵⁶ See <http://www.ahip.org/Epub/The-Benefits-of-LTC>

introduction of federally tax-qualified policies in the mid-1990s, insurers faced fewer lapses and more claims than expected and in the aftermath of the market collapse of 2008, lower returns on reserves. As a result, insurers received approval from their state regulators to increase premiums on in-force coverage, re-price new offerings, change their internal risk assumptions, and institute much stricter underwriting procedures for new applicants. Insurers now may have so overpriced policies to account for past risk assumptions that excess reserves in the future may pass to investors rather than back to the policyholders who paid those excessive rates. Some insurers have fled the market, leaving behind only about a dozen insurance companies which continue to sell freestanding LTCI products.

State insurance regulators of LTCI companies have responded slowly to complaints about marketing, sales, benefit design and pricing, often reacting after the fact rather than proactively identifying and proposing solutions to correct market problems before they negatively affect a large number of policyholders. Recent efforts to control large premium increases illustrate the problem of reacting to past problems.

Today fewer middle-class individuals can afford the newer premiums. Women, in particular, are likely to be priced out of the market by gender-based pricing. Many applicants of both genders cannot qualify for coverage under newer, more stringent underwriting standards. In the future, without private LTCI, even more elderly women are likely to become dependent on public resources, many of whom will have cared for and outlived their spouse. Without a live-in caregiver, older women are much more likely to receive their care in a high-cost institutional setting.

Many insurers today have abandoned the free-standing LTCI market and now focus on selling life and annuity products providing LTC benefits. Unfortunately, only higher net worth buyers may be able to afford these financial products. Other insurers are selling short-term care insurance products that often escape state regulatory standards LTCI products must meet.

Areas of Future Concerns

Claims

While large premium increases have triggered multiple rounds of regulatory action, claims problems often center on outdated concepts of care and disputes about definitions of places where benefits will be paid. Today, multiple generations of policies are in force; each generation of policies reflects the requirements in the year and in the state where they were issued. Older policies often contain outdated, ambiguous or even contrary definitions of the

types, places and providers of care eligible for benefits. The benefits in older policies do not reflect the changes in caregiving and the emergence of new places of care, such as memory care units in assisted living facilities.

Policies issued today may also not accurately reflect future changes in care. With fewer new sales and more closed blocks of business, insurers may be tempted to control costs through stricter claims criteria. Insurers could begin more strictly interpreting or applying their contract language, which may not match the care options most available and appropriate to the policyholder. As insurers move to third-party administrators, stricter claims criteria may be imposed, or inducements offered to control the number and type of claim approved for payment.

Too often adult children who file a claim for an impaired parent or family member face incredible amounts of paperwork and a protracted claims process appearing to be designed to discourage pursuit of a claim. Regulators need to do more to ensure people who bought benefits can use those benefits when they are needed. Regulators should make greater use of targeted market conduct exams to uncover unnecessarily complex claims requirements by an insurer or their third-party administrator.

Life and Annuity Products

Applicants often do not have a good grasp of the life insurance or annuity they buy. When the product also includes benefits that can be accelerated by triggers which include the need for LTC, it adds another layer of confusion to the purchase. Combining the complexity of LTC benefits with another complex financial product leaves most consumers befuddled about what they are buying. The current illustrations are characterized by charts and graphs creating volumes of paper that do not help consumers understand what they are buying or how each part of two complex products will work when they need those benefits. The illustrations of these products must be simplified and required to meet more stringent readability standards.

Consumers need clear, understandable documents associated with the sale of an LTCI product, regardless of its structure or underlying design. Consumers should be able to easily find information about using their benefits, the tax status of their benefits and whether any benefits received could be subject to taxes later. There should be clear disclosure if they could be required to pay an additional premium or any other charges in the future. State insurance regulators also need to pay close attention to the pricing assumptions for each component of these products and the effect future life settlement options might have on those benefits later.

Short-Term Products

A market has developed in recent years to sell short-term LTCI products. These policies purport to cover LTC for as little as three months or as long as 360 days. These products are often not regulated as LTCI products and do not meet the requirements for those products. They are promoted as a solution for people who cannot qualify for an LTCI policy, or to back fill the waiting period of an existing LTCI policy. The underwriting for short-term care policies relies on answers to a few health questions, much like those of the old legacy LTCI policies which have been subject to huge rate increases in the intervening years. One short-term care policy is not even guaranteed renewable, allowing the insurance company to cancel coverage at any time. A closer look at these products and their utility is long overdue. Regulators must scrutinize these products to ensure they are properly priced for the risk they are assuming, meet realistic loss ratios and product standards, and serve a legitimate public purpose.

Partnership Programs

State Partnership programs promise protection of assets after benefits are paid by a Partnership LTCI policy, allowing people to keep resources they might otherwise have had to spend for their care. States should evaluate other ways in which Medicaid, a sliding scale private payment and commercial insurance benefits might be combined as they implement and expand Medicaid home and community care. Care coordination and care management of all available LTC services in the most appropriate setting, a component of a Partnership policy is some states, should be available to everyone who needs LTC to ensure the best use of public and/or private resources.

Rate Increases

In the hypercompetitive marketplace of the mid-1990s following the introduction of tax-qualified policies, insurers often used premium prices to compete for market share. That strategy later proved unsustainable due to faulty assumptions of lapse and utilization, and the low return on investments and reserves. The faulty assumptions led to large, and often multiple premium increases insurers, consumers and regulators have been dealing with over the last 10 years. Three times over the last 20 years state insurance regulators have tried to prevent future rate increases by changing the pricing requirements insurers must meet. Yet another pricing dilemma is still making its way through the regulatory process.

State regulation of these products should include meaningful options for consumers when they are subject to a rate increase.

A clearly written notice of a rate increase should include:

- A clear description of the amount of the rate increase and when it must be paid.
- A clear description of all options to reduce the increased amount.
- An 800-number for contacting the company that does not require the use of a phone tree.
- A customer service representative who can readily compute the difference in premium for each option or combination of options the insured wishes to exercise.
- Information if a rate increase is staggered over a series of years.
- Information on future potential rate increases.
- A caution notice about reducing benefits if future rate increases are known or anticipated.

Rate increase notices should also be sent to the third party selected to receive a cancellation notice, as well as contact information for the State Health Insurance Assistance Program (SHIP)¹⁵⁷ to ensure an insured receives as much help as possible to keep some amount of coverage in-force.

