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## The Promise and the Reality of Long-Term Care Insurance

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**OVERVIEW** — *The aging of the nation's population will create a surge in the need for long-term care services, putting pressure on existing funding sources and fueling demand for more. This paper examines one financing option—private long-term care insurance—and summarizes its brief history and the several critical precedents that have influenced the products as currently sold. Other topics discussed include the challenges to encouraging sales growth as well as increasing the role of this type of insurance in paying for long-term care.*

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# The Promise and the Reality of Long-Term Care Insurance

Since the early 1980s, the warnings have been clear: the aging of the baby boom generation will create massive financing challenges for federal and state governments.<sup>1</sup> Substantially more people will be eligible for Social Security and Medicare, and they will not only need more acute and chronic medical care services, but also more appropriate services: home and community supportive care and medical care delivered by professionals trained in geriatrics. The growth in demand for these long-term care services will greatly increase burdens on an already strained public sector system that finances most of this care.

Yet, despite growing knowledge of this vulnerability, the nation as a whole is still not adequately prepared.<sup>2</sup> Public programs cannot bear the burden currently, new trust funds have not been created, and consensus has not been reached over whether to expand Medicare or Medicaid to finance the growing demand for services. And few members of the baby boom generation are independently prepared to finance all the care they may need in their later years.

As of late, the most frequently discussed option for raising new monies to finance long-term care has been voluntary, private long-term care insurance (LTCI). Sales of such insurance over the years have grown steadily, and although more people are now protected from unexpected long-term care costs—some through the growth of annuities or savings—the proportion of older adults who have purchased coverage remains small. Moreover, it is not clear whether the growth in long-term care insurance sales will be sustained or become sufficient enough to make a major contribution in financing long-term care.

To further an understanding of the role LTCI might play in the future, this background paper provides a brief summary of its history, reviews the key milestones that have determined the characteristics of the modern LTCI products, and highlights opportunities and challenges in LTCI becoming a major payer.

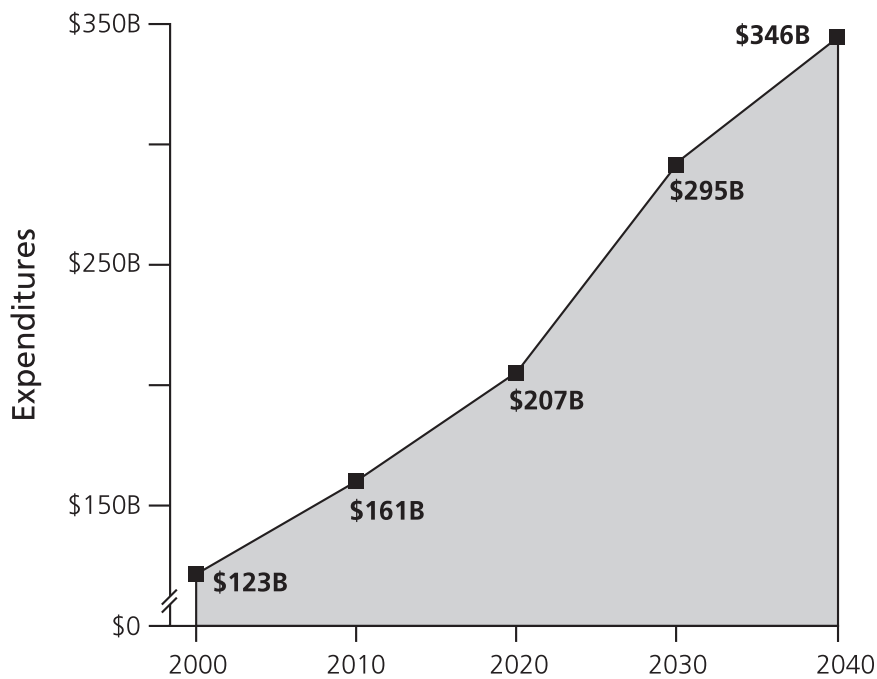
## THE AGING POPULATION: CREATING UNPRECEDENTED DEMANDS ON PUBLIC PROGRAMS

A brief look at the facts is sufficient to convey the extent of the looming long-term care crisis. Between 2000 and 2030, the number of people aged 65 and older will double, dramatically changing the proportion of the

nation's older adult population from 12.4 percent to 21.5 percent.<sup>3</sup> Older adults also have a higher prevalence of disability: one estimate puts the disability rate for people aged 18 to 64 at 3.2 percent in contrast with the rate for people aged 65 and older at 22 percent.<sup>4</sup> Given these two factors, the number of people with disabilities will swell.

With this kind of growth in the aging population, the demand for more geriatric medical and supportive services will grow substantially. The result of this increased demand will be a significant rise in long-term care expenditures for older adults, from a projected \$135 billion to \$295 billion by 2030 (Figure 1).<sup>5</sup> Such cost growth will place increased burdens on the primary payers of services of long-term care for older adults: Medicare, Medicaid, and individuals' out-of-pocket payments (Figure 2). (Although not a point of discussion in this paper, it is important to acknowledge that the growth in demand for services will also put pressure on the largest source of long-term care assistance, the unpaid care provided by family and friends.<sup>6</sup>)

**FIGURE 1**  
**Projections of National Long-Term Care Expenditures**  
**for the Aging**  
*(in billions of year 2000 dollars)*



Source: Congressional Budget Office, "Projections of Expenditures for Long-Term Care Services for the Elderly," memorandum, Washington, DC, March 1999. These numbers assume growth in LTCI sales.

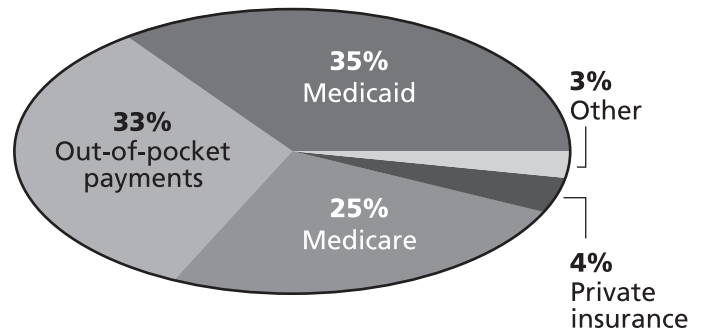
Medicare's role in financing long-term care for older adults is limited. It covers primarily medical care costs, but it also pays for some care provided by nursing homes and other suppliers of long-term care services. These services are generally received over a short period of time and are related to an acute episode. For example, the Medicare coverage of nursing home services is limited to short-term post-acute stays of up to 100 days of illness after hospitalization.<sup>7</sup> Medicare's home health benefit, the closest the program comes to paying for long-term care, does provide in-home services to some persons with chronic conditions as long as they are homebound and also need skilled care. Nonetheless, Medicare expenditures for these type of services are projected to increase from an estimated \$34 billion in 2004 to a projected \$51 billion in 2020, which is the last year projected by the Congressional Budget Office (CBO).<sup>8</sup>

The bulk of the purchased services that are more commonly associated with long-term care, that is, extended stays in nursing homes, assisted living facilities, adult day care, and in-home supportive services, are covered by the other two payers. Medicaid is the largest public sector payer of older adults' long-term care. In 2004, Medicaid's long-term care costs for older adults will amount to \$47 billion and are projected to grow to \$75 billion in 2020. The other principal "payer," consumer out-of-pocket payments, reached an estimated \$44 billion in 2004 and is projected to decline slightly to \$43 billion in 2020.

The projected total costs of Medicare and Medicaid, including acute care services, have been identified as the largest source of federal budget uncertainty in terms of spending. In 2003, the two programs consumed 3.9 percent of the nation's gross domestic product (GDP); by 2030, they could consume between 5.7 and 11.5 percent of the GDP, depending on the rate of inflation.<sup>9</sup> Thus, it is likely that there will be growing pressure to better control the growth in expenditures for the programs and not to allow them to assume more responsibility for future long-term care costs.

