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Federal Long-Term Care Insurance Program: Examining Premium Increases

Testimony on

Challenges in the Long-Term Care Insurance Market: What can be done?

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Thank you, Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee. I am Marc Cohen, Director of the Center for Long-Term Services and Supports at the McCormick Graduate School of Policy and Global Studies at UMass Boston and a former Founder, President and now advisor to LifePlans, Inc., a Boston-based long-term care research, consulting and risk management company.

I appreciate the opportunity to testify on this important topic, in large part because it raises important public policy questions that encompass not only issues related to rate increases, but also those affecting the private insurance industry as a whole as well as the potential public role in addressing long-term care financing needs.

In my testimony today, I will draw upon my more than 25 years of research on the growth and development of the private long-term care insurance market. This research has been supported by the Department of Health and Human Services, the SCAN Foundation, America's Health Insurance Plans, and the Robert Wood Johnson Foundation. I would like to make three broad points today:

1. First, the rate increases that we are discussing today should be viewed within the broader context of the long-term care insurance market, and the challenges faced by all insurers in that market; these rate increases are occurring across almost all blocks of long-term care business as actuaries learn how the product is performing and make appropriate adjustments to their initial pricing assumptions;

2. Second, these current marketplace challenges do not diminish the need for an insurance-based solution for middle class Americans, many of whom will face catastrophic costs and financial impoverishment in the absence of insurance-solutions;

3. Finally, without public action, the private long-term care insurance market alone is unlikely to play a meaningful role in financing the nation's long-term care needs. More specifically, an insurance-based public/private partnership stands the best chance of moving the needle on protecting middle class Americans from significant costs that threaten their retirement.

Let me begin by making a number of key observations to frame some of our subsequent discussion today: First, Americans are ill prepared for the financial consequences of aging and the risk of disability and needing long-term services and supports. Moreover, due to the increasing liabilities associated with long-term care other policy priorities are being crowded out. Second the lack of financial preparation for possible functional impairments in the future can force people to compromise their lifestyles in order to pay for necessary services and supports in a time of need. Third, the private market for long-term care insurance has a role to play in helping American absorb the risks of needing long-term services and supports. However, the data suggest that long-term care insurance has played too small a role. It has clearly under-achieved and experienced significant stress over the last decade and a half.

Currently fewer than 10% of Americans have insurance protection -- about 7 to 8 million people -- and far fewer people today are purchasing policies than 20 years ago. In fact, annual sales are

less than a quarter of what they were in 1995. Most disturbing is the fact that a growing number of insurance companies have left the market. In the year 2000, a study by AHIP found that more than 100 companies were selling LTC insurance to consumers. By 2014, less than 15 companies were selling a meaningful number of policies. Put simply, the market is shrinking rather than growing, and this at a time when more Americans are facing long-term care risks and costs.

There are a number of reasons why so many insurers have stopped offering policies. First, selling costs are typically very high in the individual market, which still accounts for most sales. Given consumers lack of knowledge and understanding about long-term care risks and costs, confusion about what and how public programs pay for long-term care, a general mistrust of insurers, a wariness about making decisions that are costly to reverse, and the difficulty of considering the future implications of today's uncertain and unpleasant choices selling this product is costly and challenging.

Second, insurers have faced a variety of unpredictable risks that affect the pricing of policies including needing to estimate inflation and interest rates, people's behavior regarding their desire to maintain the insurance, and changes in mortality and disability. Many of these risks are hard to spread because they are common to the whole population. Thus, insurers have had to deal with this by de-risking the product – for example, no longer selling policies that cover the catastrophic long-duration or lifetime risk -- and also by charging higher premiums.

Let me provide a concrete example. Interest rates and investment yields. The current structure of almost all policies, including the Federal LTC Insurance Program is a level funded premium. The idea is that premiums collected today are invested so as to create an accumulated fund that will support future claims payments. In essence insurance companies estimate what they think interest rates or bond yields will be for the next 20 to 30 years. Because the U.S. economy has been operating in a close to zero interest rate environment for close to a decade, and it is difficult to find long term high quality high yield corporate bonds, all insurers have been unable to earn the required return on invested premiums to support future claims and their initial pricing. If an insurer assumed a roughly 5% interest rate when it priced a policy for a 55 year old, which was in line with historical returns, and the actual interest rate was closer to say 1%, then if every other actuarial assumption was correct, the premium would need to be increased by more than 50% to support the future pay-out of claims.

Insurers have also been challenged in accurately estimating how services actually will be used in the context of insurance. Across the industry, actual to expected cumulative claims experience is running at 107% and just between 2010 and 2014, the actual to expected incurred ratio has increased from 111% to 124%. This again suggests that claims experience is unfolding in a manner that is worse than anticipated, which again puts pressure on premiums.

The implication of these trends is that there has been a major exodus of companies from the market, as returns on the product have been significantly below expectations. Almost without exception, companies have had to go back to the insurance departments, which reviewed and approved their rates in the first place, and request rate increases. In this regard, the actions of the insurer underwriting the Federal insurance program are consistent with what is occurring in the rest of the market. That said, what we do know, is that when given a choice, consumers would

prefer small but more frequent adjustments to their premiums rather than infrequent and larger changes. A recent survey of new buyers of insurance showed that 71% preferred this latter approach compared to only 2% who preferred less frequent but larger premium adjustments.

It is worth mentioning, that even with these significant industry-wide rate increases, a 60 year old new insurance buyer who becomes disabled 20 years later, will recoup all of their policy premiums in roughly 5 months of paid care, and if they had a rate increase of 50% after 10 years of having a policy, there premiums would still be recouped within 7-8 months of paid care.

The challenge however, is that premium increases have put the product out of the reach of large segments of the public. In, 2015, the average premium of policies selling in the market was roughly $2,700 a year – an increase of 42% over the last decade. These premium increases have made the product too costly for a growing number of middle-income consumers and unless there is a way to improve the functioning of this market, the insurance will increasingly become a niche product for wealthier Americans rather than the middle class who only have personal savings and or safety net programs like Medicaid to rely on should they require significant amounts of care.

Despite private sector challenges insuring this risk, LTSS has all the characteristics of an insurable risk. There is a relatively small probability of a long period of impairment and associated costs, and individuals lack the ability to predict in advance whether they will have such an event. While roughly half the population age 65 and over will never need substantial services, roughly one in five are expected to need substantial care for between two and five years and just over one in ten to need care for more than 5 years – which could cost upwards of $250,000.

The underdevelopment and growing unaffordability of private insurance, and the absence of public insurance presents a fundamental problem: people have no way to plan effectively for what is actually a perfectly insurable risk. Their current options are inefficient, unattractive or both. If people rely on savings, they will likely save too little or too much, since they cannot easily predict whether they will face catastrophic LTSS burdens. If they rely on Medicaid, they must first expend significant personal resources, and only then qualify for coverage that in many places still limits the availability of in-home care. Even when people have budgeted carefully through their working lives, they can still end up impoverished, because they receive little or no help if they need significant amounts of care.

Since current strategies have not worked well in assuring broad consumer appeal and insurer enthusiasm, what can be done? My sense is that without expanded public sector support designed to spur demand and supply, we will not be able to protect the majority of middle class Americans.

A number of concrete actions in this regard include: (1) simplifying and standardizing products with the aim of increasing the effectiveness of consumer choice and reducing selling costs which can be done by having a limit on the number of distinct products along the lines of Medigap; (2) changing the structure of premium payments so that there is some level of indexing which would likely address cost as well as premium stability issues; (3) making it easier for consumers to

purchase the product by having employers and other organized purchasers of insurance play a greater role in organizing opportunities to purchase LTCI. For example, making the insurance available in conjunction with the purchase of health insurance, other employee benefits, or even Medicare Advantage enrollment. This would reduce selling costs, the rigor of under-writing and offer consumers more convenient ways to learn about LTCI.

Even with these actions, without expanded federal and/or state support the needle is still not likely to move enough to protect the majority of middle class Americans. To reduce consumer confusion and increase awareness and knowledge of the long-term care risk, a federal educational campaign that is built on the lessons learned from successful public and private campaigns would help expand demand. These could include warnings that Social Security and Medicare do not cover LTSS.

In addition to an educational campaign we need to think more broadly about shared public and private insurance models. For example, given that the private insurance market is not willing to provide products covering the catastrophic tail risk, one might consider whether and how states or the federal government might do so. A public approach to covering the catastrophic tail risk, could provide a base that the private insurance industry could supplement or "wrap around". It would likely encourage more insurers to get back into the market, broaden the risk pool, enable the private insurance industry to fill gaps in public coverage, and lower the cost of insurance products.

It is interesting to note that there is growing support among researchers, practitioners, and stakeholders for examining this concept in more detail. In a recent survey of Americans age 50 and over that measured preferences for potential public and private insurance partnership roles, about three-in-five preferred a program where a private insurance policy would pay for roughly the first few years of long-term care services, and then public insurance would pay for more catastrophic liabilities. As well, when a group of individuals who had been offered a private long-term care insurance policy and chose not to purchase it were asked about such a program, nearly 40% indicated that if there were such a program, they would be more inclined to purchase a private policy to cover the up-front risk. Thus, what is needed to assure that more Americans come to rely on insurance to finance their long-term care needs, is a series of public and private actions.

The rate increase discussion discussed here is symptomatic of an industry in distress, one that could benefit from a number of the actions outlined above so as to expand the number of people who are insured. I appreciate the opportunity to testify about these important issues and would be happy to answer any questions that the Committee might have.

The Long-Term Care Insurance Market

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The Market, Its Challenges and Future Innovations

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Background and Market Evolution

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 only covered care provided in nursing homes, primarily skilled facilities. In the late 1970s and early 1980s there were only a small number of companies providing such coverage. They entered the market at a time when expenditures on long-term care (LTC) were less than $20 billion but were growing rapidly. By 1980 they grew to $30 billion and today expenditures on long-term care exceed $225 billion[1,2,3] Historically, the costs of care have been borne by individuals and their families and the largest payer of care – Medicaid – finances about 62% of the total bill.[4] Because Medicaid is a means tested program, there is a widespread belief that middle income individuals face a potentially catastrophic expense that can threaten their retirement security if they do not plan for long-term care needs. Private insurance has been seen as an important product for middle income individuals to plan and pay for future LTC needs.

Through the 1970's and up to the late 1980's, private LTC insurance coverage was linked to the structure of Medicare. Like many supplemental private health insurance policies, "Nursing Home" insurance focused on what Medicare "did not cover." Medicare paid for skilled nursing home care for up to 100 days and private insurance began coverage when Medicare ceased providing benefits. For this reason, early product configurations had elimination periods (i.e. deductibles) that were typically defined as 100 days – the period of care that Medicare covered -- and the coverage was focused exclusively on care resulting from a prior three day hospitalization – precisely in line with Medicare policy. If care was initially considered to be "medically necessary", private insurance carriers would continue to pay benefits even when the need for skilled care ceased and only custodial (i.e., maintenance) care was required. Thus, while these early private policies "keyed off" of Medicare coverage, their innovation was that they paid for custodial care, where Medicare did not. In essence, this extended coverage from a limited amount of skilled nursing care (paid by Medicare) to a much more generous amount of skilled and custodial nursing home care (paid by private insurance and also by Medicaid for selected populations).