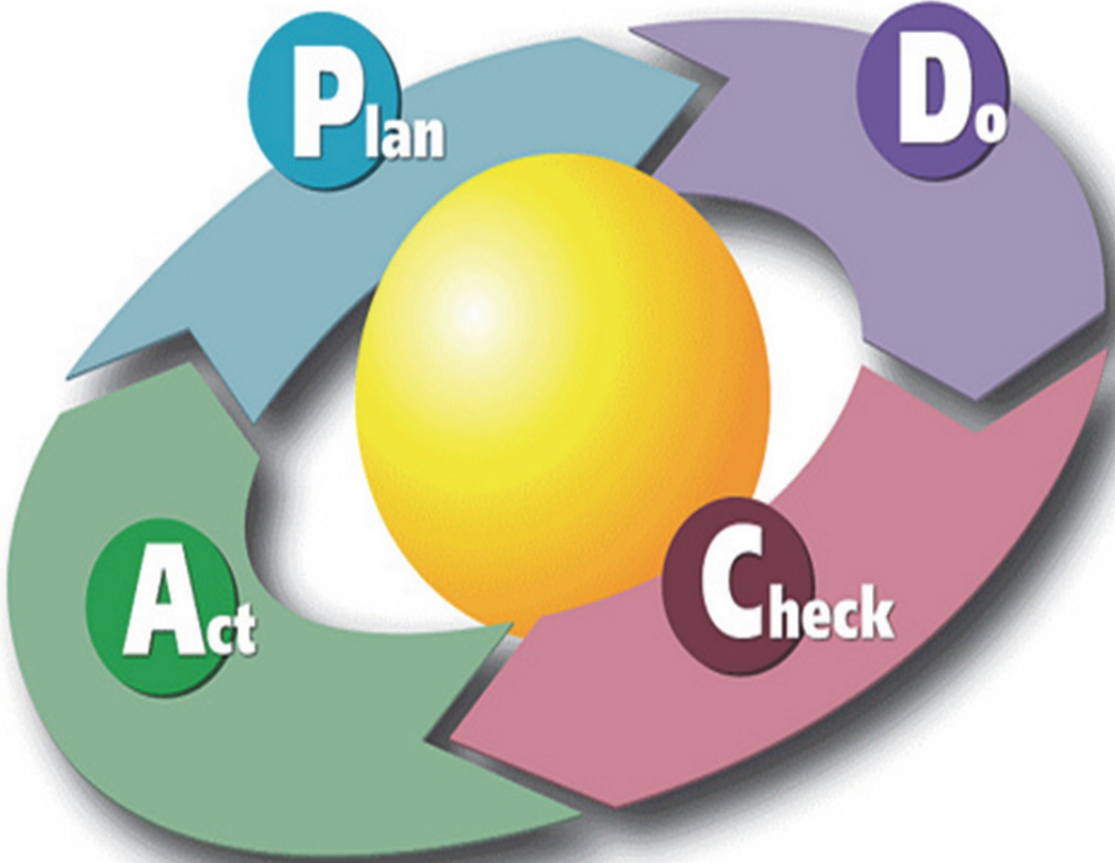
In addition, the state insurance commissioner should have the authority to order insurers to provide an option for a paid-up policy in the amount of premiums paid after taking into account the age range of the pool and the impact of a single or staggered increase on policyholders of advanced age affected by that rate increase.

Concluding Thoughts on Financing LTCI

It is unlikely the public policy problem of financing LTC will be solved by relying solely on the purchase of commercial insurance to cover that risk. Fewer people, and fewer women in particular, may be able to afford the purchase of LTC benefits and retain the coverage for the rest of their lives. Without planning, coordination, and innovative thinking by policymakers and politicians, no national solution will be found and many middle-class families will continue to struggle to pay for care until their resources run out and they are forced to transition to public benefits.

¹⁵⁷ SHIP is a state program that gets funding from the federal government to provide free local health coverage counseling to people with Medicare.

Industry Executive Views on Long-Term Care Insurance



Industry Executive Views on Long-Term Care Insurance

Introduction

By Jesse Slome, Executive Director, American Association for Long-Term Care Insurance

Markets evolve, people evolve and since the earliest long-term care insurance (LTCI) policies were introduced, change has been a constant for this industry. That change and evolution will continue.

There is a lot of truth in the statement, "we cannot predict the future, so why be unhappy about the present?" When it comes to LTCI, much has been learned since the first policies were offered. Certainly there have been mistakes and missteps. But, equally, there have been millions of Americans protected and billions of dollars of benefits paid.

There are as many opinions about how to best deal with America's long-term care policy as there are voices. To add another valuable perspective to this study, I reached out to seasoned industry executives of major LTCI companies asking them to share their viewpoints - with a look towards the future.

"Prediction is very difficult, especially if it's about the future" (Niels Bohr). The goal for the following pages is to provide some value and insight you might not have considered.

The Path Forward Runs Through a Competitive and Growing Private Long-Term Care Insurance Industry

By Tom McInerney, President and CEO, Genworth Financial, Inc.

Introduction

When I first joined Genworth in 2013, after more than three decades in other lines of insurance, I shared our board of directors' view that we should consider joining many of our former competitors and exit LTCI business. So why did not we? Ultimately, it is because we believe LTCI is vitally important—for individuals, for families, and for our nation.

The challenge is not the principle; it is the product. And when it comes to the product, I see a clear path forward. If insurers, regulators and legislators can work together to take a few specific steps, it will: 1) lead to a successful line of business within a competitive and growing industry; 2) lift a significant share of the burden from government programs; and 3) help more Americans enjoy a secure retirement.

The People Behind the Policies

I talk often with state insurance commissioners, governors and federal officials. Nearly everyone shares the same understanding of the stakes, because we are all seeing the same trends and hearing the same stories—whether it is from customers, constituents or distributors.

The data tell part of the story. As clearly illustrated in the previous sections of the study, every day from now until 2030, 10,000 baby boomers will turn 65,¹⁵⁸ and 70% of them will need some kind of LTC during their lifetime.¹⁵⁹ Then there is the cost.

When I am meeting with public officials, I often pull up Genworth's Cost of Care app, punch in their ZIP code, and show them the median pricing in their area, compared to the national figure—for instance, \$44,000 a year for homemaker services or \$91,250 a year for nursing home care.¹⁶⁰ As they are often quick to point out, too many baby boomers mistakenly believe

¹⁵⁸ AARP, 2011. "Baby Boomers Turning 65" www.aarp.org/personal-growth/transitions/boomers_65/

¹⁵⁹ Genworth, 2015. "Annual Median Cost of Long Term Care in the Nation." March 20, 2015, www.ltcfeds.com/start/aboutltc_what.html

¹⁶⁰ Genworth, 2015. "Annual Median Cost of Long Term Care in the Nation," March 20, 2015, www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html

Medicare or health insurance will cover these costs,¹⁶¹ and too few of them have enough retirement savings to foot a bill that heavy.¹⁶²

In 62% of cases, a friend or family member will step in to provide care.¹⁶³ Many informal caregivers spend more than 20 hours a week supporting a loved one.¹⁶⁴ Others leave the workforce entirely—and when they lose that source of income, the government loses a source of tax revenue.

But the numbers fail to capture the full extent of the financial and emotional burden that can accompany an LTC need. I remember reading the words of one woman, Jennifer Krychowecky, when she was asked what she gave up when her mother developed Alzheimer’s disease. She said, “My boyfriend, my house, my social life, my career, my freedom... life as I knew it.”¹⁶⁵

Ms. Krychowecky urged her peers to look into LTCI. “Had my mom gotten it, our lives would have been leagues easier, and I would not be in the financial situation I am in right now,” she said. Still, only 8% of eligible Americans have opted for private insurance—putting pressure on taxpayers, who bear much of this burden through Medicaid.

Medicaid: Not Designed to Handle Long-Term Care

Designed for the destitute, Medicaid kicks in only after uninsured Americans spend down their savings, exhaust their investments, and, often, give up their homes. Long-term care insurance is designed to protect against this scenario through leverage. For example, a husband and wife, each 59 years old, purchase a Genworth policy in 2015. Together, they might pay a total of

¹⁶¹ The Scan Foundation, 2013. “Current Issues and Potential Solutions for Addressing America’s Long-Term Care Financing Crisis,” www.thescanfoundation.org/bipartisan-policy-center-america%E2%80%99s-long-term-care-crisis-challenges-financing-and-delivery;

Robert Wood Johnson Foundation, 2014. “Long-Term Care: What Are the Issues?” www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf410654

¹⁶² Ibid.