Some policymakers are turning elsewhere to find relief. Out-of-pocket contributions are projected to continue as a significant source of payment in the future, but many baby boomers will not have sufficient savings to cover their future health care bills entirely.<sup>10</sup> Thus, attention has turned to examining whether a growth in the purchase of private long-term care insurance can address the financing challenge.<sup>11</sup>

**FIGURE 2**  
Estimated Spending on Long-Term Care for Older Adults in 2004, by Percentage of Care Type



Source: Congressional Budget Office, Financing Long-Term Care for the Elderly, Washington, DC, April 2004. This calculation does not include informal care provided by family and friends.

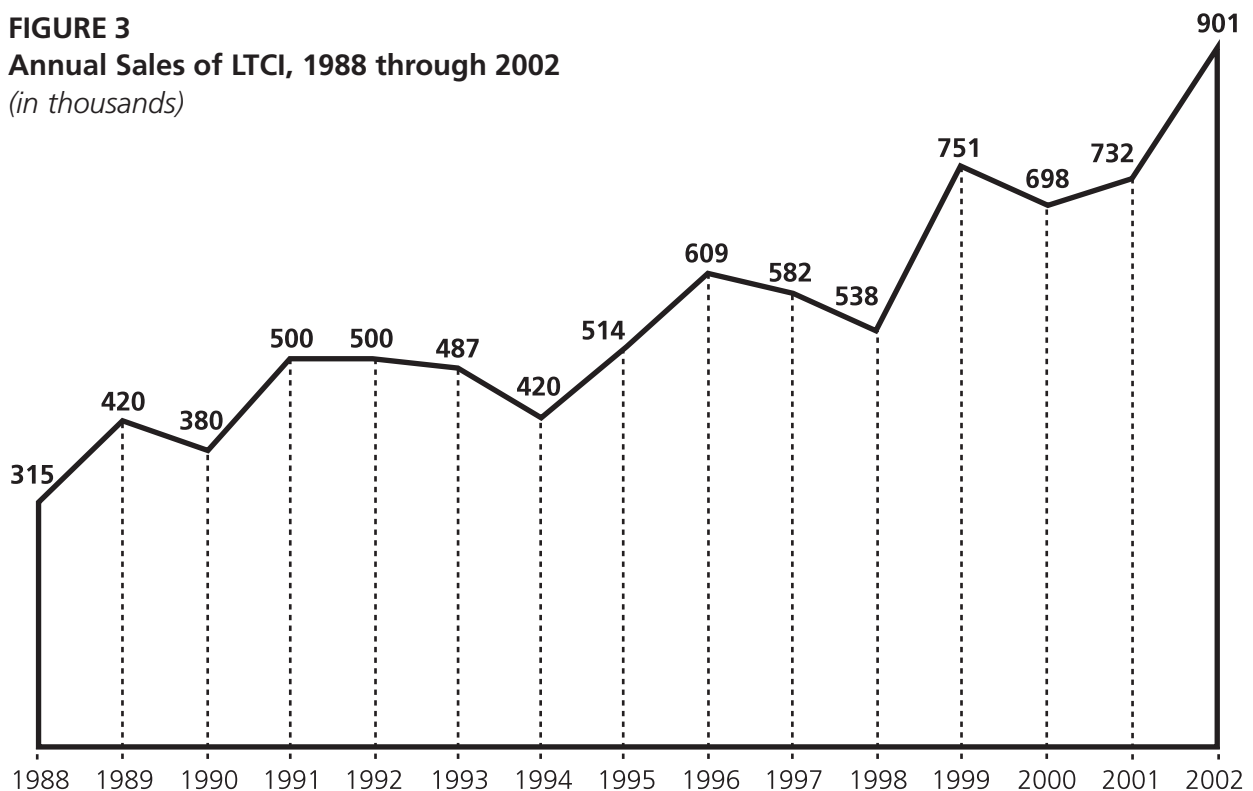
## THE ROLE OF LTCI

Voluntary LTCI plays a small role in financing the long-term care bills of older adults. In 2002, the trade association America’s Health Insurance Plans reported that \$1.4 billion was paid in claims under LTCI.<sup>12</sup> However, a CBO analysis indicated that if sales grow significantly, LTCI payments could reach \$36 billion by 2020, paying 17 percent of older adults’ long-term care bills.<sup>13</sup> Sales have been growing: from 1998 to 2002, LTCI sales increased at an annual rate of approximately 10 percent (Figure 3).<sup>14</sup>

Such figures give hope that not only will more people be protected from the risk of long-term care costs but also that increased sales can relieve some of the pressure on the struggling Medicaid program. Two studies have projected that with increased LTCI sales, Medicaid expenditures for nursing home services could be reduced by as much as 21 to 28 percent in the future.<sup>15</sup>

To achieve such Medicaid savings, sales must grow substantially, and most of the policyholders must retain their coverage over the years. For example, one of the studies projecting Medicaid savings assumed that everyone 35 and older who could afford to buy LTCI purchased it and that three-quarters of the purchasers retained their policy until 2030.<sup>16</sup>

**FIGURE 3**  
**Annual Sales of LTCI, 1988 through 2002**  
*(in thousands)*



Source: Susan Coronel, Long-Term Care Insurance in 2002, *America’s Health Insurance Plans*, June 2004.

For older adults, who were assumed to have the lowest affordability rate at 31 percent, the assumption represents a tripling of sales.<sup>17</sup> For the younger age groups, the resulting sales increase would be much higher.

## THE THREE WAVES OF LTCI

To help determine whether LTCI can achieve a growth rate in sales that meets such a goal requires a better understanding of the product, the market, and the potential purchaser. A good first step in that process is a brief overview of the three distinct phases, or waves, of LTCI's history.

### The First Wave: The Creation of LTCI

Within the family of insurance products, LTCI is one of the youngest. It first began appearing around 1970 with policies that primarily covered care delivered in facilities such as skilled nursing homes and intermediate care facilities.<sup>18</sup> Over the years, some insurers added home care services, under conditions that limited their use, which is not surprising given that at the time nursing home care was the dominant method of delivering purchased long-term care services. The policies were reimbursement-based products; policyholders were reimbursed a per diem rate (up to a daily maximum) for covered services when utilized. If the nursing home charge exceeded the daily maximum, the policyholder was responsible for the difference.

Unlike medical insurance, these early nursing home policies were not offered as group coverage through employer sponsorship. Rather, they were individual products sold through insurance brokers and agents. This reliance on the individual market generated two consequences. First, in comparison to employer-sponsored insurance, the premiums have higher administrative costs because each policy is administered on a person-to-person basis (for example, marketing, reviewing the application, processing premiums), and agent commissions have to be paid for each policy sale. The commission can be substantial for the first year, with rates of 50 to 75 percent of the first year's premium, and often 5 to 10 percent for subsequent years.<sup>19</sup>

Another consequence of basing the LTCI market on sales to individuals was the need to control adverse risk selection through medical underwriting. Adverse risk selection is a threat to the insurer's financial stability because the people with the greatest incentive to purchase coverage are the ones most likely to need the services and to utilize them sooner rather than later. To screen out bad risks, insurers conducted medical underwriting wherein the applicant would be required to respond to a series of questions regarding his or her health status, family health history, and, in some instances, undergo a medical examination.

The early days of LTCI were sometimes marked by consumer frustration. For example, some policyholders found their benefits rather restrictive: Insurers frequently stipulated that payment for nursing home care must be preceded by a hospitalization, yet many nursing home stays can be caused

**Within the family of insurance products, LTCI is one of the youngest.**

by situations or conditions unrelated to a hospitalization. A study estimated that policies with these types of requirements reduced the policyholder's chances of collecting benefits by about half.<sup>20</sup>

In some respects, the frustrating experiences were not surprising because state regulation of LTCI was also in its infancy.<sup>21</sup> For insurance regulation, the National Association of Insurance Commissioners (NAIC) develops model statutes and regulations for adoption by each state. In the first wave of LTCI, NAIC had yet to issue a statutory or regulatory model for LTCI. Consequently, many states regulated LTCI as if it were a private supplemental Medicare policy (Medigap).<sup>22</sup> For example, the requirement of a hospitalization before a nursing home stay came from Medigap regulations. (See endnote 22 for an additional example of the regulatory consequences from the initial use of the Medigap model.)