Early Medicaid policy also shaped the conception of long-term care as synonymous with nursing home care.[5] However, over time, long-term care has come to reflect the reality that the need for care, which is based on functional limitations and/or cognitive impairment, requires a broader set of service responses. These include home and community-based care and a variety of residential care settings such as assisted living, adult day care and others. It became clear that in order for the market to grow, the product would have to cover home and community-based services. As well, there had been a growing realization that measures of functional abilities were most closely

[1] Long-Term Care for the Elderly and Disabled (1977). **C**ongressional Budget Office, Congress of the United States, Washington, D.C. February.
[2]Source: Health Care Financing Administration, Office of the Actuary, Data from the Office of National Health Statistics in Health Care Financing Review, Fall 1994, Volume 16, No. 1.
[3] Commission on Long-Term Care. (2013). Report to Congress, Washington, D.C. September 30th.
[4] National Health Policy Forum, Based on data from 2011 National Health Expenditure Accounts as reported in Commission on Long-Term Care. (2013). Report to Congress, Washington, D.C. September 30th
[5] Kemper, Peter (2010). Long-Term Services and Supports. The Basics: National Spending for Long-Term Services and Supports. Presentation to the National Health Policy Forum, Washington, D.C., June 18th.

related to the need for covered services – including home care. Thus, companies began to change the basis on which benefits were paid moving away from a medical necessity model to a functional and cognitive impairment model. More specifically, individuals who had a certain number of limitations in activities of daily living – usually two or more -- or who required ongoing human supervision or assistance due to a severe cognitive impairment, were deemed eligible for benefits. This eligibility standard became enshrined in law with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA conferred favorable tax treatment to LTC policies that met a series of standards set out in the law, the most important of which related to benefit eligibility standards.

Thus, in in the mid- to late 1980s and early 1990s, carriers began to provide limited coverage for home and community-based care – either through riders or as part of the underlying basic policy design. These policies were far more attractive to consumers and it is not surprising, therefore, that consumer demand, coupled with the sense that companies could manage the underlying risk, fueled rapid growth in market share of comprehensive policies. Moreover, a growing number of companies joined the market so that by the end of the 1990s, more than 100 carriers were selling long-term care insurance. 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.

LTC policies were always sold as guaranteed renewable – they could only be cancelled for non-payment of premium – and as level funded. That is, 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. Theoretically, an individual buying a policy at age 65 for a premium of $1,000 per year could be expected to pay that same annual premium throughout their lifetime, so long as the underlying pricing assumptions employed by the actuaries were accurate. The level-funded nature of the product persists to this day, and poses unique challenges to insurers. Finally, almost all policies reimbursed the actual costs of care up to a daily benefit maximum.

Many of the key features of policies remain in effect today. In the sections that follow, 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 carriers.

Current State of the Long-Term Care Insurance Market

Market Size

After more than two decades of rapid growth, the long-term care insurance industry has undergone significant contraction, both in terms of sales as well as companies participating in the market. Table 2 below summarizes key industry parameters as of 2014. As shown, in 2014, the total number of individuals with LTC insurance 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.[6] This suggests that 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 pay-out 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, 2014

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

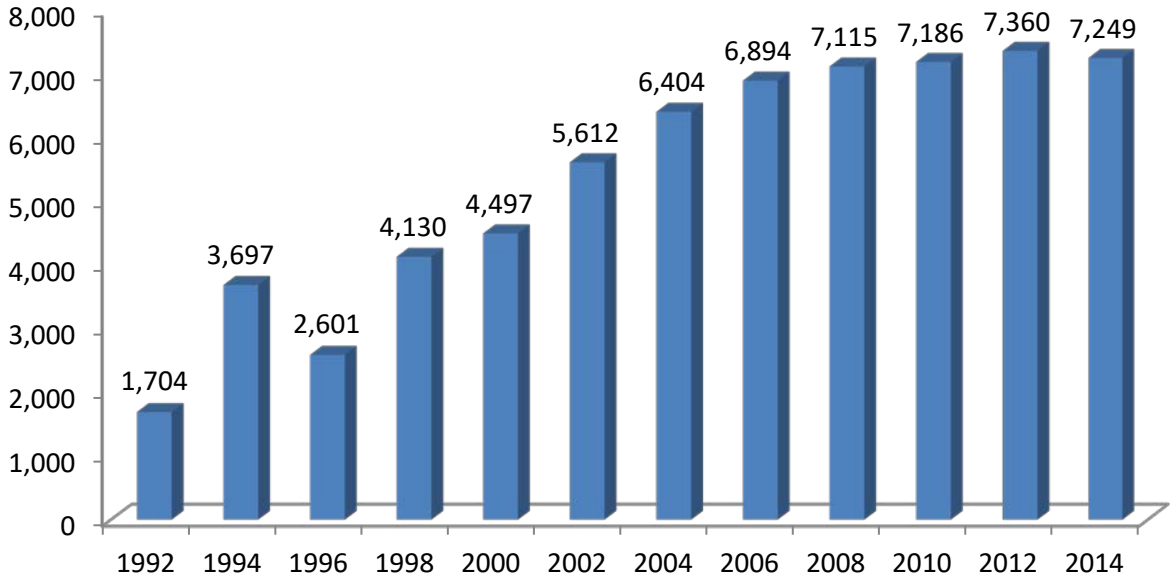
Claims payments are also growing rapidly, with slightly less than $100 billion already paid out in claims and roughly $9 billion in new claim reserves being established just this past year. More than a quarter million individuals are currently receiving benefits under their LTC insurance policy and the average value of claim reserves being established is about $119,000. This is more than enough to cover the roughly two years of care that individuals are expected to need after age

[6] NAIC, 2013, Gen Re, 2013

65.[7] It is not surprising, then that as a share of total LTC financing, private insurance is growing. The share of private insurance financing of LTSS has grown from 3% in 1991 to 12% in 2011. It is growing faster than all other sources of financing although it still plays a relative modest role in paying for the nation's bill.

What Table 2 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 below shows the total number of in-force individual and group policies from 1992 – 2014. Noteworthy is the fact that the in-force numbers have stayed relatively static over the last seven years. Of the 7.2 million policies, roughly 70% (5.0 million) are individual policies and 30% (2.2 million) policies.

Figure 1 : Long-Term Care Insured Lives: 1992-2014



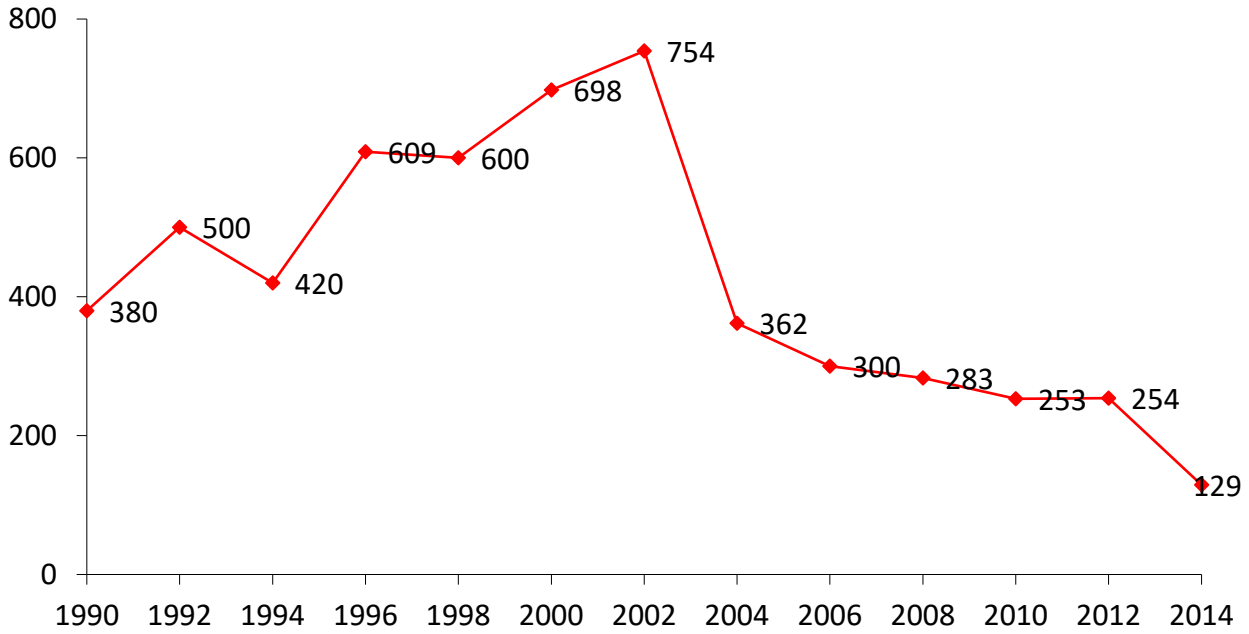
Source: NAIC Experience Reports, 2000 -2014

The next figure 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 graph 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 that figure had declined to well under 20%. Given the strong belief that a robust employer market is important for expanding the market, this trend is concerning.

[7] Long-Term Services and Supports for Older Americans: Risk and Financing. (2015). ASPE Issue Brief, Department of Health and Human Services, July.

Today, roughly 34,000 businesses offer LTCI to their employees, which represent less than 0.5% of all employers in the U.S., but 20% of companies with at least 10 employees.[8,9,10,11] Typically, employee take-up rates are between 5% and 7%. Some have suggested that there are at least 5,500 employers, representing an additional 3 million employees that have similar characteristics as employers currently offering policies.[12] This further supports the notion that there is room for market growth in this segment.

Figure 2: Individual Market Sales: 1990 -2014



Note: 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 combine LTC benefits with either life insurance or an annuity. These products can pay out if long term care 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 their long-term care benefits, the remainder would

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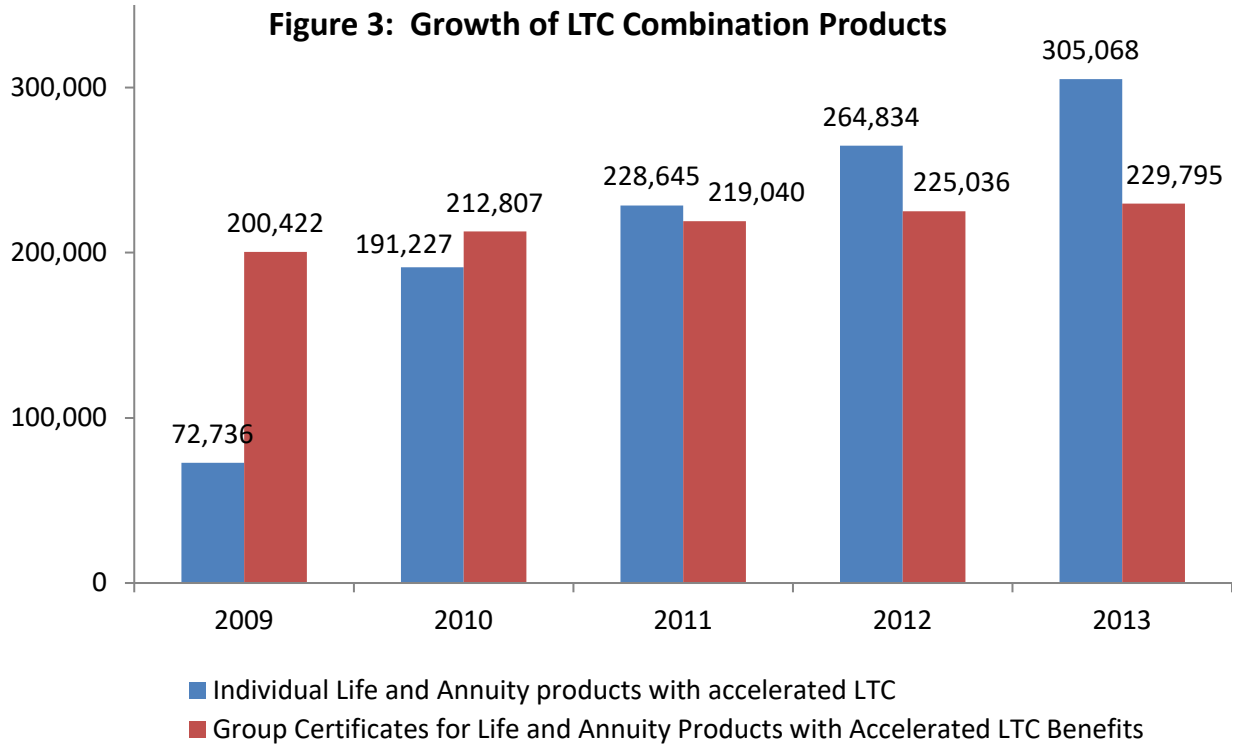
[8] Pincus J, Wallace-Hodel K, Brown K. The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage. SCAN Foundation. 2012.
[9] Mercer. Mercer National Study of Employer-Sponsored Health Plans. 2010.
[10] Pincus J, Wallace-Hodel K, Brown K. The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage. SCAN Foundation. 2012.
[11] 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.
[12] Pincus J, Wallace-Hodel K, Brown K. The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage. SCAN Foundation. 2012.