¹⁶³ The Scan Foundation, 2014. “The State of Long-Term Care Financing – Long-Term Care Spending in the United States,” www.thescanfoundation.org/infographic-state-long-term-care-financing-long-term-care-spending-united-states

¹⁶⁴ Family Caregiver Alliance, 2009. “Caregiving,” <https://caregiver.org/caregiving>

¹⁶⁵ Stephensen, M.A., 2015. “A Daughter Gives up Her Life to Take Care of Mother with Alzheimer’s.” *The Huffington Post*. April 14, 2015, www.huffingtonpost.com/mary-alice-stephenson/she-gave-up-her-life-to-take-care-of-her-mother-with-alzheimers-t-b_7051438.html

\$48,000 in premiums over the next 20 years, and in 2035 their available benefits would be about \$600,000.¹⁶⁶

As a result, not only are the policyholder and their family protected, so are both the federal and state governments. Absent insurance, in cases where costs far outstrip assets, Medicaid is not only the payer of last resort, but often the only payer.

Already, about 40% of state Medicaid budgets go toward LTC,¹⁶⁷ and baby boomers—today numbering 75 million¹⁶⁸—have only just started to strain those budgets. In 2025, the eldest baby boomers will reach age 79 and begin their peak LTC years.

Medicaid alone will not work. Private insurance alone will not work. Unpaid caregiving alone will not work. Government programs, private insurance and individuals must each share some of the risk.

There are many possible methods of collaborative financing. I recently sat on a panel at the Brookings Institution, where Wesley Yin (UCLA)¹⁶⁹ suggested a concept worth considering. He would put Medicaid dollars earmarked for LTC into an insurance pool, so instead of Medicaid paying out dollar-for-dollar, claimants would benefit from insurance leverage. Proposals suggested by others would have private insurance taking the first loss while a public reinsurer assumes the tail risk—reimbursing those who might stay on claim for decades and who would otherwise be covered by Medicaid.

These types of cost-sharing plans are worth considering. But, for any of them to work, we must first strengthen the private market by bringing more predictability to the regulatory environment.

¹⁶⁶ Based on a \$4500 monthly benefit with a 3 year maximum and 3% compound inflation.

¹⁶⁷ Center for Health Care Strategies, Inc., 2010. “Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options,” www.chcs.org/media/LTSS_Policy_Brief.pdf

¹⁶⁸ Pew Center, 2015. “This year, Millennials will overtake Baby Boomers.” Jan. 16, 2015, www.pewresearch.org/fact-tank/2015/01/16/this-year-millennials-will-overtake-baby-boomers/

¹⁶⁹ Lin, W. 2015. “Strengthening Risk Protection through Private Long-Term Care Insurance,” The Hamilton Project, www.hamiltonproject.org/assets/files/brief_yin_private_long_term_care_insurance.pdf

The Path Forward: Frequent Reassessment and Fundamental Change

A winemaker would never test a new type of stopper by bottling his entire harvest, locking it away in the cellar, and hoping everything turns out fine when it is uncorked 40 years later. But that is exactly how the first LTC insurers approached their new product line.

In the four decades after the sale of the first policies in the 1970s, every assumption that went into pricing those policies turned out to be off—inflation, interest rates, morbidity, mortality and lapse rates. Yet insurers did not re-rate their policies until the 2000s.

In the case of LTCI, people lived longer and stayed on claim longer. Interest rates dropped lower. And there were far fewer lapses—rather than 6% or 8% abandoning their policies, less than 1% did. Insurers were losing billions on those older policies. When they finally requested significant premium increases, it ended up leaving a bad taste in everyone's mouth.

While the vast majority of the requests were granted by states and accepted by customers, some insurers failed to receive increases and stopped issuing new policies in those states. Others stopped issuing new policies altogether. Some became insolvent.

When an insurer leaves the marketplace for any reason, it is bad for customers, bad for other insurers and bad for state budgets. But there are efforts underway to increase competition.

Better Regulation, Legislation, and Collaboration

To keep existing players in the market and entice new ones to it, regulators and insurers must collaborate on a three-part strategy regarding in-force rate actions:

1. **Bring older policies closer to break even:** Genworth, for one, lost \$2 billion on LTCI policies it wrote before 2002. While we have never sought to restore our profit margins, we have requested increases to cut our losses going forward and keep our finances strong enough to pay claims.
2. **Bring more recent policies back to their original pricing structure:** Policies written since 2002 require less aggressive increases. Still, state insurance regulators must act swiftly and avoid postponing them. As the American Academy of Actuaries (Academy) has

calculated, replacing five years of missing premiums often requires doubling the increase. (See Table 12 from a report by the Academy.¹⁷⁰)

3. **Bring about more predictable, more manageable rate increases:** Insurers must start with conservative assumptions and pricing, and commissioners must be open to modest, regular, and actuarially justified increases reflecting changing risk factors.

Table 12: The Cost of Waiting

Source: American Academy of Actuaries

Years Waited	Increase Needed
5	96.6%
10	173.4%
15	350.1%
20	2,691.7%

These essential steps should be supplemented with action at the federal and state level to grow the industry beyond its current 8% market penetration rate.

Insurers, for our part, are simplifying policies and creating more affordable products. We want our policies to be able to reflect the reality even less than fully comprehensive coverage products can still offer significant benefits. However, some new features require new legislation. With changes to the tax code, people could use tax-advantaged funds to purchase LTCI, or they could build up cash value in their policies and make tax-free withdrawals—much like universal life insurance.

On top of these narrow fixes, there are also broader challenges which require bigger investments—for instance, public education or publicly funded research. Many middle-class families have not taken steps to plan for a potential LTC need because they are not aware of the risks. Alzheimer’s is the most expensive disease in America,¹⁷¹ but funding for research lags

¹⁷⁰ The American Academy of Actuaries, 2014. “The Cost of Waiting: Predicting Long-Term Care Rate Increases,” <http://us.milliman.com/uploadedFiles/insight/2014/cost-of-waiting.pdf>

¹⁷¹ Reid, T.J., 2015 “Where’s the War on Alzheimer’s?” AARP, February 2015, <http://member.aarp.org/health/brain-health/info-2015/alzheimers-research.html>

far behind cancer, heart disease, and HIV/AIDS. Finding a cure for dementia would essentially remove, in one fell swoop, 35% of claims made and 51% of claim dollars paid.¹⁷²

With further public and private investment, there is no reason LTCI cannot eventually become as commonplace as home, auto, life, and health. It is a must, if we want government programs to survive without having to resort to significant tax increases.

The Cost of Waiting Is Too High

In LTCI, nothing is more expensive than the cost of waiting. It is true for consumers, insurers and state insurance regulators. Without collective action, everyone's costs and risk rise.

But, if we can make meaningful progress on everything from in-force rate actions to cost sharing to education, we will build a competitive and growing LTCI industry. In the decades to come, it will lighten Medicaid's burden and provide more middle-class families with the financial protection they need to enjoy the secure retirement they have earned. This is what makes a vibrant LTCI industry a vital part of the long-term solution.

¹⁷² Long-Term Care Claims Experience Data for Genworth Life Insurance Company and Affiliates – Dec. 31, 1974 through Dec. 31, 2014.

Three Minor NAIC Regulatory Changes That Would Revitalize Long-Term Care Insurance

By James M. Glickman, FSA, MAAA, CLU, FLMI, President and CEO, LifeCare Assurance Company

Introduction

As we have seen throughout this study, everyone recognizes as the baby boomers progress through their 80s, 90s, and beyond, a looming LTC crisis awaits the nation. Only minimal planning has been done so far to protect the population. Government resources are already stretched thin trying to keep Social Security, Medicare and Medicaid afloat. In fact, it is clear Medicaid will be unable to provide the needed financial support 20 to 40 years from now, when it has become a crisis. As the predominant payer of LTC services for the elderly, it is imperative that solutions be found to attract and encourage people to pre-plan for this risk. Insurance is obviously the best solution.