The initial wave, which ended in the mid-1980s, can be characterized as a period in which LTCI had a low profile. There were few sales because few people saw a need for coverage and not many insurers were selling the product. Insurers were cautious about entering a market in which there was so little experience on which to base product development and set appropriate prices.<sup>23</sup>

Nonetheless, major precedents were established that still influence the current market. LTCI policies are still primarily reimbursement-based products, and the predominant form of LTCI is sold on an individual, rather than group, basis. The reliance on the individual policy means most consumers rely upon an insurance agent in selecting a policy, and medical underwriting is the industry norm. Further, the use of medical underwriting results in the population with the greatest need for long-term care—people with disabilities—being denied coverage.

### The Second Wave: Growth and Controversy

The mid-1980s marked a turning point for LTCI. A new body of research examining the LTCI model as an option for financing long-term care sparked interest among insurers and policymakers.<sup>24</sup> Insurers were assisted by the development of a prototype model that aided in the design of new LTCI policies.<sup>25</sup> On the policymaker side, a congressional directive to the Department of Health and Human Services (DHHS) requested recommendations for promoting the long-term care insurance market. In September 1987, the department's task force issued a report containing 41 policy recommendations for raising public awareness over the limitations of Medicare and Medicaid, enacting consumer protection regulations, and adopting tax incentives.<sup>26</sup>

Also in 1987, NAIC issued its first recommended LTCI statute, which served as a state model for legislation to protect consumers.<sup>27</sup> The following year, NAIC issued its first model for state LTCI regulation. Among the many provisions within the recommendations was one suggesting

**Primarily, LTCI policies are reimbursement-based products sold predominantly on an individual basis.**



that states prohibit insurers from mandating hospitalization as a prerequisite for receiving skilled nursing benefits. The model regulation also suggested that policies be guaranteed renewable (that is, the insurer could not cancel a policy because of the policyholder's aging or occurrence of a disability) and that coverage should not exclude Alzheimer's disease, the condition that currently generates the most costly LTCI claims.<sup>28</sup>

Research and consumer interest have helped spur LTCI innovation. Insurers revamped their policies, such as offering optional home care coverage, and a few began experimenting with policies that gave the policyholder greater flexibility in selecting the services they wanted. One approach even melded private long-term care insurance with Medicaid.

**The Partnership Program** — The Public-Private Partnership in Long Term Care (Partnership Program) was an effort by four states (California, Connecticut, Indiana, and New York) to offer an affordable product that covered a range of facility- and home-based services. Under the Partnership Program, the policyholder's insurance would pay the initial long-term care bills. After the Partnership Program's benefit maximum is reached, the policyholder can apply for Medicaid and their assets, up to the level of protection paid for (for example, \$100,000), are not counted in determining eligibility. Medicaid then assumes responsibility for the remaining expenses for as long as care is still needed.<sup>29</sup>

Proponents of this program argued that the federal and state governments would save money. Partnership policyholders, who otherwise may have transferred assets to become eligible for Medicaid so that it would pay the entire long-term care bill, instead would pay for at least some of their care through their insurance policy. The purchasers would benefit by having their protected assets exempt from Medicaid cost recovery, should Medicaid end up paying some of the bills.

Within the four states, the Partnership Program furthered the objective of increasing consumer awareness over the value of protecting oneself against inflation. Upon purchase of a LTCI policy, the policyholder would select daily and lifetime maximum amounts to be paid for services. (See the Appendix for a description of key terms for LTCI.) Unless inflation protection is selected at the time of purchase, the maximum benefits are fixed for the life of the policy. Over a period of years, the real purchasing power of this maximum can diminish greatly. For example, some of the early LTCI policies had daily maximums of \$40 for nursing home care, which would cover less than a quarter of the average daily cost for nursing home care in 2004.<sup>30</sup>

All Partnership policies required inflation protection. Other policies in the market offered inflation protection as an optional benefit, but not everyone selected it. The decision to require such protection was controversial because it could double the premium for younger buyers.<sup>31</sup> Insurers and agents feared that this mandate would price many people

**Research and consumer interest have helped spur LTCI innovation.**

out of the market. It is impossible to precisely attribute the effect of higher premiums on sales; however, initial Partnership sales were less than anticipated.

**The Second Wave Breaks** — The luster of LTCI began to tarnish as a series of criticisms by the U.S. General Accounting Office (GAO) (renamed in July 2004 as the Government Accountability Office) surfaced, beginning in the late 1980s and continuing into the early 1990s.<sup>32</sup> One report noted many states did not adopt the NAIC model regulations quickly. More than two years after the release of the regulatory model, 11 states had not prohibited insurers from requiring hospitalization as a condition for receiving skilled nursing home benefits, 17 states had not prohibited insurers from excluding coverage for Alzheimer's disease, and 21 states did not require guaranteed renewability.<sup>33</sup> The report also raised concerns that agents did not disclose to purchasers what constituted appropriate coverage, due to examples of people purchasing multiple LTCI policies.<sup>34</sup>

Then the momentum of the Partnership Program slowed considerably. Some critics argued that the Partnership Program was an inappropriate use by middle class people of a program designed to assist low-income people.<sup>35</sup> There were also worries that there was inadequate federal oversight.<sup>36</sup> The result was a provision within the Omnibus Budget Reconciliation Act (OBRA) of 1993 requiring any new states participating in the Partnership to recover assets from the policyholder if they used Medicaid benefits. With the elimination of an important reason for a person to purchase a Partnership policy—protection of assets—state interest in the program waned.

In addition to the critical GAO reports and OBRA 1993, the 1993–1994 debate over the Clinton administration's Health Security Act, which proposed tax deductions for the purchase of LTCI and proposed a new federal program providing home- and community-based services for severely disabled people,<sup>37</sup> could have contributed to the slow down in the LTCI sales growth. Because the debate created some uncertainty over the future of LTCI, there may have been some consumers hesitant to invest in it. During the debate, LTCI sales did decline.

The second wave can be summarized as a period when LTCI became more visible to the public and policymakers. States put more consumer protection regulations in place. Annual sales increased from 315,000 policies in 1988 (the first year national sales were widely available) to 420,000 policies in 1994. Cumulative sales (that is, the total number of all LTCI policies sold) more than doubled from 1.1 million in 1988 to 3.8 million in 1994.<sup>38</sup> At the end of the second wave, around 1994, annual sales declined and LTCI ran the risk of becoming a niche product for a select number of people.

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### **The Third Wave: Renewed Interest and Growth**

Instead of retreating from the market, the LTCI insurers continued to promote and rework their products. It became more common for LTCI to cover care provided in assisted living facilities and in the home. Some began to offer payments for informal care providers.<sup>39</sup>

NAIC and the states also continued to update their oversight provisions. For example, many states incorporated activities of daily living (ADLs) into their regulations to provide greater clarity in determining when a policyholder was eligible for benefits. (See the Appendix for an explanation of ADLs and benefit triggers.<sup>40</sup>) The NAIC and several states published consumer guides for the purchase of LTCI.

In a further step to help boost sales, some employers began offering LTCI as an employee benefit, though generally requiring employees to pay the full premium.

**Government Becomes an Advocate** — In the third wave, state and federal governments assumed a new role in promoting LTCI. Several states enacted tax incentives for the purchase of LTCI.<sup>41</sup> The federal government enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Under HIPAA, taxpayers are allowed to deduct the cost of their LTCI premiums from their taxable income when they: (a) itemize their deductions, (b) have medical costs (including their LTCI premiums) that exceed 7.5 percent of their income, and (c) purchase a federally qualified plan (defined as one that meets selected provisions of the NAIC model regulations issued in 1993).<sup>42</sup>

HIPAA also clarified a tax issue. Because the benefits are paid to the policyholder and not the provider, there was confusion over whether the benefit payments constituted income and, therefore, subject to the federal income tax. HIPAA exempts LTCI benefit payments from federal income taxes.

The federal and some state governments extended their role as benefit provider by offering LTCI to their workers. The sponsoring of coverage allowed for two potential boosts in LTCI sales. First, because federal and state governments are the biggest employers in the nation, they represented the largest pool of potential buyers. Second, the governments could serve as models for other employers who might want to sponsor LTCI coverage. Two major players constitute the lion's share of the government-sponsored LTCI sales: the California Public Employees' Retirement System (CalPERS) and the federal government.