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.[13]

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 that extends the LTC benefit, if the death benefit is exhausted. An annuity/LTC combination adds an LTC rider to an annuity. The idea is that if an individual becomes disabled and requires long-term care 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.[14] Figure 3 below shows the growth in LTC Combination products over a five year period through 2013.



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

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[13] Tell, EJ. (2013). Overview of Current Long-Term Care Finance Options. The SCAN Foundation, March.
[14] LIMRA. (2009)Individual Life Combination Products: Life with Long-Term Care & Life with Chronic Illness Riders. 2011 Annual Review.

Companies in Market

There has been a rapid change in the number of companies that are currently participating in the market. In fact, it is challenging to obtain an accurate count of the total number of companies selling policies in the marketplace. Some companies 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 the year 2000, AHIP conducted a survey and found that 125 companies were selling policies in the marketplace; by 2002, however, this number had fallen to 104 -- a 17% decline in just two years (AHIP, 2004). This survey has not been replicated since 2002.

Today, the most reliable source of information on company-specific activity is provided by the National Association of Insurance Commissioners (NAIC). A report published in 2011 focused on the top 100 companies reporting premium and claims information on any long-term care insurance policies that they have in-force in 2010. The report showed that fewer than 20 companies were actively selling stand-alone LTC policies in 2010; by 2012, only 11 companies were selling at least 2,500 new stand-alone individual or group policies annually in the marketplace.[15,16] By 2014, this number was again less than 15 companies – 12 selling more than 2,500 individual policies and five selling group policies.[17,18]

It is important to note that these figures do not include companies that are selling various combination products such as Life-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, companies writing at least 2,500 individual or group policies include:[19]

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

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[15] LifePlans, Inc. (2012). 2011 Long-Term Care Top Writers Survey Individual and Group Association Final Report, Waltham, MA. March.

[16] 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.

[17] U.S. Group Long-Term Care Insurance. (2015). Annual Review 2015. LIMRA.

[18] U.S. Individual Long-Term Care Insurance (2015). Annual Review 2014. LIMRA.

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

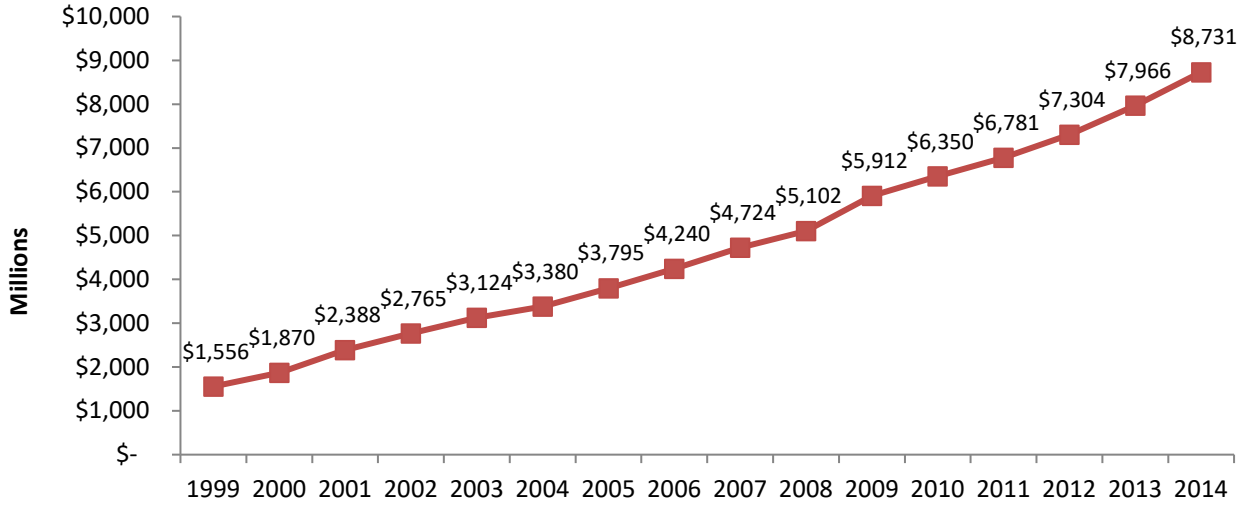
Currently, individuals with LTC insurance policies are either being serviced by companies who continue to sell in the market or by those who have exited and are no longer selling policies. The latter are considered to be in "closed blocks'. [20] In order to determine the size of the closed block market, we analyzed and updated information from recent NAIC Experience Exhibit reports.

In general, 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, companies 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 LTC insurance is now roughly $9 billion, which is less than 5% of total expenditures on long-term care services in the United States.

Figure 4: Annual Incurred Claims



Source: NAIC Experience 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

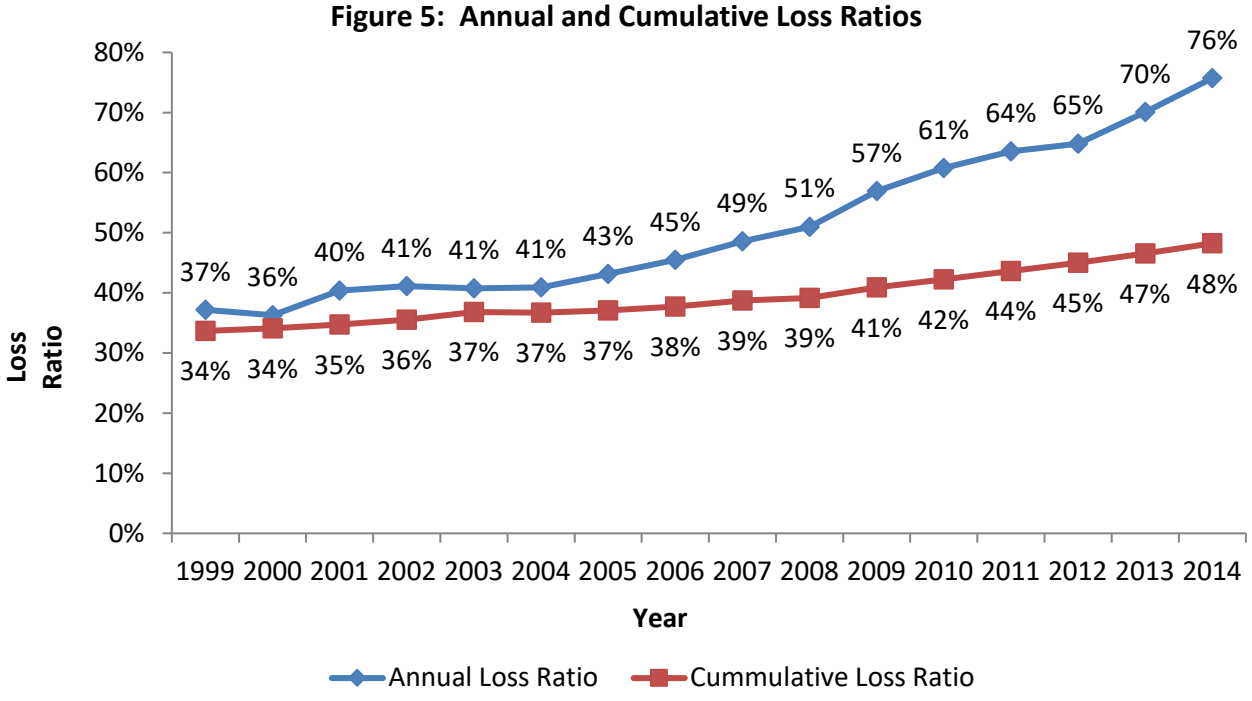
[20] A "closed-block" means that while policyholders who hold policies continue to receive services from the company, no new sales are occurring and hence, no additional individuals are being added to the risk pool.

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.

Companies typically focus on two performance measures related to this parameter: the annual and cumulative loss ratio and 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 that the company sets up. 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 that excess premium that funds the future gap between premiums and claims.

Figure 5 below highlights the annual industry-wide loss ratio as well as the cumulative loss ratio.

Figure 5: Annual and Cumulative Loss Ratios



Source: LifePlans analysis of NAIC Experience Reports.

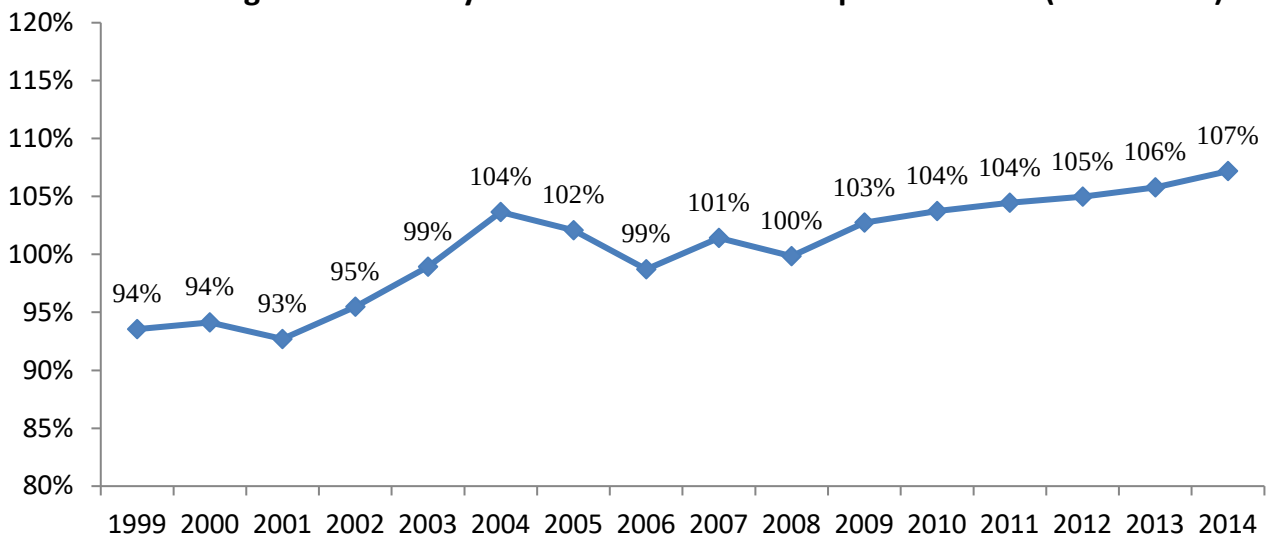
As expected, claims represent a growing percentage of premium payments over time. This reflects both the aging of the in-force policyholder base as well as the wearing off of the underwriting effect on morbidity. The slow-down in sales of new policies – with lower initial annual loss-ratios – also contributes 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 so 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 or not the ***actual*** incurred claims by a company are in line with ***expected*** claims paid.