This article briefly evaluates the two current types of LTCI offerings and then proposes three minor changes to NAIC regulations which would help eliminate future rate increases, develop better LTCI products for the consumer, and improve the position of insurers offering these products.

Types of LTCI Products

Right now, there are two types of commercially available insurance solutions for consumers to consider.

The first type, life insurance with an LTC rider, is more commonly known as an LTCI Combo Policy. It provides the ability to use the life insurance death benefit, dollar for dollar, to pay for LTC instead of being paid out later as a death benefit to the beneficiary. Cash values are likewise reduced on a pro-rata basis. While this avoids the challenges discussed below, which are associated with the LTCI standalone product, it has two major challenges of its own. The first one is the high cost. Typically, this product is paid for with a single lump sum payment of \$60,000 or more. The second one is the lack of inflation protection options at any reasonable price, which would keep the LTCI benefit up-to-date with actual cost inflation.

The traditional type of LTCI is known as a standalone LTCI policy. With a stand-alone policy, the consumer has a wide range of choices for daily benefits, benefit periods, elimination periods

and inflation protection. However, there are two major reasons this market has struggled to thrive. First and foremost, LTC protection is a use-it-or-lose-it proposition in which most people, believing they will not be the ones to need care, have a built-in excuse not to purchase coverage. Second, as it has been noted in previous sections, some of the actuarial assumptions on standalone policies of the 1990s and early 2000s were far enough off of the correct assumptions, that substantial rate increases were necessary to correct those errors. This has created an atmosphere of distrust on the part of both agents and consumers regarding the rate stability of standalone products being sold today.

Needed Regulatory Changes

There is a solution available that solves the shortcomings of both types of LTCI products, but to really make it work, three basic changes are needed to the stand-alone product regulations. First, regulations which currently prohibit cash values for a stand-alone policy should be changed to mandate cash values.

Perhaps surprisingly, the only cost associated with mandated cash values is the equity that must be paid to those policyholders who lapse their policies. When current regulations were originally developed in the late 1980s, pricing lapse rates were substantially higher, and thus there was a significant cost associated with mandating cash values. However, current policy pricing assumes a lapse rate of near zero, so this additional feature would have little effect on today's policy price.

Yet, there is one problem with mandatory cash values that would need to be fixed in the product design before cash values could be added safely. When someone is in their final days prior to death, there would be a significant incentive for the family of the insured to claim their cash value since there is no death benefit. This would cause enough anti-selection to significantly drive up the cost of the policy. However, there is a solution rather easy to design. Instead of receiving a lump sum cash value, the insured could receive a lifetime annual income instead, beginning one year after surrender. This design would eliminate any possibility of anti-selective behavior by the insured. What is more, the existence of a cash value reduces the potential magnitude of rate increases. This is due to the fact an insured in good health would generally decide to take the cash value out of the policy rather than agreeing to pay anything more than a very modest increase, while the unhealthy insureds would gladly pay the increase and soon become claimants.

A second minor change in NAIC regulations would help incentivize insurers to create a non-cancellable feature policyholders would greatly value. This would eliminate all concerns about

future rate increases. Currently, a non-cancellable policy carries a large financial penalty for the insurance company, requiring it to hold up to 400% more capital for this type of policy.

The cost of this extra capital must be passed along to the policyholder in the form of a much higher than otherwise necessary price. By eliminating this capital charge penalty in conjunction with a cash value mandate, insurers would be incentivized to offer a non-cancellable policy, thus providing further assurance rates cannot be increased.

A third change in the NAIC regulations for this new type of stand-alone policy should allow insurers to create more effective death benefit designs for those insureds who want to purchase them. This change would allow a return of premium on death rider (with or without a claims offset feature), which currently is limited to the premiums paid to exceed the premium collected up to some reasonably modest amount, such as 250% of the premium paid. In this way, insureds could choose a full range of possible benefits, starting from the most basic stand-alone policy all the way through to a product that has all of the advantages of the current life insurance/LTCI combination policy, without any of the current disadvantages.

These three modest regulatory changes would provide a boost to the LTCI industry and help create a quality product for the consumer, while eliminating all of the risks associated with purchasing either the current style of stand-alone policy or the current life insurance/LTCI combination policy.

Closing Remarks for Recommended Regulatory Changes

In summary, if the NAIC made the following three changes to the Long-Term Care Model Act (#640), the resulting LTCI products would combine the best features of the current Life/LTCI combo products with the best features of the current stand-alone products:

1. Require (rather than prohibit) mandatory cash values for LTCI, with the cash values representing the equity interest in the LTCI policy.
2. Eliminate the current penalty for a non-cancellable policy form that effectively discourages insurers from even considering the consumer- and regulator-friendly non-cancellable policy form.
3. Allow the return of premium death benefit riders to provide up to 250% of the premiums paid instead of the current limitation of 100% of the premiums paid.

State Insurance Regulator Views on Long-Term Care Insurance



State Insurance Regulator Views on Long-Term Care Insurance

Introduction

By Dimitris Karapiperis, Analyst, NAIC, Center for Insurance Policy and Research and Eric Nordman, Director, NAIC, Center for Insurance Policy and Research

The uneven development and use of private insurance for long-term care (LTC) needs has contributed to a surge of individual household LTC expenditures to levels often unsustainable for large numbers of middle-class families. A great challenge facing both regulators and insurers is inadequate premiums for legacy long-term care insurance (LTCI), which in many cases, as discussed extensively in previous sections, have caused large rate increases. This leads to significant loss of LTCI coverage, often by the most vulnerable policyholders—adding not only to personal but also societal costs.

This presents a major social challenge and a serious policy dilemma for state insurance regulators, as well as for the insurance industry to devise efficient programs and mechanisms for the provision of this critical and increasingly needed service for the country's aging population. State insurance regulators play a key role in ensuring pricing of LTCI policies is both accurate and reasonable while striving to promote LTCI that is both affordable and available to those who need it most.

The NAIC first released the *Long-Term Care Insurance Model Act* (#640) in 1987 to provide state legislators with a set of minimum standards and practices for insurers. Over the course of the following years, the NAIC has adopted additional standards to address new emerging concerns and issues in the LTCI market as discussed in the regulatory section. The existing regulatory framework is continuously being reviewed launching new initiatives to maintain its flexibility and compatibility with the evolving delivery of LTCI products in a changing marketplace.

In this section of the study, we present the views of a number of select state insurance regulators on LTCI. Drawing from their knowledge and experience as top regulators in their respective states, they discuss their domestic, as well as national, LTCI market and the issues they are confronting. They also explore new ideas and solutions for making LTCI viable going forward and able to meet consumer needs.

**Kevin M. McCarty, Commissioner, Florida Office of Insurance Regulation,
NAIC Past President**

The LTCI Experience in Florida

One of the more challenging areas, given Florida's large senior citizen population, is the market for LTCI. Although the LTCI market is decreasing, Florida—historically—is one of the three top states in terms of LTCI sales. At the same time, the product mix has changed over the years. We have fewer insurers offering these products. A number of the insurers that historically sold the product no longer offer it.

Long-term care insurance products are really difficult to price appropriately, because unlike traditional health policies where an insurer's loss ratio can be considered on an annual basis in determining rate increase needs, an LTCI insurer needs to try to correctly anticipate lapses and scrutinize mortality assumptions decades into the future. What we have found over time is LTCI policies lapse at a much lower rate than life insurance policies. Like life insurers, LTCI insurers count on premiums paid for policies lapsing to create the necessary insurance leverage. The lower lapse rate of LTCI has often resulted in prices being inadequate.