**Leading By Example: CalPERS** — California, under CalPERS, was neither the first state to offer employer-sponsored LTCI to state workers nor that with the highest percentage of employees enrolled (those distinctions belong to Alaska).<sup>43</sup> However, CalPERS was a pioneer in

**In the third wave, state and federal governments assumed a new role in promoting LTCI.**

developing marketing strategies that encouraged workers to carefully consider the ramifications of different LTCI options and the benefits of inflation protection for young buyers. By the end of the 1990s, CalPERS had the largest employer enrollment in the country, with 170,000 participants. Its program became so popular that the California legislature expanded eligibility to siblings of public employees and of retirees.

**The Federal Government Follows** — In 2000, Congress enacted and the president signed into law The Long Term Care Security Act, authorizing the federal Office of Personnel Management to offer LTCI to federal employees, military personnel, postal workers, retirees, and their spouses. Implementation of the Long Term Care Security Act was highly anticipated because it represented the largest single offering in the history of LTCI.

One innovation of the federal program was to make the inflation protection a default decision for enrollment: the applicant had to choose either “compound inflation” protection or the “step increase” option (also known as the “future purchase” option) in which the policyholder has future opportunities to increase their daily and lifetime maximums without undergoing a new round of medical underwriting.<sup>44</sup> (See “Inflation Protection” in the Appendix for further explanation.) The federal offering also represented the most organized and ambitious marketing effort ever designed for LTCI.

In several respects, the federal offering was a success. The first year’s enrollment of 200,000 made the federal program the largest in the nation, surpassing the previous leaders, CalPERS and AARP.<sup>45</sup> The federal marketing campaign, coupled with extensive coverage in the local media, is credited with the generation of additional sales in the individual market.<sup>46</sup> And, there was another positive result: almost 70 percent of the enrollees chose the best inflation protection possible, compound protection.<sup>47</sup>

Although the number of enrollees is impressive, the program did not set new marks for worker participation. The federal worker enrollment rate of 6 percent stayed within the usual 5 to 8 percent range for employer-sponsored plans<sup>48</sup> and well below the 16 percent experienced by the state government plans in Michigan and Minnesota.<sup>49</sup>

The third wave was noteworthy not only in its public-private partnering but also as the beginning of employer-sponsored LTCI coverage. It also marks a time during which the federal rules for becoming a tax-qualified plan had the effect of introducing a basic level of standardization for plans across the country.

## FOUR CHALLENGES IN LTCI

For LTCI to become a much more significant payer of long-term care services, sales must experience even greater growth than the first three waves were able to achieve, and most of those policies must be retained

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until the policyholder is in his or her 80s, when the majority of expensive claims are submitted. LTCI's success in navigating the rocky path to being a significant source of long-term care funding will relate to how four major challenges can be addressed:

- Identifying and marketing to the optimal population for purchasing LTCI
- Reducing the complexity of purchasing LTCI
- Maintaining effective consumer protection in an evolving market
- Reducing the unknowns created by LTCI's long time horizon

### Identifying the Optimal Purchaser

Public policy interest in LTCI stems from the hope that increased sales will mean fewer people left unprepared for long-term care expenses and less fiscal pressure on public programs, especially Medicaid. But sales growth alone cannot address all concerns. One issue is whether the appropriate segment of the aging population is making preparations for their future long-term care needs. Analysts are exploring this issue.<sup>50</sup>

From a public policy perspective, the people who have extensive savings, assets, and income are not especially worrisome (other than to ensure that adequate consumer protection insurance laws are in place and being enforced). These "Financially Independent" people can easily afford to purchase the most comprehensive policies and are less likely to transfer assets for purposes of becoming eligible for Medicaid.<sup>51</sup> Those at the very highest end of the income and asset scale can even afford to go without LTCI; they can "self-insure," meaning they can pay all of the costs out-of-pocket.

At the opposite end of the spectrum are low-income people with little discretionary money to pay LTCI premiums, few assets to protect, and a high risk of experiencing one or more periods of financial crisis (such as becoming unemployed) that could force them to stop premium payments.<sup>52</sup> Sales to this group is considered inappropriate.<sup>53</sup> The major public policy challenge for this group is to shore up the program on which they will depend: Medicaid. Consequently, this group has been termed the "Medicaid Bound."

**The "Tweeners"** — Between these two extremes of public program independence and dependence is a very large group of people that are able to afford their regular household and retirement expenses but may not have enough discretionary income, savings, and assets to "handle a long term care shock."<sup>54</sup> Many have not made provisions for covering their future long-term care needs and are at varying degrees of risk for having to rely on Medicaid after spending their savings and liquidating (or transferring) their assets. This group has been termed the "Tweeners."<sup>55</sup>

Some analysts suggest that policymakers should focus on encouraging the Tweeners to make better preparations for their future long-term care

**LTCI sales growth depends on successfully *finding* the optimal purchaser, *reducing* purchase complexity, *protecting* the consumer, and *reducing* uncertainty from the long time horizon.**

costs. In particular, policymakers may target public resources, say through educational activities and tax incentives, to encourage the Tweeners to make better preparations.

Tailoring public policy to address the needs of the Tweeners, however, is difficult in practice because they are hard to define: there is no clear line to differentiate Tweeners from the Medicaid Bound or the Financially Independent. Rather, the Tweeners fall along a continuum in which the more income and financial assets one has, the greater the ability to pay the premiums and the greater the interest in protecting their assets. The converse is equally true: the less income and assets one has, the lower the ability to pay premiums and the fewer assets to protect (and thus less reason to buy LTCI).

Other factors complicate attempts to define the optimal buyer for LTCI because the Tweeners may be unprepared for other types of financial shocks. For example, many insurers view working people in their 40s and 50s as a primary group for purchasing LTCI. At that age, premiums are low and people are more likely to pass medical underwriting screenings. But one critic argues that people in their 40s and 50s may have other, more pressing risks that need to be addressed first, such as preparing for their children's college expenses, building an adequate amount of retirement savings, and ensuring that their family is adequately protected with health, life, and disability insurance.<sup>56</sup>

Another report suggests an additional risk that will compete for the Tweeners' limited income. In the past few years, many private-sector employers have been limiting their contributions to retiree health coverage, with some dropping it entirely.<sup>57</sup> Authors of the report believe that the trend is likely to continue and that future retirees should accordingly set aside more savings—in some instances substantially more—to pay for future major medical health insurance coverage and uncovered acute care costs. In short, after all financial considerations are taken into account, the actual size of the Tweener market could be smaller than envisioned.

### Reducing the Complexity in Purchasing LTCI

A perennial challenge to the sales of LTCI has been consumer anxiety caused by the complexity of selecting the right policy. The LTCI market provides the consumer with lots of choices: In 2002, 104 companies marketed policies, with many companies offering more than one insurance policy and many agents selling numerous policies from several companies.<sup>58</sup> For some policies there can be over 350 potential benefit combinations to consider, each with varying effects on the premium.<sup>59</sup>

Purchases are further complicated when trying to determine the best fit between the consumer's circumstances and the many LTCI options. A person's need for long-term care varies by many factors including income level, total assets, health risk, personal preferences, housing arrangements,

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availability of public programs, supply of long-term care services, presence of immediate and extended family, and other informal support systems. And these factors are likely to change over time. Not surprisingly, the effort to understand the pros and cons of each option and to judge which combination will best suit future needs can be intimidating to potential buyers.<sup>60</sup>

### Updating and Enforcing State Regulations

Another challenge to LTCI sales growth is to build consumer confidence that there are adequate protections for this complex, ever-evolving product. States have the difficult responsibility to oversee the business of insurance, including LTCI. At its foundation the inherently complex LTCI is a hybrid insurance product that is relatively new: it is part major medical, life, annuity, and disability insurance.<sup>61</sup> Thus, regulatory provisions cannot be borrowed wholesale from the other insurance products; they must be created or refined specifically for LTCI, sometimes on a trial and error basis (see endnote 22).