If a company ***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 a company 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 that 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, companies 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 below 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 Analysis of NAIC Experience Report

As shown, there has been variability in cumulative industry performance over the last decade and a half. If we focus exclusively on the last ten years, in most of these years the actual-to-expected loss experience has been over 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 that 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 companies currently selling policies in the market, there is greater market concentration, and morbidity experience has presented a challenge to carriers. On the other hand, more than seven million policies are in-force and there has been significant growth in combination or hybrid policies. Table 2 below summarizes a number of key parameters and their change between 2000 and 2014.

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

Industry Parameter	**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	56%	55%	41%	37%
Top 10	71%	69%	63%	13%
Top 15	80%	78%	74%	8%
Top 20	85%	84%	81%	5%
Carrier with Largest Market Share	17%	15%	10%	70%

Note: LifePlans analysis of NAIC Experience Exhibit Reports.

Product Evolution

As mentioned, in the early 1990s, most companies began providing more comprehensive policies that covered 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 polices are integrated in terms of their benefit payments. That means that individuals have access to a "pool of benefits" that 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 HIPAA standards – having two or more limitations in activities of daily living or having a severe cognitive impairment. Table 1 highlights changes in product design over 20 years.

Table 3: Characteristics of Policies Selling in the Market: 1990-2010

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

Source: LifePlans analysis of 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 in 1990. Reported in: Who Buys Long-Term Care Insurance in 2010 – 2011? A Twenty-Year Study of Buyers and Non-Buyers (in the Individual Market), AHIP, 2012

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 long-term care 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 $153 daily benefit amount in 2010 would cover 70% of the average daily cost of nursing home, 155% of the daily cost of assisted living, and roughly eight hours of home care a day seven days a week.[21] 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 companies to move away from this policy design stems in part from pressure by ratings agencies and fewer reinsurance options.[22] It represents one of a number of actions insurers have taken to "de-risk" the product.

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. Much of the recent rate increase activity is related to the fact that 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 companies in the face of increasing claims liabilities.

Stand-alone LTC insurance product designs have largely stabilized over the past five years. As shown, however, there has however, 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 a LTC insurance policy. The LTC Financing Strategy Group estimated that penetration among individuals who are considered to be suitable purchasers (i.e., have incomes 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 age 45 to 64 age group.[23] The profile of individuals purchasing long-term care insurance 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 2 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 that most people purchase

[21] 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.
[22] Moody's: Long-Term Care Insurers Face Uncertain Future (2012). Moody's Investor Service, Global Credit Research, New York. September 19th.
[23] LTC Financing Strategy Group, 2008. Washington, D.C.

the insurance to protect current consumption patterns (e.g., maintain standard of living, avoid dependence, maintain affordability of services) rather than to protect assets.[24]

Table 3: Characteristics of Individual Long-Term Care Insurance by Purchase Year

Characteristic	2010	2005	2000	1995	1990
Average Age %> 70	59 years 8%	61 years 16%	65 years 40%	69 years 49%	68 years 42%
% Married	69%	73%	70%	62%	68%
Median Income % > $50,000	$87,500 77%	$62,500 71%	$42,500 42%	$30,000 20%	$27,000 21%
Median Assets % > $75,000	$325,000 82%	$275,000 83%	$225,000 77%	$87,500 49%	N.A. 53%
% College Educated	71%	61%	47%	36%	33%
% Employed	69%	71%	35%	23%	7%

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

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 long-term care insurance policies to access Medicaid benefits without having to spend down their assets to Medicaid levels, if and when their long-term care insurance benefits are exhausted. A growing number of states – upwards of 45 by the end of 2012 -- have implemented such programs.[25] Even so, few people age 50 and over – less than 25 percent – actually know whether or not their state has a Partnership Program. However, the Program does hold appeal: fully 45 percent of a random sample of individuals

[24] Authors' analysis of data summarized in AHIP Study of Buyers and Non-Buyers of Private LTC Insurance in 2010, Washington, D.C.

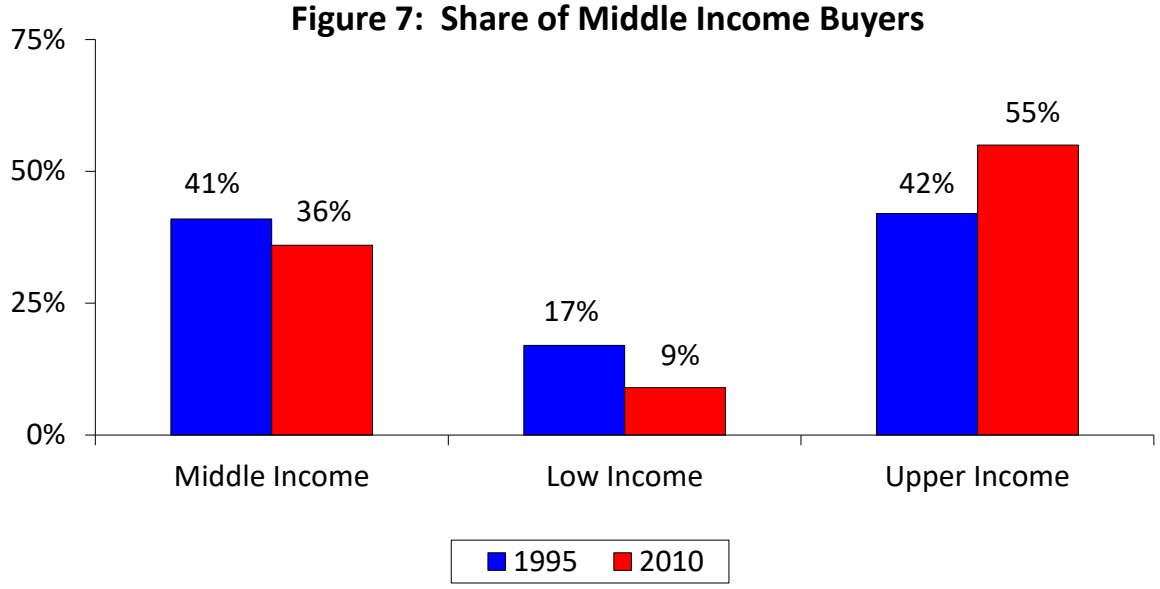
[25] Website on Partnership Programs: http://w2.dehpg.net/LTCPartnership

over age 50 indicated that they would be likely to purchase a policy if their state participated in a Partnership program.[26]

Another way to reach middle income buyers that has been encouraged is the provision of tax incentives. Today, more than half the states provide tax incentives for the purchase of LTC policies, and most of these are linked to qualified policies.[27] Even so, there is little evidence that such policies have led to a discernible effect on LTC insurance take-up rates. This is not too surprising given that the value of incentives is fairly low compared to the costs of the policies themselves.[28]

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 LTC insurance is declining.

Figure 7: Share of Middle Income Buyers



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. Author's analysis of buyers data and census data.

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

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

[27] Stevenson, D., Frank, R. and Tau, J. (2009). Private Long-Term Care Insurance and State Tax Incentives. Inquiry 46:305-321. Fall.

[28] 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.

confidence in insurers to pay benefits as stated, and the desire to wait to see if better policies come on the market.[29]

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 Department of Health and Human Services, roughly 1,400 claimants were asked a series of questions about their experience filing a claim with the company.[30] 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 that they were approved and had become "claimants" while 7% reported that they were still waiting for a decision. Only 4% reported that their claims were denied. Of these denials, the majority stated the reason for the denial was that 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 insurance company 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 that 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 suggest that at the time that 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 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 company. This does not mean that process errors and incorrect decisions do not occur. Clearly, they do. However, based on the empirical evidence, these tend to be more the exception than the general rule regarding industry

In terms of the financial benefits to consumers, data indicate that between 69% and 75% of claimants reported that their policies were paying for most or all of their care at any given time during the course of a year.[31] Clearly, those who purchase LTC insurance do so in the hope that should they need care, their policies will pay for most of it and their out-of-pocket expenses will

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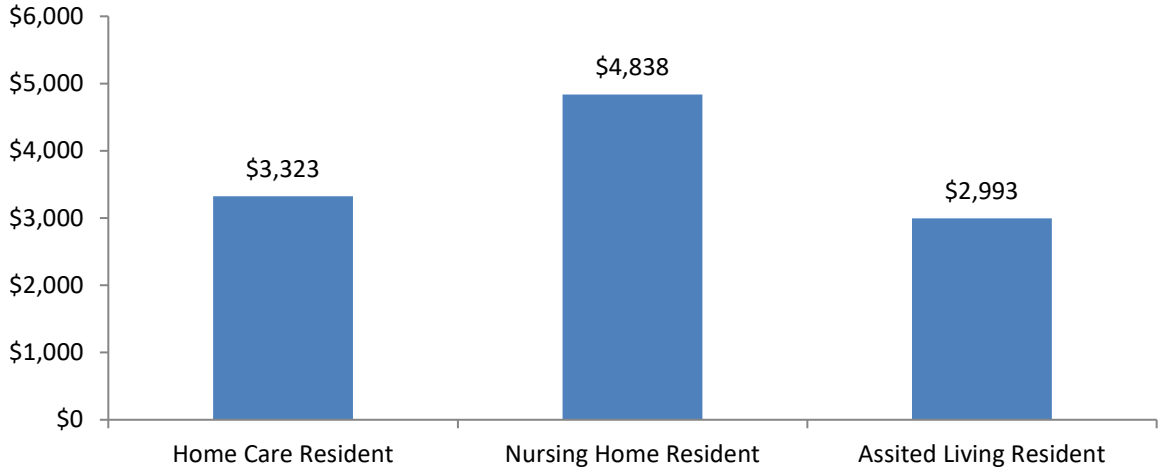
[29] Who Buys Long-Term Care Insurance in 2010 – 2011? A Twenty-Year Study of Buyers and Non-Buyers (in the Individual Market), AHIP, 2012

[30] 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, D.C. April.

[31] 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, D.C.

be reduced. Figure 8 shows the average amount of money that a privately insured disabled elder saves each month that 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 dollars)

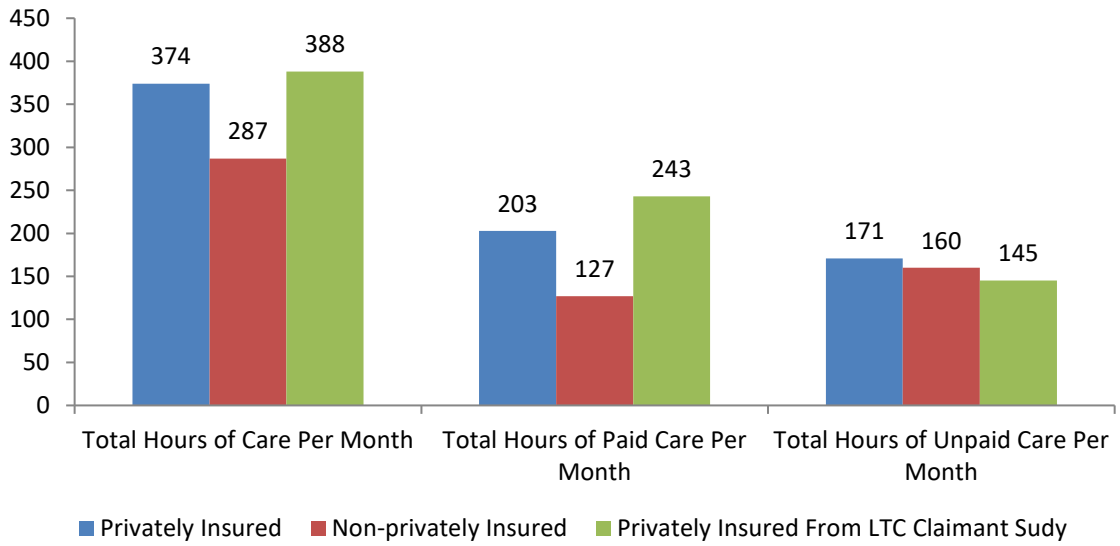


Source: Department of Health and Human Services (2006). Decisions, Choices and Care Management among an Admissions Cohort of Privately Insured Disabled Elders. Washington, D.C. and the 2012 Metlife cost of care survey data. Data were inflated to the cost in 2014 with assumptions of 1%, 3.5% and 4% increase in the costs of home care, nursing home and assisted living care.