Also, as life expectancy has increased beyond expectations and health conditions have improved with more people living longer, we have seen an increasing utilization of LTCI benefits. Clearly, a lot of the assumptions for LTCI were miscalculated.

In a way, perhaps the classification of LTCI as health insurance may have resulted in a bad fit. While the benefits are triggered by a health event, LTCI benefits do not cover medical costs or services to restore health. The purpose of LTCI is essentially for asset protection. LTCI seems to be more in line with life insurance risk; so if it were reclassified, LTCI policies could potentially be allowed to build cash value, which is prohibited under Florida state law, for health policies.

Containing LTCI Cost

It is hard to envision, as things stand now, LTCI to be an affordable product for middle-class consumers. One possible solution is to make it a combination product, which appropriately hedges the mortality risk. Another option is to viaticate a life insurance product¹⁷³ to fund LTC

¹⁷³ The buyer pays the policyholder (seller) less than the full benefit of the policy in order to earn a return on the investment. The seller uses the proceeds to pay for medical treatments and/or improve quality of life while he or she is still alive when other sources of funds are exhausted.

needs. One has to look at this in terms of bifurcating. First, look at the policies on the books today and what can be done with those, and continue wrestling with the issue of rate adequacy, and then decide if it makes sense to have LTCI products in the future that look like the ones found in the market today or if other product designs are more viable.

For insurers concentrating more on LTCI products there is the potential of facing solvency issues if they are not allowed to increase their rates. What Florida has done to alleviate the concern, with consumer protection in mind, is allow policyholders who purchased LTCI with the assumption there would be a stable rate overtime to restructure their policies, instead of paying the new higher premiums.

I think going forward it does make sense to re-evaluate every few years, the mortality, morbidity, life expectancy and lapse rates so better adjustments can be made. Better to do that than wait 10 years to make the adjustments and then increase premiums by 80% or 100%.

The state of Florida has a provision for LTCI policies to impose a cap based upon the current cost of LTCI. Essentially, it caps any rate increase at the rate level of products currently being sold. Although Florida has been granting rate increases—not as high as some other states have been granting—there are other laws in the state that require rates to be reasonable. We are looking at what could be done, re-evaluating the LTCI rate law, what changes can be made to help insurers to more accurately estimate rates and provide more consumer protections going forward.

To reduce the burden placed on our most vulnerable seniors the rate increases in Florida differ by issue age group and are distributed accordingly. The younger issue age group, between 50 and 65 years old, gets the highest rate increases while older consumers, 80 years old and above, get the lowest. Some of the pricing difficulties were really self-inflicted. Some insurers did not take into consideration the best available information and they were more interested in the marketing side of the business rather than the actuarial indications and support for their LTCI products.

Alternatives to Increase LTCI Affordability

One of the things insurers can do is price their LTCI policies using very conservative assumptions, and then they could guarantee the rate for a certain time. They could also potentially include a rebate to policyholders in the event their assumptions do not materialize, to avoid a windfall for the insurer. The problem is to adequately price products in the future when you have the changes in assumptions, the prices jump much higher than consumers can afford.

Given that the average stay in an LTC facility is less than three years, a shorter duration of benefits could help reduce the cost.

One of the things that could be considered is catastrophic-type policies which allow individuals to self-fund their LTC needs and have a high-deductible policy that kicks in after a set time period. This type of policy would not be allowed in Florida because waiting periods beyond six months are not permitted. Possibly, if a dollar threshold is set—e.g., the \$100,000 you self-insure and then you can buy an LTCI policy for needs exceeding that amount. These policies would be more affordable. Also, more thought should be given to various alternatives to make policy modifications in order to better contain cost.

We need to be really creative with thinking how these products will look in the future. We need to not just limit the amount of benefits but rather look at the front-end to have a degree of self-funding by consumers. Prefunding at the front-end would most likely favorably affect pricing. Another thing that could be done is to allow for something like the health savings accounts (HSAs) where people would contribute.

The CLASS Act

The federal Community Living Assistance Services and Supports (CLASS) Act would have helped create a voluntary public LTCI option for employees, a development that could have helped a lot. The CLASS Act included specific elements that would have allowed enrollees to pay monthly premiums through a payroll deduction making it more financially accessible for many consumers. Enrollees also would have received a lifetime cash benefit after meeting benefit eligibility criteria. Had the Act not been repealed, it would have benefited middle- and lower-middle-class people and it would have helped spread the risk in a much broader pool making LTCI more affordable for working people.

NAIC Efforts

The NAIC is embarking on a new effort to look at what the future will bring for a new generation of LTCI consumers. A new group has been formed to examine the future direction for LTCI.

It is important to look at all of the options available and see what other ways exist for funding LTC. Combination products hedging mortality risk may be in the form of a life policy providing LTC benefits in exchange of the reduction of death benefits. Annuity products with accelerated payment in the event of terminal illness could be another option, as well as various types of catastrophic policies with limited benefits. We have to find better tailored products for a new generation purchasing LTCI.

Laura N. Cali, Commissioner, Division of Financial Regulation, Oregon Department of Consumer and Business Services

The LTCI Market in Oregon

We have faced similar challenges with other states regarding the LTCI market. The most important challenge has been the significant rate increases we have recently seen.

Largely, the pre-rate stabilization books of business are hugely unprofitable and insurers are generally seeing their policyholders are not lapsing at the rate they expected. Inflation and interest rates were much lower than they had expected creating a number of the issues we are grappling with today. The post-rate stability blocks of business are also not performing well, though typically not to the extent of the pre-rate stability blocks.

In Oregon, we have just eight insurers selling LTCI policies, a significant reduction from a decade or so ago. About 49% of insurers selling LTCI in Oregon have stopped writing new business and just maintain their closed blocks. Most are trying to raise the rates in their closed block of business. Due to winnowing down of options in the market, the market share for some of our larger insurers has continued to increase over the years. For example, Genworth is our largest insurer, with about 18.4% of the total market. The five largest insurers have in aggregate a 49% share of the Oregon market. Together with Genworth the other four are John Hancock, Bankers Life, Northwestern Long Term Care Insurance Co., and State Farm.

Although, there are some differences among the insurers, all of them project significant lifetime loss ratios that it would be nearly impossible to increase their rates to a point they would actually break even.

Lapses are becoming even less frequent than before, while the length of stay for claims is increasing, so the situation for insurers is getting worse. Currently, the common LTCI products in the market are cafeteria-style and allow the insured individual to select benefit features at the time of issue. The typical selections for benefit periods are three years, or five years, and for daily benefit amount between \$100 and \$300. Most often, consumers select comprehensive coverage with the available options being facility-only, home healthcare and adult day-care. For the elimination period, the typical selections are 90 days to 180 days. The selections of inflation protection options run the gamut of the options with rates ranging from 1% to 5%.

When insurers are coming to us to request rate increases, one of the most common options given to policyholders is to reduce their inflation protection option to keep the increase in check. In terms of riders, the non-forfeiture feature is probably the most common but as the

rate changes are coming through, we are working with insurers to offer non-forfeiture even if they had not initially built it into the policy or if the policyholder had not selected it.

The scenario is probably changing a little bit. I think we possibly do not know in real time how the landscape is shifting as consumers are getting some of the rate changes. Generally speaking, a lot of people are electing to reduce their inflation protection rather than lapsing, so they are trying to keep their policies at affordable levels. If consumers have LTCI policies, the benefits are attractive enough to keep them as they are getting older and more likely to file a claim at some point in the near future.

Non-forfeiture features to negotiate rate increases with policyholders are offered across the board by insurers. If they do not offer these features, when they come to us to file for rate changes, we are pushing insurers to offer them. Although not always the case, it has now become more of a tool to manage rate increases. Insurers have voluntarily been trying to do it to appease regulator concerns and if they come to us we are always very encouraging.