The newness of LTCI coupled with the market's penchant for change and innovation generates another regulatory headache: the constant need to revise state regulations already in effect. LTCI model regulation has become the most frequently updated of the NAIC insurance models.<sup>62</sup> NAIC updates begin with the convening of a workgroup to develop the new provisions. A year or more can pass between the meeting of the workgroup and incorporating the update into the model regulation.<sup>63</sup> Another two or three years can pass before most of the states adopt their regulations, with some states adopting a different version of the model and a few not adopting it at all. Thus, not only are updates time consuming, regulatory variations persist across state lines.<sup>64</sup>

And because each state uses its own method to conduct oversight, enforcement is also likely to vary. For example, states use different methods to review new LTCI policies. Very few use a strict prior approval process in which a policy cannot be sold until the state explicitly approves the policy. Most states use variants of a model where the state must disapprove the sale of the policy within a time period (for example, 45 to 60 days); otherwise, the policy is considered authorized for sale.<sup>65</sup> Regardless of the review method, one study on state oversight questions whether some states will commit sufficient resources for oversight because LTCI accounts for less than 1 percent of the total insurance business states must regulate.<sup>66</sup>

### Addressing the Risks Created by the Time Warp

Of all the challenges to LTCI sales growth, the most perplexing result from the long time horizon between the initial purchase of a LTCI policy and the payment of claims. LTCI is constructed on the concept of

**The newness of LTCI coupled with the market's penchant for change creates the constant need to revise state regulations.**

prefunding: setting aside money today, via the payment of premiums, that over time will build into sufficient reserves to pay the claims of tomorrow. This “time warp,” in which claims can lag as long as 10 to 40 years after the initial purchase of the policy, creates challenges for both policyholders and insurers that, if not properly addressed, may result in unexpected premium hikes, dropped coverage, an insurer leaving the market, or even insurer insolvency.

There are six key types of challenges created by the LTCI time warp:

- Changing financial and personal circumstances of the consumer
- Risk of future premium increases
- Projecting the elusive lapse rate
- Estimating future earnings
- Predicting future claims
- Projecting the future rate of disability

**The Changing Financial and Personal Circumstances of the Consumer** — For some people, the period between purchase of a plan and when the policyholder needs services spans a time where personal finances and preferences change. This is particularly true for policyholders who purchase coverage in their 40s and early 50s, for most are not likely to start submitting substantial claims until they are in their 80s.<sup>67</sup> During the intervening period, a person could encounter a financial crisis that leads to missed payments and cancelled coverage, or simply decide that the money to pay for premiums could be better used for another purchase.

Dropping coverage has other consequences in addition to being uninsured for long-term care. Unlike life insurance, LTCI usually does not have equity built into the policy, so the policyholder who drops coverage would not only lose all benefits but also the cumulative value of all premium contributions. A person can buy optional protection known as a nonforfeiture benefit that allows the policyholder to stop payments but still maintain coverage at a reduced level. However, such coverage is not frequently selected because it increases the premium by about 25 percent.<sup>68</sup>

Another policyholder risk is the potential for coverage to become dated by the time claims are made. Under the reimbursement model, LTCI benefit options are fixed at the time of purchase.<sup>69</sup> Thus, the policy benefits are generally frozen in time while the long-term care delivery system changes, sometimes dramatically. In the first wave of LTCI, many policies covered only care delivered in a facility, yet home health care and adult day care have grown in popularity. Similarly, the future is likely to bring an explosion of technology alternatives that can delay institutionalization and help alleviate the projected shortage of long-term care workers. Few plans explicitly cover assistive technology.<sup>70</sup>

**The time warp between the initial purchase of LTCI and the payment of claims creates a host of challenges.**



Of course, policyholders do have the option of replacing an out-of-date policy with a more comprehensive policy. Doing so, however, would cause them to forfeit the advantages of buying a policy earlier in life due to medical underwriting screening. Premiums would likely be higher because they would be based on the policyholder's age when making the new purchase.

**The Risk of Future Premium Increases** — LTCI is usually purchased with the expectation that premiums will stay fixed for the life of the policy (known as a level premium). Some companies have never increased the premium of an original policyholder.<sup>71</sup> Nonetheless, some policyholders have experienced premium increases. Although an insurer cannot increase an individual's premium based on a change in the policyholder's circumstances (for example, getting older or becoming disabled), insurers can request an increase in the premiums for the entire group of people who purchased that particular policy. This premium increase can be necessitated by inadequate medical underwriting, premiums that were initially set too low, or insufficient growth in reserves meant to cover future claims.

Premium increases, when they do occur, have often been in the 10 to 20 percent range, although hikes of 40 percent or more have been imposed.<sup>72</sup> However, even relatively low increases can be substantial if imposed frequently: during a period of eight years, some North Dakotans received a series of increases that resulted in an overall premium hike exceeding 700 percent.<sup>73</sup>

To reduce the possibility of premium increases, the NAIC revised its model regulation in 2000 requiring companies to provide actuarial information to certify the adequacy of all proposed rates and to show that the vast majority of premium increases are devoted to paying claims.<sup>74</sup> Further, when premiums are increased, 85 percent of the increased portion of the premium must be available to cover claims. These provisions have reduced, but not eliminated, the risk of future premium increases; the uncertainty over future revenues and claims is unlikely to be reduced further.<sup>75</sup> Consequently, some LTCI consumer guides suggest a person should not purchase a policy unless they can afford at least a 10 to 20 percent premium increase.<sup>76</sup>

**Projecting the Elusive Lapse Rate** — Insurance companies must do a series of intricate calculations to project the revenue needed to build the reserves to help pay future claims. One key estimate is the number of people who decide to stop paying premiums, known as the voluntary lapse rate. In the early years of LTCI, voluntary lapse rates were often high, with some insurers experiencing annual lapse rates from 9 to 15 percent in each of the first four years, resulting in approximately 40 percent of the initial policyholders dropping coverage by the end of the fourth year.<sup>77</sup> Lapse rates that are higher than projected could actually improve the profitability of the insurer because the premiums paid

**LTCI is usually purchased with the expectation that premiums will stay fixed.**

helped build reserves and the lapsed policyholders did not draw on much (if any) of the funds devoted to paying claims.

Lapse rates seem to be shrinking, at least for individual policies.<sup>78</sup> Though such a result is positive from a public policy perspective, because it means more people are maintaining their protection against future long-term care costs, it can cause the insurer problems. A lower than projected lapse rate means there will be more people submitting claims in the future than projected. This may require insurers to raise more revenues, through either increased premiums or better earnings from reserve investments.

The importance of understanding the voluntary lapse rates cannot be over-emphasized; they can have a great impact on the number of people with protection as well as an insurance company's profitability. For example, over 25 years, even a seemingly moderate assumption of a 2 percent annual lapse rate would result in over one-third of the policyholders dropping coverage by the end of the twenty-fifth year.<sup>79</sup> A recent survey of 80 LTCI insurance executives cited the lapse rate as the most significant factor expected to impact their profitability over the next five to ten years.<sup>80</sup>

**Estimating Earnings** — Miscalculations in these projections of future earnings from the investment of the reserves may force insurers to raise additional revenue. For example, in December 2003 CalPERS raised its LTCI premiums by an average of 17 percent because their reserve investments produced earnings that were lower than projected.<sup>81</sup>

**Predicting Future Claims** — The time lag between policy purchase and claims, coupled with the relative newness of LTCI, also makes it difficult to accurately project future claims. In contrast, actuaries determining premiums for major medical insurance can make reliable projections based on complete utilization data from recent years; they need to forecast only a year in advance.

For LTCI, however, the utilization data are not sufficiently robust to ensure accurate predictions for the long term. Some of the data become irrelevant when they originate from old policies that covered only nursing home care.<sup>82</sup> More recent utilization data from newer comprehensive policies are not always representative because a relatively small percentage of policyholders have submitted claims.<sup>83</sup> Though it is expected that the structure of the nation's long-term care delivery system will change, no one knows precisely what form it will take and, therefore, what impact it will have on future claims.