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 that 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; here individuals typically have a higher level of need than in assisted living settings and the duration of care is typically about 2 years.

A closely related and important issue is the extent to which having LTC insurance leads to more hours of care received and potentially to a reduction in unmet needs. Given the costs of care, it is conceivable that 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 LTC insurance.

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



Source: AHIP (2014). The Benefits of Long-Term Care Insurance and what they Mean for Long-Term Care Financing. Washington, D.C.

Figure 9 clearly demonstrates that 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. 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 that insurance-financed benefits do not replace family caregiving, but likely 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% and 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 this graph is the fact that 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 .71 times as likely to report having an unmet/under-met need as those without private insurance.[32] Thus, the extra hours afforded by the insurance leads to a reduction in reported levels of unmet/under-met need.

[32] AHIP (2014). The Benefits of Long-Term Care Insurance and what they Mean for Long-Term Care Financing. Washington, D.C.

Insurer Challenges[33]

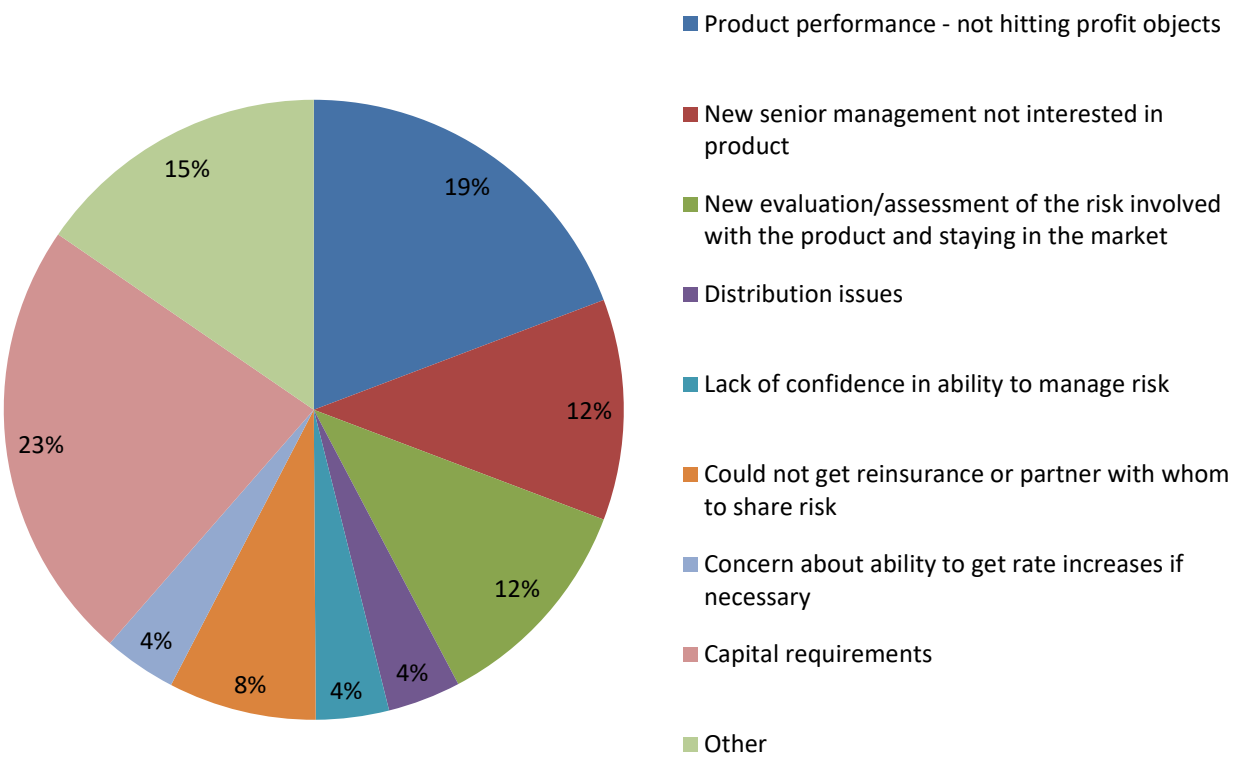
With few exceptions, most companies that stopped selling LTC policies did so over the past decade. In fact, more than half of companies in the sample have exited the market (or specific market segments) in the past eight years. In a relatively recent report published by the U.S. Department of Health and Human Services, executives at major companies who had exited the market reported their primary reasons for doing so.[34] 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 companies. Product performance that is, 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 companies 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 that only a single company cited an unfavorable public policy environment specifically as a reason for exiting the 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. Some of the other reasons cited include a concern that a continued focus on LTC insurance detracted from other core products, that tax qualification guidelines inhibited certain innovative product designs, and others. 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.

[33] Much of this section is drawn from a study conducted by the author for the U.S. Department of Health and Human Services examining why carriers have left the market. The findings are referenced in a report entitled "Exiting the Market: Understanding the Factors behind Carriers' Decision to Leave the Long-Term Care Insurance Market." Which was published in July of 2013.

[34] 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. Washington, D.C.

Figure 10: Single most Important Reason that the Company Left the Market



Source: Survey of executives from 26 LTC carriers who exited the market or exited segment of the market.

Concerns related to capital requirements and rate increases may represent something unique about the structure and regulatory requirements relating to LTC insurance that have a major impact on profitability. LTC insurance is a guaranteed renewable product which means that as long as an individual pays premiums, 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 that 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 that have been in the market for enough time to gain credible experience. This means that policyholders would typically be older and more likely to be on fixed incomes at the time that a company might be seeking a rate adjustment. Given the sensitivity around increasing rates for older policyholders, it is not surprising that companies are concerned about their ability to raise rates; in fact, many companies have experienced significant challenges obtaining the level of rate increases that they

request, even when such increases may be actuarially justified. For example, a company may request (and require) a 35% rate increase, yet be allowed to adjust premiums by only 15%. This does not mean that regulators have ignored requests for rate adjustments. With few exceptions, most companies have increased rates on some if not all of their policy series, and clearly the increases have been significant.[35]

The capital requirements for LTC insurance 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 that rating action impacts are muted as policyholders continue to age.[36] The implication is that it has been very difficult for carriers to effectively manage the product and assumes its underlying profitability.

Conclusions

By almost all measures, the private market for long-term care insurance has under-performed. Yet no one disputes the need for a product that insures against the financial risk associated with long-term care services nor is there an argument about the fact that this need will increase over time. There are a number of actions that carriers should consider in order to make the product more manageable. These include (but are not limited to): (1) changing the underlying funding structure so that 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; (3) finding creative ways to reduce selling costs.

For its part, regulators do need to provide companies with more certainty regarding the anticipated actions that would be taken in the context of requested rate adjustments. Insurance regulators must of course balance insurer solvency and consumer protection, and it is not the role of insurance regulators to guarantee a certain level of profit to 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.[37]

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. [38] Some of the reasons relate to

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[35] 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

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

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

[38] See Frank, R., Cohen, M. and Mahoney, N. (2013). Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Terms Care Insurance. Unpublished policy brief submitted to the SCAN Foundation, January.

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 LTC insurance to health insurance, simplifying the product, providing more support for employer-sponsorship of insurance, educating the public about the risk and costs of long-term care, forcing active choice, providing state-based organized reinsurance pools to provide a "back-stop" for industry experience, implementing targeted subsidies, and others. All of these strategies are designed to increase demand – both through lowering selling costs and through changing peoples' attitudes about the value of LTC insurance – 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 companies actively selling policies, it is worth noting that the LTC insurance market covers more than seven 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 companies 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. There remains a critical role for public sector support of the market on both the demand and supply fronts. While LTC insurance 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.

Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance

By Richard G. Frank, Marc Cohen, and Neale Mahoney

This series summarizes current issues in financing long-term care and outlines policy options for increasing affordable access to services.

Introduction

Americans are ill-prepared for many of the consequences of aging and possible disability. They save too little, they do not prepare emotionally for separation from work, and they are not prepared to absorb the costs of needing long-term services and supports (LTSS) in the event that they experience functional impairments. This leaves most Americans exposed to the potentially catastrophic costs of LTSS. Public programs such as Medicaid pay for care primarily in institutional settings, and the program is targeted to poor individuals or those who must impoverish themselves trying to pay for such care. Most other Americans can try to save for this potential liability and/or purchase private long-term care insurance (LTCI), yet few do so. *The Patient Protection and Affordable Care Act* (ACA) contained provisions for a public insurance program – the CLASS Act –but this program was deemed to be unworkable in its proposed structure and was recently repealed in the "Fiscal Cliff" legislation.

We argue that the current private market for LTCI is not functioning well. For a variety of reasons, there is both an under-demand and undersupply of LTCI. Regardless of whether one is talking about private or public insurance, today's political environment demands that when one considers policy towards expanding protection against the financial consequences of needing LTSS, insurance program designs be structured as voluntary. The recent debates over the design of the ACA highlight that there is little taste for new mandated benefits and the criteria for making new financial outlays by government will be extremely demanding. This means that program designs must have some level of medical underwriting, have low budgetary impacts, and be structured in a way that makes them attractive to a broader population of consumers, as well as profitable or break-even for program sponsors.

In this brief, we review a number of the issues that have led to the problem of underinsurance and explore potential options that could result in more Americans being insured against the costs of LTSS. Our goal is to present realistic policy options to increase LTCI take-up rates. We present ideas that may be acceptable to a wide range of parties with different political views and conceptions of the proper role of government. As a result, our measure of success is modest. If the combination of approaches results in the percentage of Americans over the age of 50 that are insured against the cost of LTSS increasing from under 10% today to over 20% during the coming decade, we will consider that to reflect an improved well-being of an aging America.

Problem Statement and Aims

The lack of financial preparation for possible functional impairments in the future can force people to compromise their lifestyles in order to pay for necessary services and supports in a time of need. It also hurts the larger society by making claims on public budgets that are already stressed by economic pressures and demographic changes. For example, a recent set of estimates by Webb and Zhivan suggest that, for a couple turning 65, the expected out-of-pocket spending on LTSS costs over the remaining life years is $63,000.[1] The estimates also show that couples turning age 65 face a 5% risk of incurring costs of over $260,000 for LTSS alone. These figures emphasize that unprotected financial risks associated with LTSS are likely to result in households having to reduce their standard of living, as well as accumulated savings, in order to pay for LTSS. It also highlights the fact that this liability -- with its low probability of a high cost event – may be well suited to risk-pooling, which is the essence of insurance. These data also underscore the point that more middle income Americans will be making claims on safety net programs, like Medicaid, as a result of being financially ill-prepared to bear the risks of needing LTSS during a period of rapid population aging. This would further threaten the financial health of those safety net programs.