Containing LTCI Cost

In Oregon we do not have a maximum for rate increases. What we try to do in evaluating rate increases is to look at a lot of different factors. Obviously we look at the available data, we look at how recently they filed for their last increase and we look to see if they are asking for the same rate increase which was previously denied. We look at whether conditions have deteriorated since the last time they filed, and we look to see whether they are still writing business in the state. Also, we look at what is happening in the rest of the country to give us a sense of our rate levels relative to other states. It is important to see whether Oregon consumers are paying rates which subsidize rates in other states. We also try to make sure insurers are providing policyholders options to adjust their benefits to keep rates relatively affordable.

In a perfect world, I believe something closer to a level premium would be more desirable from a public policy and, consequently, consumer perspective. People have been conditioned to think this way. So, this is more of my utopian view of the world. Unless it becomes a fixed lump sum benefit tied to a life insurance policy, it is going to be more challenging to happen. I think a more realistic way to go about it is to see more frequent, smaller rate increases if they are needed to cover the cost of the policy as medical cost inflation has pushed costs much higher than what was priced 20 years to 30 years ago. Being able to adjust for rising costs a little over time—instead of waiting for decades is more ideal—but there must be some protection for people when they are transitioning into their non-income earning years. I think this is one of the biggest problems. Consumers purchase these policies typically at the height of their career

in terms of earning power, and after some years, they move into retirement or to a period of reduced income. If a big rate increase coincides with a period of lower incomes, this process is not sustainable. So I think there is a way to align the timing of rates better to possibly front load or somehow look at ways to help people to pay when they do not have the purchasing power to do so or consider tools like savings accounts, allowing them to put money away sooner rather than later.

When rates are set, the expectations are they will remain level. Recognizing it has not been the case so far; insurers are struggling to get the pricing down. We do have new rules that became effective in January 2016. These rules require insurers to communicate with the state's Division of Financial Regulation on an annual basis, either for a rate filing or to furnish information about how the product is doing, so we regulators are comfortable the insurers are monitoring their book of business and are implementing those smaller more frequent increases as experience dictates.

State Programs and Initiatives

We did have a tax credit for LTCI premiums in Oregon that expired at the end of 2015. The tax credit which was available for individuals purchasing LTCI policies providing coverage for the taxpayer, dependents, or parents of the taxpayer was not extended by the state legislature's current session.

We have a broad goal to help people plan for their future, to make sure they have taken whatever steps appropriate to meet their LTC needs. Long-term care insurance products may provide one avenue but there are other options available to consumers and we would like to see them make an informed choice for their personal needs rather than pushing LTCI as the one and only solution. We have done some consumer alerts saying LTCI may be a part of an LTC strategy but not necessarily the only solution and it might not be right for everybody, depending on their specific needs.

Although we do believe LTCI is an important product, we are not entirely convinced it completely solves the LTC issue and we are fairly certain it does not solve it on a global basis. It can be helpful, but changes are needed to make it a more viable product. Many consumers purchase LTCI in order to assure they will have the ability to pay for care and protect their families' assets in the future. While this type of insurance can be an important part of a broader financial strategy, the Division of Financial Regulation is concerned the volatility of the LTCI market puts responsible consumers at risk and is committed to developing proactive solutions to protect Oregonians.

The Division issued a bulletin outlining practices insurers must implement to help existing policyholders make informed decisions about their coverage options when rates increase. Additionally, we now post explanations of rate decisions on our public website after each rate decision is made. The Division is also reviewing current Oregon statutes and administrative rules to identify possible enhancements to better mitigate future rate increases and provide more value and protection for Oregonians who buy LTCI. Some ideas under consideration include:

- 1) Mandatory offering of non-forfeiture benefits.
- 2) Incentives or requirements for insurers to issue policyholder dividends if rates are ultimately set too high.
- 3) Subjecting LTCI rate increase requests to higher public scrutiny through processes in place now for health benefit plans, such as public hearings.
- 4) Stronger requirements for justifying rate changes, such as more explicit requirements about overall profitability, duration of policies affected, and distribution of changes based on age.
- 5) Requirements for more effective consumer disclosures at the time of purchase, lapse, and when a premium increase causes a policyholder to consider dropping the policy.
- 6) Developing mandatory suitability standards.

Long-term care partnership plans are also available in Oregon to allow policyholders to protect more of their assets if they require LTC. Every dollar a partnership policy pays out in benefits is a dollar not counted toward the resource limit if an individual applies for Medicaid. For example, if an LTC partnership policy paid \$50,000 for your care before you applied for Medicaid, Medicaid would collect \$50,000 less from your estate.

Teresa D. Miller, Commissioner, Pennsylvania Insurance Department

The LTCI Experience in Pennsylvania

Long-term care insurance held a lot of promise when it first became popular. The baby boomers were nearing retirement, and extended family living arrangements were becoming less common leaving fewer family members available to care for the elderly. These products seemed like the perfect way for boomers to prepare for the future and pre-fund their LTC needs. But as we now know, while the idea was well-intentioned, the products were based on certain assumptions that have proven to be misplaced.

Fewer enrollees voluntarily lapsed their policies than predicted, mortality was lower than expected, and claims were higher than expected. The result: Insurance companies began taking in far less premium revenue than they would need to cover all of their claims. At the same time, the insurers have earned far less than anticipated on the contract reserves generated by their LTCI sales.

As a state insurance regulator, two of my primary roles are to: 1) monitor the financial solvency of insurers; and 2) to review and approve the rates and forms for insurance policies being sold in my state. While my Department strives to achieve both of these goals every day, it is undeniable these two core functions can sometimes be at odds with one another. In reviewing rates, the impact of rate increases on consumers is always at the forefront. But, when an insurer is struggling financially and requires greater rate increases to ensure it is able to continue paying claims for the enrollees relying on them to do so, as is often the case with LTCI, I have a difficult decision to make.

Pennsylvania has had some of the largest insolvencies of LTC insurers in the country, so I take this tension very seriously and do my best to balance the financial security needs of the insurer with the impact on consumers.

Containing LTCI Cost

For me and our department, the hardest part of these decisions is the impact on consumers. When consumers purchased LTCI policies, they were making an investment. They have been paying hard-earned money since they made their purchase so they will be protected in the years to come. They did this trusting the annual or monthly premium they had been quoted for the policy would be enough, and many of them did not understand the amount could change. When we talk to these consumers, it is difficult to explain the different factors we have to weigh and the reasons why we make the decisions we do, because the big picture of the market

forces and rating mistakes is too abstract for someone worrying about their living costs month-to-month and the care they may need at the end of their life.

The pattern of rate increases observed over the past 20 years has resulted in a loss of trust in the market. So, it is not surprising to me that between issues of affordability and perception, the number of consumers purchasing LTCI policies has rapidly declined. According to the NAIC, traditional LTCI sales dropped 65% between 2000 and 2010.¹⁷⁴ Today, less than 10% of Americans over the age of 50 are insured against the costs of LTC.¹⁷⁵

At the same time the demand for LTCI products decreased significantly, so did the supply of those products. In 2002, there were more than 100 insurers selling LTCI products in the U.S.¹⁷⁶ Today there are less than 20 companies. Recently, Med America Insurance Company became the latest insurer to announce its departure from the market, evidence this number may continue to decline if nothing changes. So the question becomes: With fewer consumers buying LTCI products and fewer insurers selling LTCI products, where does the market go from here? And, what can state insurance regulators do about it?

What Are the Answers?