**Projecting the Future Rate of Disability** — Accurate estimates of future claims also depend on a projection that may become more variable: predicting the future rate of disability. Over the decades, the disability rate for older adults has declined about 1 percent annually.<sup>84</sup> Should this decline in disability continue, the growth in future health care costs should lessen.<sup>85</sup> The decline might be greater if there are dramatic breakthrough

**The lapse rate is the most significant factor affecting insurers' profitability in the near future.**

discoveries in treatments for such chronic disabling conditions as Alzheimer's disease.

However, there is some concern that the current obesity epidemic could reduce or even reverse the historical decline in disability. One study estimates that between 2000 and 2020 with the current growth in obesity rates, the incidence of disability among 50- to 69-year-olds might increase by 18 percent for men and 22 percent for women.<sup>86</sup> If this proves accurate, the current claims projections could be underestimating future payouts.

## **EFFORTS TO BOOST SALES**

It will take time before many of the LTCI challenges are better understood and methods are developed to address them. With the oldest baby boomers fast approaching retirement, LTCI supporters assert that the federal government should stimulate sales sooner rather than later.<sup>87</sup> Consequently, several strategies for boosting sales are being proposed.

**Educating the Public** — Several studies have revealed that many people understand neither their risk of needing long-term care services nor their financial vulnerability due to limitations in Medicare and Medicaid.<sup>88</sup> The 1987 federal government task force on LTCI recommended that DHHS create a public information campaign to make people aware of Medicare and Medicaid coverage limitations. In early 2005, the department will test a public education campaign in four states to inform the public about their vulnerability for long-term care costs.<sup>89</sup>

**Adding New Tax Incentives** — There are federal proposals to make the tax deductions under HIPAA more extensive. Many LTCI policyholders do not itemize their deductions or they fail to meet the 7.5 percent medical expense threshold, limiting the effectiveness of the deduction currently allowed. The Bush administration's FY 2005 budget request proposed that the LTCI tax deduction be made available (as an "above the line" deduction) to all filers regardless of medical expenses or whether the filer itemized.<sup>90</sup> The proposed Long-Term Care and Retirement Security Act of 2003 (S. 1335 and H.R. 2096) would amend the tax code to allow the coverage of workers' LTCI premium contributions under employer "cafeteria" benefit plans (where employees get to choose among a variety of benefit options) and flexible spending accounts.

**Revisiting the Partnership Program** — There is a resurgence of federal policymaker interest in expanding the Partnership Program. A total of 17 states have enacted legislation to create a Partnership Program should the OBRA 1993 restriction requiring Medicaid recovery of assets be repealed.<sup>91</sup> The Long-Term Care Partnership Program Act of 2004 (S. 2077 and H.R. 1406) would remove the OBRA 1993 restriction on allowing additional states to create LTCI policies similar to those in the Partnership Program. The Bush administration's proposed FY 2005 budget also encourages the repeal of the OBRA 1993 restriction.

**There is a possibility that the current obesity epidemic could reduce or even reverse the historical decline in disability.**

**Tapping into Personal Assets** — Another strategy to spur sales is to encourage people to use untapped assets for the purchase of LTCI. The most discussed is having aging homeowners take advantage of their home equity via a reverse mortgage. Almost 80 percent of people age 65 and older own a home, and their average home equity exceeds \$111,500.<sup>92</sup> Homeowners can purchase a LTCI policy with the proceeds of a standard reverse mortgage, but under The American Homeownership and Economic Opportunity Act of 2000, an additional incentive has been created: the up-front premium on government-insured reverse mortgages, equal to 2 percent of the home's value, is waived if the person uses all proceeds from that mortgage to purchase a federally qualified LTCI policy.<sup>93</sup> The Department of Housing and Urban Development is responsible for promulgating the regulations.<sup>94</sup>

The DHHS Web pages on Medicare also suggest older adults consider converting other types of financial instruments to pay for LTCI premiums or for long-term care services, such as life insurance settlements, viatical settlements, and deferred annuities.<sup>95</sup>

**Sponsoring of LTCI by Employers** — A strategy championed by some insurers and policymakers is to boost the sales of employer-sponsored group coverage; only 0.2 percent of all employers with 10 or more workers sponsor LTCI.<sup>96</sup> Two options for encouraging sales are to include LTCI premiums under cafeteria benefit plans or to classify them as a medical expense to deduct from a flexible spending account.

Even without such tax incentives, however, the benefits of participating in employer-sponsored LTCI versus individual plans are still substantial. Marketing is made easier and less costly because the employer provides the insurer with a potential pool of applicants, and because materials, sales presentations, and enrollment are provided at the work site. Also, there is no insurance agent commission to pay (although consultants are often paid to organize and operate the program).

In addition to lower costs, another benefit to employer sponsorship is that medical underwriting becomes less restrictive perhaps because workers enroll in group policies at a younger age, thus reducing the threat of adverse risk selection. Some insurers in the employer-sponsored market to use the short-form of underwriting (which excludes detailed questions on medical history)<sup>97</sup> and others to enroll workers on a guaranteed issue basis.<sup>98</sup>

**Moving Beyond the Reimbursement Model** — Besides the numerous governmental initiatives for improving the sales of LTCI, some attention has shifted to examining the incentives the insurance industry might create. One idea is to adopt a policy that is more flexible than the LTCI market's prevailing reimbursement model. Under

### A Different Type of Group Market

The employer-sponsored group market for LTCI is different than that for medical insurance. Only 6 percent of employers sponsoring LTCI provide some type of premium contribution.<sup>99</sup> And less than 10 percent of workers offered LTCI actually enrolled in the benefit.<sup>100</sup> Participation rates are much higher for other types of insurance offered as an employee benefit: 32 percent for accidental death, 36 percent for supplemental life, 48 percent for long-term disability, and 83 percent for major medical insurance.

the reimbursement model, the insurer pays the policyholder (not the provider) when he or she meets two conditions: the required benefit triggers (for example, needing assistance in some activities of daily living) and the receipt of covered services.

There are several shortcomings with the reimbursement model. As already noted, services are fixed at the time of purchase, yet the long-term care delivery system continues to change. Reimbursement models also lack an important benefit common among modern major medical insurance plans: bargaining power.<sup>101</sup> Most major medical insurers negotiate with providers to obtain discounts on their payment rates, often by contracting with some type of provider network like a managed care system or a preferred provider organization (PPO). As a result, the consumer benefits from premiums that are lower than they would be if full provider charges were paid and if bills had not been lowered by smaller coinsurance payments.

In long-term care, however, insurers have not been able to negotiate significant price discounts. The problem is that the total payments by LTCI are small in comparison to Medicaid and Medicare, so the lack of a significant volume of payments, or market share, leaves insurers with an inability to negotiate which in turn leaves the policyholder to seek out and pay for services on his or her own, often at the highest rates. Thus, the pressing question to ask is, if the primary benefit is simply cash reimbursement for specific services but without a significant provider discount, why tie it to the reimbursement model?

**Disability Model as an Alternative** — An alternative to the reimbursement model is one that provides payments to the individual irrespective of the type of services being delivered. This LTCI option, known as the “disability model,” has been around for over a decade.<sup>102</sup> It provides a cash benefit once the ADL benefit trigger is met, regardless of whether the insured actually utilizes services by a health provider. The money is used by the recipient as he or she sees fit. A few insurers have been selling disability model policies, but sales are hindered by their more expensive price. The reason for the higher cost is that the disability model has one condition for qualifying for benefits (that is, the ADL requirement), whereas the reimbursement model has two conditions (that is, the ADL and receiving services covered by the LTCI policy). The addition of the second requirement reduces the likelihood of future payout of benefits.

A more radical alternative is an annuity model that links long-term care and income security through a combined life and disability annuity. One model proposes a base benefit consisting of a monthly life annuity payout of \$1000.<sup>103</sup> When a person incurs one level of disability, an additional \$2000 is added to the monthly base; for a more severe level of disability, another \$1000 monthly increment is added. This money could be used to purchase the type of services the policyholder finds most appropriate for

**A more radical alternative is an annuity model that links long-term care and income security through a combined life and disability annuity.**

his or her circumstances. This annuity model is expensive: for a person purchasing an inflation-protected policy at age 65, the one-time purchase cost is estimated to be \$219,000.<sup>104</sup>

## WHAT DOES THE FUTURE HOLD?

The obstacles to creating effective LTCI may seem daunting. The future demands for services will be great, and most baby boomers are not prepared for their future long-term care needs. Consequently, a close examination of any option addressing the long-term care financing problem will likely reveal complex challenges and present difficult trade-offs. Nonetheless, LTCI is the primary long-term care financing option most discussed as a solution.