While the ability of today's households to absorb such risks is modest, that ability is projected to decline in the coming years. Current median net worth is roughly $200,000 for households where the head is age 65 or over with the majority of that wealth existing in housing assets.[i] Between 2007 and 2009, wealth declined by 16.9% for households with a head age 65 and over.

Unlike much of the rest of the population, this group has less time and ability to supplement income to gain back wealth losses. Moreover, the decline in net worth interacts with ill health to accelerate spend down to Medicaid in the presence of significant LTSS needs. Given the financial risks associated with LTSS reported above, only people in the wealthiest 10% to 20% of older adult households have savings that could absorb risks of high LTSS spending (top 5% of risk). The expected costs of LTSS would account for about 31% of the net worth of households with a head 65 to 74 years of age. Thus, the typical household is not in a position to both pay for LTSS and to maintain basic consumption levels. This situation is likely to be aggravated in the coming years by the expanded use of paid LTSS due to increases in longevity and changing demographics that will reduce the availability of supplementary non-paid care from family and friends.

The lack of financial preparation for possible functional impairments in the future can force people to compromise their lifestyles in order to pay for necessary services and supports in a time of need.

In many areas where households face risk to their life, health, or property, they turn to private insurance markets for protection. This is less true for the financial risks associated with needing LTSS. Private LTCI covers the costs of LTSS such as home health services, nursing home, and assisted living. Currently, 7 to 7.7 million individuals have LTCI coverage.[2,3] The rate of coverage is 12.4% for adults age 65 and older and 5.4% for those aged 45 and over.[4,5] Even when taking into account the percentage of the income eligible market (i.e. those having incomes greater than $20,000 and not being on Medicaid), the percentage of the 65+ population covered increases to only 16%. This is generally seen to be a small share of the potential market.

[i]There are a number of mechanisms for transforming housing wealth into protection for LTSS. For example, reverse mortgages can be used to annuitize savings to pay for LTSS. A second method is to use proceeds from a reverse mortgage to purchase private long-term care insurance. Yet, it is worth noting that if we return to long-run historical trends, housing will not be the high yield investment that it was in recent years.

Sources of the Problem

The problem of underinsurance can be thought of as stemming from two sources. The first source is household behavior related to savings, purchase of insurance, and health related behaviors, which is a problem of demand. The second has to do with the efficiency of the current private insurance market, or supply (see Table 1).

The expected costs of LTSS would account for about 31% of the net worth of households with a head 65 to 74 years of age.

The demand for protection against the risks of LTSS involves making purchasing decisions today to protect against events that might occur decades in the future. Consumer information will be incomplete because of uncertainty about the future, thereby creating conditions that may compromise decision-making.[ii] Decisions about LTCI also involve confronting the potential for large financial and emotional losses (like the loss of independence and the specter of living with disability), choices that are costly to reverse once a decision about policy features has been made, and inexperience in making such choices when options are presented.[iii,6] LTCI products are complex. They typically offer numerous specific design choices such as inflation protection, time limits on benefit duration, daily amounts of benefits, and options for elimination (e.g. deductible) periods. These require fairly sophisticated financial calculations and assessments of multiple risks (mortality, disability, level and duration of disability, and future costs) over multiple decades –difficult assessments to make even if information were readily available.

Consumers face additional risks in the American LTCI market. Among the most important and hardest to judge for consumers is the competence of LTCI firms in managing long-term risks. Some of the most sophisticated LTCI plans have made extremely optimistic (and sometimes unjustifiable) judgments about investment returns for premium dollars that resulted in setting LTCI premiums far too low. For example, the CalPers LTCI that covers state and local government employees in California recently assumed rates of return on investments well over 7% per year.[7] The result was a 32% deficit in 2009 and premium increases of about 22% for what were supposed to be level premium products. More recently an increase in premiums of 85% was announced. This also means that households considering buying LTCI face risks of insolvency by insurers or rate increases in the product that they may not be able to afford at a time when they are at their highest risk for needing LTSS. Thus, key attributes affecting the stability and performance of the product being purchased are largely unobservable to consumers.

There are also several systematic misperceptions and decision-making biases that are relevant in this market. Myopia is widespread in decision-making as people have difficulty considering future implications of today's choices. This is especially true when the future events to be considered are both uncertain and very unpleasant.[8] One study found that the high levels of uncertainty make people less interested in planning for future care needs.[9] There is also widespread tendency to underestimate the risks of needing LTSS, where around 50% of people underestimate those risks.[10] Significant portions of the population also mistakenly believe that existing health insurance plans (either a public program such as Medicare or private plans) cover LTSS, although public understanding appears to be improving.[11]

Regarding the supply of LTCI, there are at least two sets of factors that influence its

[ii]This point has been made in the context of analyses of pension policy (Barr and Diamond 2006). In fact, the economics of long-term care financing shares much with the economics of pensions.

[iii]These characteristics of a decision problem have been referred to as high stakes choices. Krunreuther et al (2001) catalogue the errors that commonly result in making such decisions.

provision and the reliance on other forms of risk protection. Adverse selection affects health insurance markets generally and LTCI in particular. Since LTCI is usually purchased later in life and involves a long-term contract, there is more opportunity for the development of private information on the risks of needing LTSS. The existing evidence suggests that people with a higher risk of needing LTSS tend to be more likely to seek purchase of LTCI.[12,13] This is consistent with some recent case studies of problems with specific LTCI plans.[14] Insurers respond to potential adverse selection among consumers by engaging in underwriting so as to screen out people at elevated risks.[iv] Insurers in the U.S. make extensive use of underwriting. In 2009, underwriting rejection rates across the industry were at 19.4%. Declination rates are below 10% for applicants under age 45, whereas rates increase to slightly more than two in five, or 44%, for those over age 80.[15]

A second set of major supply side factors that may result in the under-provision of LTCI is the problem of spreading risks for common "shocks" shared by the entire population.[16] That is, insurance works when the risks to each insured individual are independent. Macroeconomic shocks, changing mortality and disability rates, and cost increases in LTSS affect all insured people. In addition, many of these common "shocks" are highly uncertain over the long-term (30 years), which makes risk-spreading challenging. Insurers respond to this situation by "de-risking" the product in ways such as limiting the duration of coverage (median is three years) and the daily amount of coverage ($150 per day is most common).

Together these supply and demand conditions result in premiums that are beyond the reach of many Americans, limitations on the amount of protection offered, a costly underwriting process, unpredictable premium increases, and consumer confusion and mistrust in the industry.

Elements of Policy Design:

Our analysis of the sources of underinsurance for the costs of LTSS identified information gaps, product complexity, and consumer misperceptions and biases as sources of too little demand. We also point to adverse selection and limits on risk-spreading ability as central supply sources of too little LTCI. To address these issues, we propose policies to expand financing of LTSS by improving the overall functioning of the private LTCI market. The policies we consider target both demand and supply. We consider three classes of policies to address these challenges: (1) Changes in LTCI products that could address issues of product complexity, presentation of products, and alignment with household preferences; (2) Fundamental features of risk-bearing and consumer understanding of LTSS; and (3) Choice architecture for purchasing LTCI. The policies we propose

TABLE 1 **Current Challenges in LTCI Market and Policy Design**

Demand Issues	Supply Issues
• Lack of information/shrouded attributes	• Adverse selection
• Misperceptions about need, costs, and coverage	• High selling costs
• Myopia, or difficulty understanding future implications of today's choices	• Inefficient risk-bearing: common shocks
• Consumer confusion/product complexity	
• Mistrust of industry/contracts	

[iv]While some evidence has been reported on positive selection into LTCI, it is conditional on having passed underwriting (see Brown and Finkelstein note 17).

are institutionally neutral—most could be advanced by government, employers, or other organizations.

Relatively high take-up rates for LTCI in a number of settings leads us to conclude that there is potential to increase LTCI coverage even in the presence of relatively expansive Medicaid programs, which some have posited reduce the demand for LTCI.[17] Table 2 provides some examples. Six states and the District of Columbia have take-up rates for people over age 45 that are double the national average.[18] Private employer-sponsored LTCI coupled with little to modest underwriting requirements, active outreach and education campaigns, and reduced selling costs realized market penetration rates of 9.4% in CalPers and 20.4% for the Minnesota Public Employees LTC program.[v,19]

TABLE 2 Population Take-Up Rates of LTCI, Ages 45+

U.S. Overall	5.14%
DC	14.5%
Hawaii	13.0%
South Dakota	12.9%
North Dakota	12.8%
Nebraska	12.0%
Iowa	10.4%
CalPers	9.4%
Minnesota State Employees	20.4%

Product Design Options

Product Simplification

The complexity and variety of LTCI products appears to pose a significant barrier to take-up and may distort choices even when take-up occurs.[20] There is a well-developed literature that shows how complexity can distort consumer focus and result in buyers ignoring important information that can improve the quality of decisions. Some of these studies have focused on how large numbers of choices of health insurance inhibits the exercise of effective choice.[21,22,23] Others show that product complexity results in decision-making errors.[24] The buyer/non-buyer studies in LTCI report that buyer confusion about the complexity of choices served to reduce purchasing among potentially interested individuals.[25]

The results of recent Earned Income Tax Credit (EITC) experiments highlight the importance of reducing complexity that is especially relevant to the LTCI case.[26] In one of the treatments, extraneous information was removed from the notices and application worksheet. This increased the response rate by 9 percentage points on a base of 14%.

A strategy of simplification that promotes effective consumer choice would restrict the number and complexity of LTCI options by standardizing the basic set of offerings and presenting simple and clear descriptions of the key elements of the products. The simplification could be structured to ensure that the fundamental decision is about the amount of real risk to be covered. This has been done in the context of supplemental insurance for Medicare where regulations were put in place that standardized a set of product offerings. This resulted in a large number of firms competing on price rather than on product design. Recent experiences in LTCI programs lend support to this idea. The State of Minnesota's employee LTCI plan offers a relatively simple set of choices with four plans offered. Only two variables change between the choices: the duration of coverage (3 vs. 5) and the daily maximum benefit ($100 vs. $150). The Federal Long-Term Care Insurance

[v]The CalPers program relies on a moderate level of underwriting, known as a short form. The Minnesota program is a guaranteed issue program and therefore does not use underwriting methods. The Minnesota program also includes non-forfeiture provisions to the coverage.

Program (FLTCIP) recently standardized and simplified their offerings, the latest of which consist of four basic plans. Three variables were permitted to vary: the daily benefit amount, duration of coverage, and inflation protection level. The results are encouraging, as there was a 20% jump in applications during the 2011 Open Season.[27]

The implications of simplification are potentially profound because 1) consumers seem responsive to being presented clear, relatively simple differences between alternative options, and 2) most policies are sold through brokers who command large commissions. Total selling costs have been estimated in the range of 20% to 30% of premiums.[28] Standardizing LTCI offerings may have an important impact on lowering sales costs, and hence, premiums. This has been the experience in standardization of Medicare supplementary coverage where selling costs were lowered and loss ratios have increased, suggesting a higher portion of premium dollars is paid out in beneficiary claims.[29]

Nesting standardized choices within an electronic market can strengthen the impact of introducing more uniform LTCI products through regulation into the market. The apparent success of the Massachusetts Connector points to the potential of such actions. Within such markets, decision aids can be structured to help align consumer preferences and circumstances with the products on the menu of choices. In addition, consumers can rate their satisfaction with products and services to inform new buyers.[vi] Tying standardization to an electronic market also opens up the possibility of linking LTCI purchase with private health insurance products (discussed below).