While there are no good answers yet, looking for answers to these questions is the next step. We need to have a broader and more focused conversation on the future of the private LTCI market in the U.S. State insurance regulators will be dealing with LTCI legacy products and re-rating issues for years to come, but we should also be looking forward and examining how the aging population of today will meet their LTC financing needs. I am not naïve; the private market alone cannot solve this country's LTC financing crisis. But, I believe we can do better. The more people who have private LTCI coverage, the fewer who will be relying on Medicaid and the more people we will see with the opportunity to pass on to their families the assets they accumulated through a lifetime of hard work.

One encouraging trend is that while the sale of traditional LTCI policies has been declining, interest in new types of products has been growing. Sales of traditional LTCI products decreased 20% from 2012 to 2013, but at the same time, sales of newer hybrid or combination

¹⁷⁴ www.onefpa.org/journal/pages/feb15-long-term-care-insurance-comparisons-for-determining-the-best-options-for-clients.aspx

¹⁷⁵ www.thescanfoundation.org/sites/default/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf

¹⁷⁶ www.contingenciesonline.com/contingenciesonline/may_june_2015?pg=1#pg1

products increased by 58%.¹⁷⁷ This indicates there is interest in this market and a need for these products, but it also indicates further changes may be necessary.

NAIC Efforts

If the products available today are not meeting the needs of the market, we have to change that paradigm. That is exactly why I proposed and will be chairing a new working group within the NAIC focused on the future of the private LTCI market.

The goal of this working group is to come up with some concrete solutions such as new types of LTCI products, more effective tax incentives, or legal and regulatory barriers that, if removed, could bring more interest to the market. We need to find solutions which will address both the supply and demand of LTCI products, bringing more insurers and products to the market and attracting more consumers to a private solution.

State Programs and Initiatives

Alongside efforts at the national level through the NAIC, I will continue working towards the same goals within Pennsylvania. Our Medicaid program, called Medical Assistance, currently pays for 65% of resident days of care in Pennsylvania's nursing homes.¹⁷⁸ So, while the needs of consumers are foremost in my mind, this initiative is also imperative for our state as we continue to grapple with tight budgets and rising health care costs. Growth of the private LTCI market has the potential to increase financial security for consumers, while at the same time, reducing the burden of LTC expenditures on state budgets.

¹⁷⁷ www.onefpa.org/journal/pages/feb15-long-term-care-insurance-comparisons-for-determining-the-best-options-for-clients.aspx

¹⁷⁸ www.phca.org/research/long-term-care-statistics.htm

Tanji Northrup, Assistant Commissioner, Utah Insurance Department

The LTCI Experience in Utah

We do not collect detailed data on the amount of LTCI sold within the state of Utah. We have some data showing the number of policies in-force, and the number has changed very little over the four-year period 2010-2013. One could infer from the new policies are being issued at the same rate the old policies terminate (due to lapses, deaths, and exhaustions of benefits).

Since 2007, 10 insurers made a total of 18 short-term care policy form filings. These products are, therefore, available to be marketed in the state of Utah.

In Utah, hybrid products are required to separate LTCI provisions from life insurance provisions to facilitate separate review of respective pieces by an analyst familiar with the particular line of business. Otherwise, LTCI provided through a hybrid product is subject to the same review.

While there are virtually no non-cancellable standalone LTCI policies, quite a few of the hybrid products have LTCI premiums or charges guaranteed for life and not subject to change. To the extent the rate review's goal is to minimize the risk of a need for a rate increase in the future, these products may require less scrutiny.

Short-term policies covering LTC benefits are allowed in Utah. There are no specific rules applicable to short-term care policies. They are subject to the same rules as other accident and health policies.

Neither Utah code nor any Utah regulation specifically addresses the renewability clause of the short-term care policies. However, all of the policies filed with the state since 2007 were guaranteed renewable and subject to a 55% minimum loss ratio standard.

Premiums for short-term care policies have to be filed, and have to be accompanied by an actuarial memorandum and a certification they are expected to meet the minimum loss ratio standard. All rate filings are reviewed with respect to the loss ratio compliance.

Containing LTCI Cost

Mandatory re-rating of products might be preferable to today's regime for a variety of reasons:

- It could be structured to provide both increases and decreases as necessary.
- It could be structured to evaluate entire book of business.
- Credibility theory could be used to allocate overall rate change between the policy forms or blocks of business.

- Rate changes would likely be small and gradual.
- Rate history would provide more useful information to the prospective buyers.
- There would be less expectation of rates never increasing.

In the past, any regulatory suggestion of making LTCI non-cancellable was very strongly opposed by the industry. Industry takes a position this would place insurers under too great of a risk and would force them to abandon the product.

There is probably no way more consistency or certainty could be provided regarding rate increases, unless individual states were ready to give up some of the authority to approve/disapprove rate increases. The review process is necessarily highly subjective. In many smaller states, like Utah, state-specific data is not credible, and any rate action has to be based on the nationwide experience. Rate increases are often driven more by expectations as to the future than the past experience. Past experience needs to be adjusted to reflect difference between product designs, underwriting standards, changing care options, etc.

For legacy blocks of business, especially in cases where the insurer might be in financial distress, it might be possible to coordinate rate increase actions through a cooperative process used in the market conduct cases. However, this has never been attempted.

The NAIC model prohibits premiums increasing beyond age 65. The model would allow a premium pattern that increases from issue until the insured attained age of 65, and is level thereafter. Given many LTCI policies are issued to consumers in their late 50s or older, the period over which premium is allowed to increase due to age is rather short. Most insurers are not interested in such design, but it is possible more insurers would be interested if the age limit was removed.

From our experience, insurers are quite often using non-forfeiture to negotiate rate increase approval with the regulators. Legacy blocks rarely have any non-forfeiture provisions, and often rate increases do not trigger contingent non-forfeiture benefits available in policies subject to rate stability requirements. An insurer may propose to the regulator that if the rate increase is approved as requested, the insurer will offer non-forfeiture benefit to all affected policyholders.

The insurers are not allowed to negotiate with individual policyholders. Any offer made to alleviate rate increase needs to be made available to all policyholders. Some insurers are experimenting with new approaches designed to share the risk more with the consumers. These new approaches introduce some elements of either experience rating or participation. Products may be priced using conservative assumptions and reflecting any positive experience in forms of dividends, premium reductions, or benefit increases.

Dan Schwartz, Deputy Commissioner, Wisconsin Office of the Commissioner of Insurance

The LTCI Market in Wisconsin

In Wisconsin, take-up for standalone LTCI policies has been decreasing slightly. Policies in effect decreased by 1,352 from 152,757 in 2013 to 151,145 in 2014, although insurers sold 4,936 policies in 2014.

As in other states, the biggest challenge has been the large rate increases in recent years. Existing books of business are very unprofitable, and policy lapses are significantly below the rate predicted by insurers. Without the income available from lapses, prices have been inadequate. In addition, life expectancy has increased with the improvements in healthcare in recent years. This has resulted in significantly increased utilization of LTCI benefits in the later years of life. The total result of all these factors is that insurers are experiencing very high loss ratios, with little ability for the product to become profitable without significant rate increases.

Regarding the use of non-forfeiture features as a negotiating tool with policyholders for premium increases, 71 of 82 LTCI rate filings in Wisconsin between 2012 and November 2015 included an offer of either non-forfeiture or contingent forfeiture.

For LTCI products, Wisconsin does not have any laws or regulations requiring guaranteed renewability, minimum loss ratios, or a formal review and approval process. Rather, we work to ensure consumers have a vast array of choices and assure the market is competitive, which we believe provides for good consumer protection.

As far as short-term policies covering LTC types of benefits are concerned, Wisconsin, after reviewing this issue in the summer of 2014, determined short-term products are ancillary products and not subject to Wisconsin's LTCI regulations.