Many factors will influence the exact role LTCI will play in financing long-term care. Some of the factors are inherent to the issue of financing long-term care: the direction and magnitude of future disability rates, a future era in which resources in the public sector will likely be increasingly constrained, and the unpredictable effects of a changing long-term care delivery system.

But other factors are more specific to LTCI: consumer awareness of the need to prepare for long-term care needs, the changing lapse rates, the effectiveness of state insurance oversight, and the growth in the employer-sponsored market. Although the effect of these individual factors is not certain, LTCI is sure to continue to change.

### A Fourth Wave?

The LTCI market is continuing to evolve, suggesting that LTCI has already entered a fourth wave of its history. Major changes include the following:

- Changes in policy coverage. Several companies are offering policies that eliminate specific benefit maximums for each major category of benefit (for example, nursing home and home health), replacing them with “pooled benefits” in which covered services can be selected in any combination; the policyholder will be paid until the overall policy maximum is reached. Several insurers have increased their spousal discounts under individual policies. And one insurer has begun offering a “cash and counseling” plan that allows the policyholder to apply the daily benefit to a wide array of home and community services.<sup>105</sup>
- Some companies provide long-term care management services that coordinate care and negotiate provider discounts.<sup>106</sup>
- Nine states have agreed to join an interstate insurance product compact proposed by NAIC whereby state insurance regulators will jointly set uniform national standards and establish a single point of filing for insurance products including LTCI.<sup>107</sup> A total of 30 states are required for the compact to take effect.

**The LTCI market is continuing to evolve, suggesting that LTCI has already entered a fourth wave of its history.**

■ Two surveys on 2003 sales provide mixed news. A survey of employer-sponsored insurance found that sales grew by 20 percent, bringing the compounded annual growth rate for the last five years to 54 percent.<sup>108</sup> But when the sales from the one-time roll out of the federal program are excluded, the remainder of the employer-sponsored market experienced a 17 percent decline in 2003. The other survey found a 7 percent decline in individual LTCI sales.<sup>109</sup>

■ Restructuring within the industry. Several companies have either merged or are no longer selling LTCI. In 2002, there were a total of 104 companies selling LTCI, 23 fewer than the year before and the lowest number since 1988.<sup>110</sup> One of the more recent exits was long-time seller TIAA-CREF, which sold its share of the business to MetLife in December 2003.<sup>111</sup>

### Window of Opportunity May Be Closing

The pressures created by the growing need to care for the aged are unrelenting. Existing delivery systems of long-term care will have to be expanded; new systems of health and medical care will have to be built; and more experts in geriatric care will have to be trained. While some of this effort may be financed by existing programs, new funds would lower the barriers to care.

The window of opportunity for developing new funding in advance of the financing squeeze will not remain open forever, and other pressures are expected to mount concurrently, creating even greater demands on scarce resources. In a 2002 testimony, the GAO noted that without “substantive reform of entitlement programs, a rapid escalation of federal spending for Social Security, Medicare, and Medicaid beginning in less than 10 years from now is virtually certain to overwhelm the rest of the federal budget.”<sup>112</sup> Prefunding long-term care needs, that is, creating financial protection of older adults through savings, social insurance, or the purchase of LTCI, could lessen the need to compete with other public programs for funding in the future.

There is no consensus on which is the best model to pursue when addressing the long-term care needs of the nation. Some prefer a social insurance model, whereas others prefer a voluntary insurance model that is based on personal responsibility. How important a role LTCI will play in either model is not clear. But the debate is likely to get heated at times. As one analyst noted, “No other part of the healthcare system generates as much passionate dissatisfaction as the organization and financing of long-term care services.”<sup>113</sup>

**Prefunding long-term care needs could lessen the need to compete with other public programs for funding in the future.**

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42. Joint Committee on Taxation, "Description of Federal Tax Rules and Legislative Background Relating to Long-Term Care" (JCX-18-01), March 26, 2001; accessed on May 24,

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43. Minnesota Department of Employee Relations, "Survey of States That Offer Long Term Care Insurance to Employees and/or Retirees," updated August 2003; accessed May 10, 2004 at [www.doer.state.mn.us/ei-gen/pdfs/STATESUR.pdf](http://www.doer.state.mn.us/ei-gen/pdfs/STATESUR.pdf).

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46. One ballpark estimate credits the federal offering for spurring the purchase of an additional 50,000 individual policies. John Haslett, Haslett Management Group, Reston, Virginia, telephone communication with author, June 25, 2004.

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48. Very few people of the other eligible groups, such as parents of workers, enrolled in a plan.

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50. See James R. Knickman and Emily K. Snell, "The 2030 Problem: Caring for Aging Baby Boomers," *Health Services Research*, 37, no. 4 (August 2002), 849-884; James R. Knickman, Kelly A. Hunt, Emily K. Snell, Lisa Maria B. Alexih, and Daid L. Kennell, "Trends: Wealth Patterns Among Elderly Americans: Implications for Health Care Affordability," *Health Affairs*, 22, no. 3 (May/June 2003): 168-174; and Mark Merlis, *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?*, prepared for The Kaiser Family Foundation, March 2003, accessed April 10, 2004 at [www.kff.org/insurance/upload/14370\\_1.pdf](http://www.kff.org/insurance/upload/14370_1.pdf).

51. The terms "Financially Independent" and "Medicaid Bound" are from Knickman and Snell, "The 2030 Problem," 864.

52. In the early years of LTCI, it was found that many low-income people were purchasing LTCI (see GAO, *Long-Term Care Insurance: Better Controls Needed*). This led the NAIC and states to set up "suitability rules" that require insurance agents to better examine the financial status of applicants in order to screen out inappropriate purchases by people who cannot afford LTCI.

53. For a report on sales to people with low incomes, see GAO, *Long-Term Care Insurance: Better Controls Needed*.

54. Knickman and Snell, "The 2030 Problem," 864.

55. The term "Tweeners" was coined by Tim Smeeding "Nonmoney Income and the Elderly: The Case of the Tweeners." *Journal of Policy Analysis and Management* 5, no. 4 (1996): 707-724. It has since been popularized by James Knickman and Emily Snell.

56. Merlis, *Private Long-Term Care Insurance*, iii.

57. Fronstin and Salisbury, "Health Care Expenses," 4.

58. Coronel, *Long-Term Care Insurance in 2002*, 16.

59. Merlis, *Private Long Term Care Insurance*, viii.

60. A survey of nonbuyers found that 46 percent responded that it was too confusing to know which policy was right for them (LifePlans Inc., *Who Buys Long Term Care Insurance in 2000? A Decade of Study of Buyers and Nonbuyers*, Health Insurance Association of America, Washington, DC, October 2000, 34).

61. Bonnie Burns, "Consumers," in *Who Will Pay for Long Term Care? Insights From the Partnership Program*, Nelda McCall, Ed. (Chicago: Health Administration Press, 2001), 128.