High deductible/flexible benefit designs

We now consider some simple insurance designs that have not emerged in the market through a combination of regulatory constraints and market dynamics. Such designs may be attractive for certain market segments that currently do not purchase coverage. We therefore envision such products being offered as part of the standardized benefit offerings discussed in the previous section. As noted earlier, there are small but significant risks of 65 year-olds incurring out-of-pocket costs for LTSS of $100,000 or more over their remaining lifetimes. More than two-thirds of individuals require less than two years of formal paid services. Given the annual costs of a nursing home in 2012 totaling over $80,000, this particular service represents a potentially catastrophic risk for a small number of people. On the other hand, an individual using roughly eight hours a day of home health aide or homemaker services seven days a week can expect to pay $54,000 per year.[30]

We propose policies to expand financing of LTSS by improving the overall functioning of the private LTCI market. The policies we consider target both demand and supply.

It is precisely the desire to avoid the catastrophic expense and self-insure for the non-catastrophic expense that could attract more people into the LTCI market. For example, a policy offering a one- or two-year deductible would allow someone to self-fund home care services before moving to more costly institutional alternatives. Catastrophic policy designs – one- or two-year deductible periods –can have a significant impact on the premiums of policies. Table 3 below shows the impact for various ages.

[vi] We are grateful to Peter Kemper for suggesting this extension to standardized products.

TABLE 3 Impact of Alternative Deductibles on Sample of Annual LTCI Premiums

Age	Base policy of 3 years of coverage, $150 per day and 5% inflating benefit		
	90 day deductible	1 year deductible	2 year deductible
55	$3,312	$2,017	$1,210
60	$3,677	$2,240	$1,344
65	$4,236	$2,582	$1,549
70	$5,475	$3,340	$2,004

Source: LifePlans LTCI pricing model; 3.5% interest assumption.

As shown, moving from a 90-day deductible (the predominate choice of individuals today) to a one- or two-year deductible decreases the premium by 40% and 64% respectively, which makes the insurance far less costly.

The primary reason why such designs have not been permitted is because of a concern that consumers would not be able to fully understand the difference between what they would have to pay for and what the insurance company would have to pay for.[vii] There has also been a concern that consumers would pay premiums for many years, need significant levels of care, and never receive insurance benefits. However, we believe that, in the context of overall product simplification, use of electronic markets, and consumer education (discussed below), such objections can be overcome.

An additional design worth considering relates to the way that the product is structured to fund future benefits. Many companies have exited the market over the past decade because of the extremely low interest rate environment, which means that they could not generate sufficient income on the reserves they were holding to fund future liabilities. This is an especially significant risk for products that offer a fixed (level) premium. There may be good reason, however, to change the nature of the funding. First, simply by indexing to inflation both premiums and benefits in time blocks, one attenuates a source of uncertainty (inflation risk) and the initial premiums are reduced compared to a fixed premium arrangement that includes inflation protection. Second, one could also consider "term pricing" of the risk at young ages (below age 65). In "term pricing," the annual premium covers the risk (expected claim costs) over the term (e.g. one year), and there is an understanding that every year the premium increases a small amount to cover the increase in expected claims. At a certain point, say at age 70, the premium is fixed and level-funded. One can define a term to be one year, five years, or even ten years, and a specific schedule of premiums would be established. The schedule may also include a small amount of pre-funding. Such an approach minimizes the importance of interest earnings and makes the product more affordable and attractive at younger ages, leading to a more pervasive awareness of future LTC risk. This in turn should help to reduce selling costs and "mainstream" the product as part and parcel of a standard retirement plan.

Current regulations do not prohibit such approaches. However, insurers have not offered these approaches in part because of a concern

[vii] We recognize some important practical problems of educating and supporting consumers to take steps that will start the deductible "clock" when they first become disabled.

about introducing additional complexity into the product. There is also a 30-year history of level-funded premiums for this product, in part because of the concern that increasing premiums for people who are on fixed incomes will cause them to drop their policies. A design that begins with term or indexed pricing, and then adjusts the indexing rate downward at a certain point can reduce these concerns. In practice, experience has shown that proper estimation of level premiums is very difficult and the result has been large, unexpected increases in premiums for allegedly "level-funded" premium products.

LTCI and Health Insurance

In our discussion of the problem sources, we noted that consumers are unfamiliar with LTCI and have little experiences purchasing such products. There has been an emerging consensus that integrating health care and LTSS has the potential to improve care and save money for vulnerable people that participate in public health insurance programs like Medicare and Medicaid. Typically, private health plans serving older adult populations, such as Medicare Advantage (MA) Plans, are responsible for managing the care of their members by providing an approved set of services in return for a fixed monthly per-member payment from the payer (an employer or Medicare). LTSS have not traditionally been included in such coverage, since the most common service -- home health aide care -- is not a covered Medicare service unless it is provided in the context of a skilled need. Most people who require LTSS do not have ongoing skilled needs. The desire to attract new members and find ways to address total care needs in an efficient manner may offer an important opportunity for expanding the LTCI market through linkages to MA plans. Such linkages can reduce both the sales costs and the claim costs underlying the insurance, thus making it more available and more affordable. This situation could occur because combined acute care and LTSS coverage in the context of a strong care management approach may provide a channel to influence the underlying claims experience of products. The need for costly acute and long-term care stems from the same underlying cause: the presence of multiple chronic conditions and their manifestation into ongoing functional and/or cognitive needs. To the extent that health plans assume greater responsibility for managing the entire continuum of acute and supportive services, more costly and inappropriate use of acute care services (i.e. multiple and avoidable hospitalizations) can be substituted for less costly supportive services (care managers and home health aides). The implication is that if health plans managed the ***total continuum*** of acute care and LTSS, it may be possible that the ***total costs*** of care could be reduced. Currently, evidence on cost savings is mixed. However, such substitutions and related savings are more likely to occur as health plans become more adept at managing the needs of chronic care populations.[31,32,33,34,35]

An example of successful linkage of coverage for acute medical care and coverage for LTSS can be found in Israel. There, more than 60% of the population has insurance coverage for LTSS. About 83% of such coverage is provided through the country's four managed care plans, and the other 17% through commercial sales of individual policies or group policies sponsored through employers and labor unions.[36] Each health plan purchases a group policy through a commercial carrier and this coverage is made part of a supplemental benefit package, which includes coverage for other popular services. We are not proposing the Israeli approach, but rather making the point that a significant share of the high take-up reported in Israel is attributable to the linking of the purchase of health insurance to opportunities to buy LTCI.[viii] The health

[viii] The Israeli insurance is relatively inexpensive and uniform for all members, which enhances simplicity. Benefits are not designed to cover catastrophic costs, and they are a function of the age at which a member joins the health plan.

plan acts as the "informed sponsor" and positions LTSS coverage as one of a number of attractive supplemental benefits for which members pay additional premiums.

Alternatively, a health plan could private label a policy offered by commercial carriers and wrap this into its overall benefit package to members. If such a combined product were marketed as one piece of a broader insurance package, rather than a complete stand-alone policy, adverse selection may be attenuated. For the younger population, one might include such coverage but on a term-pricing basis so that premiums are very low, increase with age and/or with benefit levels, and then rate increases are lowered at age 65 or 70. This would make the insurance more affordable, place the coverage itself in the broader context of overall health and well-being, and ensure that the health plan has longitudinal information to better manage both the acute and long-term care service needs as the individual ages.

A policy mechanism for promoting the linkage of health insurance and LTCI is mandated availability. Mandating availability means that sponsors of health insurance, such as employers and health insurance exchanges or Medicare, must offer enrollees the option of voluntarily purchasing an LTCI policy at the time they are purchasing their health insurance. For example, CMS could encourage MA plan sponsorship of insurance by a forced-choice provision (discussed below) at the time of enrollment in a plan. A similar arrangement could be put into place for traditional Medicare at the time of initial enrollment. In a private insurance context, a modest base plan could be part of the standardized options.

Options for Altering Fundamentals of Risk-Spreading and Consumer Understanding

Reinsurance

Our analysis of the undersupply of LTCI focused on the fact that sellers of LTCI face the problem of spreading risks for common "shocks."[37] This circumstance has led insurers to lessen their exposure to risk through rigorous underwriting and limits on offered coverage. The high level of uncertainty also makes insurers build significant risk premiums into premiums charged to consumers, which has contributed to low lifetime loss ratios of 60% or less and reduced demand for LTCI.[ix]

As noted earlier, deep mistrust in LTCI has been created by insurer exit from the LTCI market, unexpected large premium increases to policies that consumers believed were fixed, and aggressive and inconsistent approaches to underwriting.[38,39] As a result, when potential buyers of LTCI in focus groups were asked about what role government might take in this market, consumers repeatedly suggested that a function analogous to the FDIC for banks may be warranted. That is, the government would arrange to "back stop" the industry and set standards for firms selling LTCI with respect to reserves, and investment return projections and other risk management parameters that are largely invisible to consumers. Such a function could be structured so that the federal government or a designee (e.g., the National Association of Insurance Commissioners) would establish national standards for state governments to implement uniformly.

To address key inefficiencies and ensure that all firms can benefit from appropriate risk-spreading, we propose a system of state or multi-state organized reinsurance pools. Such risk pools could be organized by state governments and would reimburse LTCI firms

[ix] A lifetime loss ratio is the total amount of claims that are paid out over the life of a policy compared to the total amount of premiums paid.

when losses exceed a pre-specified level. The pool would be privately funded by charging each insurer selling in the market a premium akin to the current state premiums tax designed to support guarantee pools. The losses could be defined in terms of those suffered by individual companies, in which case there is some concern with potential moral hazard in risk management. Alternatively, the losses could be defined with respect to aggregate industry losses and payment would be prorated to each firm according to their share of total losses. In that case, the likelihood of collecting benefits is less closely tied to any one company's actual performance.

A number of states at elevated risk of natural disasters have organized such pools with the aim of stabilizing the disaster insurance market that shares certain similar risk-spreading challenges as the LTCI market. In some cases, these pools are entirely privately financed. In the case of the state disaster pools, firms are reimbursed a portion of the losses (e.g. 75%), thereby making firms responsible for 25%. This provides an incentive to be judicious in managing risk. Purchase of additional, private reinsurance is permissible so long as total payments do not exceed a firm's actual losses.[40]

In our view, LTCI firms seeking to qualify for state reinsurance would have to apply a standardized set of assumptions for use in constructing premiums and other factors associated with financial risk. These include investment return assumptions and projections of policy forfeiture rates, which have been the source of sudden premium increases and firm exits from the market.[41,42] The creation of state-sponsored LTCI reinsurance pools should be attractive to consumers and policy makers for several reasons. First, the pools would offer protection to the industry for the uncertain tail of the LTC cost distribution that results in coverage limits and high risk premiums. Thus, we expect that the presence of such reinsurance arrangements would serve to lower LTCI premiums. Second, by reducing the inherent risk in the product, capital requirements are likely to be lowered, which makes the insurance more attractive to carriers who may be considering entry (or re-entry) into the market. Given the small number of carriers currently selling in the market, this may promote more competition and create downward pressure on premiums, especially when accompanied by product designs that are simplified and standardized. Third, state sponsorship where a state-organized reinsurance stands behind the firms selling LTCI and establishes consistent standards for risk management responds to two sources of distrust in the industry: consumer inability to observe risk management approaches and concerns about market exit. Together these forces would be expected to increase demand for LTCI. A variation on this approach might involve a publicly organized consortium of major private reinsurers to offer a national reinsurance pool where a transparent set of insurance company standards would be set out as a condition for participation.