Containing LTCI Cost

While there is certainly benefit to some type of level funded pricing for fixed income consumers, small and predictable increases are far more manageable than infrequent but substantially larger rate increases meant to cover claim loss and expense factors over a longer period of time. The issue is consumers tend to purchase LTCI products late in their careers while they are still employed, which generally means they purchase the product when they are around the peak of their employment earnings and can most afford the product as well as incremental increases. Then, when consumers generally need the product after retirement and their income is fixed, even small rate increases become problematic for this population.

Perhaps we, as regulators, should be looking at ways to allow those increases during the income earning years of the consumers, but require level funding once the consumer retires.

Wisconsin insurance law does not require level premium for LTCI, although, as stated above, we believe this issue needs to be addressed more globally. To expand on the thought, single state solutions are difficult to manage in this instance. If one state mandates level premiums without ability for increases to sustain their block of business, the concern is the possible cost shift of the needed increase to states not requiring level premiums and allowing for appropriate increases by insurers in order to sustain the solvency of the insurer.

Long-Term Care Insurance Study Conclusion



Long-Term Care Insurance Study Conclusion

By Dimitris Karapiperis, Analyst, NAIC, Center for Insurance Policy and Research and Eric Nordman, Director, NAIC, Center for Insurance Policy and Research

Long-term care (LTC) is one of the greatest generational challenges the U.S. must confront as its population ages. Increasingly people will need services for which they have not adequately prepared either in terms of savings or insurance. While it is sensible to prepare for such a financially difficult and potentially catastrophic event, only a small segment of the population has purchased insurance against this risk.

We hope the insights gained from the contributions of our invited authors will stimulate discussion among all participants in the long-term care insurance (LTCI) market. The ultimate goal, shared equally by all the authors, is to develop and promote those solutions on benefit design and financing options that would best realize the required improvement in the quality of life for a great number of elderly Americans in need of LTC today and in the future.

Given the critical need for LTC, the private market for LTCI plays a key role in meeting the growing demand. However, the dramatic rate hikes on both new and legacy policies have affected demand, which remains at relatively low levels. Consumers are faced with the prospect of policies offering less coverage at a time when LTC costs keep on rising. For the market to really thrive, new and more affordable products are required, as well as close partnerships with public payers, providers and health plans. Also, as we have seen, the role of the public sector support of the market on both the demand and supply fronts is indispensable in the effort to meet the LTC needs of all. A great number of states are actively exploring and developing ideas and programs to reform LTC financing as well educate and encourage their residents to plan ahead for their LTC needs, with Minnesota's Own Your Future program being a prime example of these efforts.

Furthermore, in order to lessen the burden on the public sector, having more people privately insured for LTC is required. The demographic shift is expected to severely strain public budgets and the existing public service system. Furthermore, it has been shown demand for LTCI products would greatly improve if the products themselves were more appealing to consumers. New innovations in LTCI products are critical in making LTC accessible and economical for our elderly citizens.

While each of the contributing authors brings a unique perspective to the study, there are areas of agreement among them. They all agree there is no great zeal among consumers for the

current LTCI products, while at the same time there is widespread agreement about the need of insuring against the financial risk associated with LTC. Also, despite the diversity of opinions, there seems to be an agreement: The difficult public policy problem of how best to finance LTC cannot be resolved by solely relying on the private provision of LTCI or government programs.

Due to the critical importance of LTC for the country's elderly population, the insurance industry and for the state and federal governments, the NAIC Long-Term Care Innovation (B) Subgroup has been formed to examine the future of financing LTC and consider what types of LTCI products can offer the most viable and effective solution.

For the convenience of the reader, a list of a number of suggestions for change discussed in the study is included, with references to the page numbers in the study where the suggestions are presented in more detail. The following suggestions are offered for public policymakers to consider:

- Expand the support of Partnership Programs between state Medicaid programs and the private LTCI industry to enable LTCI policyholders to access Medicaid benefits without having to spend down their assets to Medicaid levels, if and when their LTCI benefits are exhausted p. 19.
- Provide tax incentives for the purchase of LTCI policies and tax credits for LTC expenses pp. 20, 108, 109, 111, 118, 146.
- Change the underlying funding structure so products might be priced on a “term-basis” up to a certain age—much like life insurance p. 26.
- Index both premiums and benefits to account for LTC cost increases to reduce inflation risk uncertainty, as well as lower initial premiums p.26.
- Link LTCI to health insurance p. 27.
- Allow withdrawals from employer-sponsored retirement plans for LTC expenses or the purchase of LTCI without early-distribution penalties pp. 107, 109, 111.
- Propose LTCI policy with premiums treated like 401(k) contributions. Offer LTCI products as part of employee benefit package pp. 27, 85, 107, 120.
- Provide state-based organized reinsurance pools to provide a “back-stop” for industry experience p. 27.
- Provide the ability/option to build up cash value and cash out of LTCI products pp. 53, 146, 149, 153.
- Eliminate capital charge penalty for non-cancellable policies p. 150.
- Propose new LTCI product concept not subject to default risk, premium risk, inflation risk or the uncertain claims process pp. 57, 66.

- Create an immediate annuity for a short duration to fund income shortfall for remainder of life p. 79.
- Develop a shorter-term (up to one year) LTCI product with more modest benefits at a lower cost pp. 83, 105.
- Design a life stage product, combining LTCI with life insurance providing different benefits at different points in policyholders' lives. pp. 83, 85, 96, 121.
- Viaticate life insurance to fund LTC expenditures p. 153.
- Allow a return of LTCI premium on death rider up to 250% of premium paid p. 150.
- Create LTCI providing back-end coverage following public front-end coverage for a short period (1-2 years) p. 84, 91.
- Develop a high-deductible, catastrophic LTCI with private front-end expense coverage for a set period (1-2 years), and public back-end coverage paid for the remainder of the LTC need pp. 84, 92, 99, 105, 120, 125.
- Develop a high deductible, catastrophic LTCI with self-funding in the first period or up to a certain amount p. 155.
- Develop a high deductible retirement LTCI product with longer-than-typical waiting period (one year) as well as limited benefits, choices and duration p. 106.
- Design a mandated LTCI product with opt-out features for certain groups or conditions pp. 91, 104.
- Require annual CPI adjustments for premiums p. 107.
- Require the rerating of premiums (increase or decrease) on three-year cycles to allow for updated assumptions pp. 107, 154.
- Require full disclosure and listing of options prior to rate increase and/or change in benefits pp. 140, 159.
- Mandate the offering of non-forfeiture benefits p. 159.
- Allow modest, regular and actuarially justified increases reflecting changing risk factors p. 146, 154, 157, 163.
- Impose stronger requirements for justifying rate increases p. 159.
- Provide incentives or require insurers to issue dividends if rates are set too high p. 159.
- Allow the conservative pricing of LTCI with rate guarantees p. 154.
- Allow legacy policies to break even to control insurer losses p. 145.
- Incorporate LTC services into Medicare and/or Medicare supplement plans pp. 96, 117.
- Look to California's Coordinated Care Initiative involving mandatory enrollment of dual eligibles into Medi-Cal's managed care program as well as the integration of Medi-Cal-funded LTC into managed care p. 98.

Long-Term Care Insurance Study Conclusion

- Propose public progressive cost-sharing subsidies for insurers to lower premiums pp. 110, 144.
- Public universal and mandatory LTC coverage pp. 99,100, 105.

The CIPR thanks the contributing authors to this important study, as well as the readers. The CIPR expresses the sincere hope this study met their needs and stimulated their thinking about possible solutions to this most critical challenge facing our nation.



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