62. Senkewicz, telephone communication, June 23, 2004.
63. Senkewicz, telephone communication, June 23, 2004.
64. Counteracting this state variation is the practice of some insurers who voluntarily comply with the new NAIC standards, unless the state standard is more stringent.
65. Steven Lutzky, Lisa Maria B. Alecxih, and Ryan Foreman, *Long-Term Care Insurance: An Assessment of States' Capacity to Review and Regulate Rates (#2002-02)*, AARP Public Policy Institute, Washington, DC, February 2002, 9; accessed May 22, 2004 at [http://research.aarp.org/il/2002\\_02\\_ltc.pdf](http://research.aarp.org/il/2002_02_ltc.pdf).
66. Calculations by author based on the premium revenue figures cited in Lewis, Wilkin, and Merlis, *Regulation of Private Long Term Care Insurance*, 36.
67. Trapnell, telephone communication, July 12, 2004.
68. Calculations by author comparing base coverage premium rates for younger age groups with same coverage plus the addition of a nonforfeiture benefit, using data from Coronel, *Long-Term Care Insurance in 2002*, 32, table 7.
69. As for much of the industry regulations, there are variations: some states can go back to an insurer and require a previously approved policy to meet newly adopted standards.
70. More policies are including an "alternative plan of care" provision in which an insurer can approve of other services not explicitly covered under the plan, such as assistive technology. However, payment of the alternative care is usually subject to the insurance company's review and may require that the alternative service be less expensive than what would otherwise cost under the usual benefits.
71. Joyce Ruddock, MetLife Long-Term Care, telephone communication with author, April 2, 2004; and Jane Bryant Quinn, "Your Policy May Be Sold," *Cincinnati Post*, May 5, 2000.
72. There are little data available on the magnitude and frequency of rate hikes. However, the California Insurance Commissioner has produced two annual rate guides listing the recent premium rate increases requested by companies selling LTCI in that state. The reports include rate increase requests from every state the insurer that sells LTCI (California Department of Insurance, "2003 Long-Term Rate Guide," revised December 22, 2003; accessed May 24, 2004 at [www.insurance.ca.gov/SAB/Premium\\_Surveys/LTC-Rate\\_Guide/rate\\_history.html](http://www.insurance.ca.gov/SAB/Premium_Surveys/LTC-Rate_Guide/rate_history.html)). Also, increases of 40 percent or more were reported in "Thousands See Rise in Long-Term Care Insurance Premiums," *Minnesota Senior News*, Saint Paul/Minneapolis, MN, October 2003, 26, no. 10, 3; and Ann Davis, "Shaky Policy: Unexpected Rate Rises Jolt Elders Insured for Long-Term Care," *Wall Street Journal*, June 22, 2000, A1.
73. Allan Kanner, "Long Term Care Insurance," testimony before the Special Committee on Aging, U.S. Senate, September 13, 2000; accessed June 1, 2004 at <http://aging.senate.gov/events/hr58ak.htm>. After a lawsuit was filed by policyholders, the premium increases were rescinded by the insurer.
74. Kathleen Sebelius, Commissioner of Insurance, State of Kansas, "Long-Term Care Insurance: Protecting Consumers from Hidden Rate Hikes," testimony before the Special Committee on Aging, U.S. Senate, September 13, 2000; accessed April 14, 2004 at <http://aging.senate.gov/events/hr58ks.htm>.
75. Gordon Trapnell, Actuarial Research Corporation, telephone communication with author, July 28, 2004.
76. California Department of Insurance, "2003 Long-Term Care Rate Guide."
77. Lewis, Wilkin, and Merlis, *Regulation of Private Long Term Care Insurance*, 27.
78. Marianne Purushotham, Jennifer L. Douglas, and Wendy P. Weston, *Long-Term Care Insurance Persistency Experience*, LIMRA, International, Inc., Windsor, CT, 2004, 8.
79. Calculation by author. The use of a 2 percent lapse rate is for illustrative purposes only. Actual rates are higher in the early years and can be lower in the latter years.
80. Purushotham, Douglas, and Weston, *Long-Term Care Insurance Persistency Experience* 11.

81. Tom Peterson, CalPERS, telephone communication with author, July 7, 2004.
82. Lewis, Wilkin, and Merlis, *Regulation of Private Long Term Care*, 28.
83. Lewis, Wilkin, and Merlis, *Regulation of Private Long Term Care*, 29.
84. David M. Cutler, "Declining Disability Among The Elderly," *Health Affairs*, 20, no. 6, (November/December 2001): 11.
85. Cutler, "Declining Disability," 24.
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87. James Cantwell, "Long Term Care Insurance: Sooner Rather Than Later," in *Who Will Pay for Long Term Care? Insights From the Partnership Program* (Chicago: Health Administration Press, 2001), 264.
88. Nelda McCall, "Long Term Care: Definition, Demand, Cost, and Financing," 23.
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## APPENDIX

### Glossary of Key Terms in LTCI

- **Activities of Daily Living (ADL).** Activities of daily living are everyday functions and activities that able-bodied individuals can perform without help: bathing, continence, dressing, eating, toileting, and transferring oneself from a bed or chair. The ADLs are used by state insurance regulations, the federal HIPAA law, and the insurance industry as one of the prerequisites (also known as “benefit triggers”) in determining eligibility for claims payments.
- **Benefit Period.** The length of time the insurance coverage will last, with common periods of one, two, three, or five years of coverage. Some offer lifetime coverage.
- **Benefit Triggers.** In order to qualify for payment, the policyholder must meet certain conditions known as benefit triggers that determine whether a person has a physical or cognitive impairment that requires assistance with an ADL. The physical benefit trigger frequently requires assistance in two or three ADLs, whereas the cognitive impairment standard stipulates that the person needs supervision to protect him or herself or others from harm. Under reimbursement policies, the policyholder must also be receiving services.
- **Covered Services.** A policyholder can select a facility-only policy, a home health-only policy, or a combination or comprehensive policy that includes benefits for all levels of care. Facilities-only coverage means services will be paid only when the policyholder is in a nursing home, assisted living facility, or hospice. Home health care can vary; some reimburse only for licensed or certified health care practitioners, some cover untrained personnel if under the supervision of a home health agency, and others provide benefits for informal caregivers such as friends and family.
- **Daily Benefit Amounts.** Plans do not pay the provider for the service. Under the most common model, the reimbursement model, the insurer reimburses the policyholder for actual charges up to an amount selected by the purchaser. For example, the daily nursing home benefit amounts for the federal employees program range from \$50 to \$300. Home health rates are usually a percentage of the nursing home payment. Again, the policyholder can select from a range of percentages (for example, 50 to 100 percent of the daily nursing home benefit). Benefits can also be provided in weekly or monthly payments.
- **Elimination Period.** After the policyholder meets the benefit triggers, the policyholder must wait for the plan to reimburse for services; wait times can range from 30 days to 180 days. For a 30-day elimination period, for example, the policyholder would start receiving reimbursement after paying 30 days of the covered service.

*Appendix continued*

- **Guaranteed Renewability.** The insurer cannot cancel coverage because a change in the policyholder's age or health status. But the insurer can cancel for fraud or missed premium payments.
- **Inflation Protection.** Because the time between initial selection of the benefit amount and claiming benefits can be significant, the policyholder is at risk of having inadequate coverage due to rising costs in long-term care. The policyholder can select one of three inflation protection options: **fixed**, which increases the original benefit by a fixed amount each year; **compound inflation** protection, which increases the protection by an increasing amount over the years; and the **future purchase option**, which gives the policyholder the option to increase the daily benefit amount in future years without being subjected to a new round of medical underwriting.
- **Maximum Lifetime Benefit.** This is the maximum amount the plan will pay in benefits. It often is determined by multiplying the daily benefit amount for the most expensive service times the total number of days in the selected benefit period.
- **Medical Underwriting.** Because of the potential for adverse risk selection inherent with a voluntary insurance plan, insurers use medical underwriting techniques to screen out the bad risks. Thus, people with existing physical or mental disabilities, or people viewed as being at great risk of becoming disabled in the near future, are likely to be denied coverage. Employer-sponsored policies sold to the company's workers usually have less restrictive underwriting requirements for active employees.
- **Nonforfeiture.** This option allows the policyholder to maintain some reduced level of coverage if they do not make premium payments in the future. The NAIC model regulations include "contingent nonforfeiture" for people who have not selected nonforfeiture coverage and experience a substantial premium increase. The consumer has the option of paying the old premium and accepting lowered benefits, or converting the coverage to a "paid up" status with a shortened benefit period.
- **Reimbursement Model Versus Disability Model.** Unlike major medical insurance, LTCI usually does not pay providers directly. Rather, payment is made to the policyholder under one of two methods. Under the predominant method, reimbursement, the policyholder receives payment after they have met the ADL benefit trigger and have utilized a covered service. Under the less common disability model, the policyholder receives payment after they meet the ADL trigger, regardless of whether they are utilizing any services.
- **Waiver of Premiums.** Most policies include provisions that waive premium payments while a policyholder is receiving benefit payments.