Educational Campaign

Misperceptions about the risks associated with LTSS and the nature of LTCI are widely held. Among the most significant misperceptions are those relating to the risks of needing LTSS, the cost of LTSS, a tendency towards myopia, and the public coverage of LTSS. Correcting such misperceptions offers an important avenue though which information can affect the purchase of LTCI. One recent example is an intervention that focuses on older adults to examine whether information can correct misperceptions about the Social Security earnings test. Researchers found that a mailing brochure combined with an invitation to participate in a 15-minute online tutorial raises labor force participation among adults approaching retirement age by 4 percentage points on a base of 74%. One particularly appealing aspect of the intervention is the use of vignettes about actual retirees to help convey the returns to working longer. Making the issue salient in this manner may have increased the

effectiveness of the intervention compared to an approach that relied on figures and statistics about the benefits formula. Thus, the details of campaign design are of great importance in making the new information "cognitively available."

Including an informational brochure on LTCI in an employee benefits package is a relatively inexpensive intervention. Including a discussion of LTCI in a benefit fair may also have a relatively low incremental cost. Targeting has the potential to be high, at least to the extent that the information provided is "informative" rather than "persuasive."

The downside of information interventions is that they may not be sufficiently powerful to increase appropriate take-up of LTCI. Using vignettes and peers can help amplify the effects of information, but these effects are still likely to be limited for two reasons. First, purchasing LTCI involves relatively high upfront costs despite the long-run benefits. Thus, the tendency towards myopia will emphasize the costs and discount the benefits. Second, issues related to follow-through and complexity provide substantial barriers to purchase, even for consumers with strong initial interest. We discuss strategies to reduce these hurdles below.

Even when informational interventions create strong intentions to purchase LTCI, the path from intentions to action is far from short and simple. There is evidence for this based on so-called buyer/non-buyer studies of LTCI.[43] Again, salient sources of information were important and advice has been shown to play a central role. LTCI purchase decisions were shown to be most strongly influenced by family and friends. There was some evidence of peer effects from co-workers. Studies conducted in Germany and in the U.S. show that engaging people in planning for their future retirement and long-term care needs increases the likelihood that LTCI will be purchased. Detailed case studies based on the experiences of the CalPers and Minnesota Public Employee Long-Term Care Insurance Program suggest that well-designed outreach and educational campaigns can significantly affect take-up rates.[44,45] The Minnesota experience highlights the impact of a successful education campaign on reducing adverse selection into LTCI. The CalPers program conducted several waves of an education and outreach program. They found that targeted marketing was effective, and that interest and take-up rates were strongly affected by messaging.

Warnings

One key misperception about LTCI is that there are other programs available to pay for LTSS when the need arises. Medicare and private health insurance (including Medigap) are often identified as sources of protection against the costs of LTSS. Such misperceptions can be addressed in a similar fashion to product warnings. That is, each year income earners receive a summary of accumulated benefits from the Social Security Administration. Likewise, every month workers are notified that they paid a Medicare payroll tax. These communications offer an opportunity to remind future beneficiaries that neither Medicare nor Social Security offer a source of insurance coverage against the costs of LTSS. Such a warning would provide regular reminders that social insurance programs that insure income against disability and provide coverage for health care do not provide protection for LTSS.

Targeted Subsidies

Johnson and Mermin show evidence that approximately 40% of older adults that use Medicaid-financed nursing home services fell into the top two terciles of lifetime earnings.[46] The implication is that a substantial portion of these people might well have been able to purchase LTCI and likely would have been better off. Mermin and colleagues extended this analysis and simulated the impact of a subsidized savings account that would cover health care costs and showed substantial savings to Medicaid for a 20% matching subsidy that was targeted to lower income groups (less than 200% of poverty line and smaller savings when targeted at 400%

of poverty).[47] The simulations also showed notable increases in the take-up of subsidized savings accounts. One possibility these observations raise is that well-targeted subsidies might both increase demand for LTCI and yield significant Medicaid savings.[x] Thus, the subsidies could be offset over time by Medicaid savings. This could be accomplished through targeted tax credits that would have to be larger than those currently used by states or through tax advantaged savings accounts where funds would be designated for the purchase of LTCI or LTSS directly.

Choice Architecture

More central role for employers and other organized purchasers

Employers frequently play central roles in the sponsorship and organization of health, disability, and life insurance. There are several reasons for this reality, which include efficiency in purchasing, the limiting of adverse-selection, and the value of these benefits in competing for labor. The new health insurance exchanges created under the ACA serve to mimic the efficiency in purchasing of large employers. Both these types of institutions are positioned to improve the efficiency of purchasing and the supply of LTCI. LTCI penetration among the working population is less than 5%, despite the fact that more than 80% of recent buyers are actively employed and the average age of individuals purchasing the policy continues to decline.[48] The majority of people purchasing LTCI do so through individual agents, group associations, or employers. This latter market has been expanding relatively more rapidly than individual coverage over the past decade and roughly 2.2 million people currently have employer-sponsored coverage.

Today, roughly 34,000 companies offer LTCI to their employees, which represent less than 0.5% of all employers in the U.S., but 20% of companies with at least 10 employees.[xi,49,50] Typically, employee take-up rates are between 5% and 7%. Pincus and colleagues suggest that there remains a great deal of untapped potential in this market and that at least 5,500 employers, representing an additional 3 million employees, have similar characteristics as employers currently offering policies.[49]

For a number of reasons, marketing insurance through employers and similar sorts of purchasers represents an attractive distribution channel for the product. First, there are economies of scale in selling so that, everything else being equal, premiums should be lower due to lower sales expenses. Second, the risk of adverse selection is diminished because workers join firms for reasons other than health care coverage and because they are actively employed. The implication is that coverage and premiums are likely to be more stable. In addition, underwriting is less rigorous in practice for employed populations, which makes coverage more inclusive and selling costs lower. Third, employers can play an important "filtering" and "soft-sales" role for the product because of the high education requirements for LTCI consumers. Employers and exchanges can both shop on behalf of employees like they do with other voluntary benefits, and also bring to bear negotiating power over rates and policy designs. Both serve to bring down premium levels. Employers are used to organizing "choices" for their employees. Finally, employers represent a natural channel for playing a larger role in increasing the number of individuals with private LTCI. Fewer than 10,000 agents actually sell the product today in any meaningful way and it is very unlikely that they will be able to reach the more than 155 million people in the labor force who are not insured.

Voluntary employer participation remains at low levels. There are a number of ways to encourage employers to either sponsor or facilitate the

[x] We recognize that the targeted income levels would be higher than in the simulations for savings.

[xi] 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.

distribution of LTCI to their workforce. As noted earlier, states or the federal government can mandate employers of a certain size to purchase or to offer approved plans to employees as part of a standard benefit choice set. We see the politics of mandated ***purchase*** as standing in the way of addressing the issue in this way. Instead we would propose that the ***offer*** be mandated. Also, a small per-employee tax credit could be provided to employers when certain take-up rate thresholds are met. This would encourage a more "active" role in the marketing approach of employers once a decision to sponsor a program has been made. If employers contribute to the purchase of a plan, preferential tax treatment of the expense should also be considered. Because of the characteristics of the potential high yield employers, a federal policy may be preferable (because of ERISA). We underscore that this would involve employers offering products sold by LTCI companies.

Forcing active choice

Given the challenges posed by low information, poor follow-through, and complexity, default choice options have potential as a powerful strategy to increase LTCI take-up. Under most current arrangements found in either the individual LTCI market or in employer-based purchasing arrangements, a consumer can choose not to enroll by simply doing nothing. In other settings, such a default results in low levels of take-up of the product in question. The CLASS Act was based on an opt-out approach. Wide scale use of a "pure" opt-out strategy may be costly and difficult to administer in the case of LTCI, especially since it is unlikely to benefit more than 30% to 40% of the population.[xii] A modified opt-out could be structured in the context of an electronic market where people were asked a series of questions about income, assets, and preferences and based on their answers could be "defaulted" into a product where they would be given the opportunity to opt-out. A more broadly acceptable and possibly practical option may be "forced active" choice approaches to expanding participation in LTCI. States have used mandated availability for specific forms of health insurance as a way to expand coverage for mental health and substance use care and there is no reason why a similar approach should not be taken for LTCI.

In other arenas, "forced-choice" mechanisms have been found to increase organ donation in Europe and in laboratory experiments in the U.S.[51] In the laboratory experiments, forced-choice resulted in significantly higher rates of organ donation endorsement than in the case where the no action default was not to endorse donation. In fact, the take-up rates were similar to the "opt-out" approach. While LTCI differs in important ways from organ donation, we believe that a forced-choice environment would result in significantly higher take-up rates than current arrangements.

Another strategy that has proven highly successful is the *Save More Tomorrow* program.[52] In the standard design, employees are given the option to commit to future increases in retirement savings that occur when they receive future pay raises. When the savings and pay increases are synchronized, employees never experience the psychological cost of having a decrease in pay. Because the increases are automatic, savings decisions are not thwarted by issues of follow-through or complexity. In the first implementation of this program, 78% of those offered took up the program, committing to 3% savings increases when they received pay increases of 3.25-3.5%. Four years later, savings rates for this group reached 13.6%, with many employees saving at the maximum 15% match rate. Just as important, employees did not seek to reverse the default saving increases despite the low transactions cost of doing so. *Save More Tomorrow* programs have been adopted by Vanguard, T. Rowe Price, TIAA-CRED, Fidelity, and Hewitt Associates, and are available in thousands of employer retirement plans.[53]

[xii] We arrive at this number by taking the largest estimates of Medicaid crowd-out as a percentage of all potential buyers and subtract that from 100%. The estimates of crowd-out were reported by Brown and Finkelstein (see note 17).

TABLE 4 Possible Solutions to LTCI Market and Policy Design Challenges

Demand Solution Set	Supply Solution Set
• Simplify/standardize products	• Create reinsurance pool
• Index premiums	• Expand employer role
• Expand educational campaign and warnings	• Foster joint marketing with health insurance
• Expand employer role	
• Mandate availability	
• Create smart opt-out/ forced-choice	
• Create targeted subsidy	

Conclusions

Americans are ill-prepared for a future with raising rates of disability and increasing spending on LTSS. Given the gridlock in Washington, a social insurance approach to this problem seems unlikely in the foreseeable future. New strategies are needed to ensure that Americans with functional impairments will not be plunged into poverty or experience sharp drops in their daily living standard.

This paper develops policy options to strengthen the private market for LTCI (see Table 4). We emphasize several key elements. First, we propose a simplification and standardization of LTCI products. This calls for limiting the number of benefits designs sold in the market, including new designs and streamlining the purchasing process. We see this as a means of reducing selling costs and increasing demand. Complementary to that is the linking of the standardized product offering to the purchase of related products (e.g. health insurance) that occur regularly for the large majority of the population. The third cornerstone of our package of policy actions involves changing the structure of risk-bearing in this market through publicly organized and privately financed reinsurance. Alongside that basic change to the supply side is to build on past successes in mounting an educational effort that informs and makes salient the risks and costs of needing LTSS, and the benefits of taking action to mitigate risks. We expect this to shift demand and better align products and preferences. Targeted subsidies would aim to encourage LTCI take-up among the segment of the population that may be able to afford some LTCI and who are most likely to spend down to Medicaid in the absence of any private protections. Finally, we would aim to alter the choice environment so that more favorable purchasing conditions are put into place using employers and other institutions. In addition, offers would be structured so that passivity did not default people out of the market.

While private LTCI as currently constructed has had a disappointing track record, we think there is scope to expand the role of private insurance in modest but meaningful ways. Based on simple projections, we believe that our package of policies could more than double the share of adults over age 55 with LTCI. We also hope that an expansion of LTCI would serve to bolster the financial footing of the Medicaid program that serves as the nation's LTSS safety net.

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