

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program – the CLASS Act –but this program was deemed to be unworkable in its proposed structure and was recently repealed in the “Fiscal Cliff” legislation.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.¹ 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.

¹There 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

ⁱⁱThis 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.

ⁱⁱⁱThese 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
<ul style="list-style-type: none"> • Lack of information/shrouded attributes 	<ul style="list-style-type: none"> • Adverse selection
<ul style="list-style-type: none"> • Misperceptions about need, costs, and coverage 	<ul style="list-style-type: none"> • High selling costs
<ul style="list-style-type: none"> • Myopia, or difficulty understanding future implications of today’s choices 	<ul style="list-style-type: none"> • Inefficient risk-bearing: common shocks
<ul style="list-style-type: none"> • Consumer confusion/product complexity 	
<ul style="list-style-type: none"> • 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}

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

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%

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

^vThe 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 through 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

^xWe 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-CREF, 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.

Authors

Richard G. Frank, Ph.D., is the Margaret T. Morris Professor of Health Economics at the Harvard Medical School's Department of Health Care Policy.

Marc Cohen, Ph.D., is Chief Research and Development Officer at LifePlans, Inc.

Neale Mahoney, Ph.D., is an RWJF Scholar in Health Policy Research at Harvard University.

Acknowledgements

We are grateful for constructive comments and discussion of the issues in this paper provided by Gretchen Alkema, Mark Costello, Paul Forte, Ruth Katz, Peter Kemper, Bill Marton and Paul Van de Water.

References

1. Webb A, Zhivan N. How Much is Enough? The Distribution of Lifetime Health Care Costs. Center for Retirement Research Working Paper CRR WP 2010-1. 2010.
2. America's Health Insurance Plans (AHIP). Results from 2010 Survey of Long-Term Care Insurance Buyers and Non-Buyers. 2010. Washington, D.C.
3. Life Insurance Manufacturers' Research Association (LIMRA). Data on Number of Policies Sold and Average Premiums. 2010.
4. Johnson RW, Park J. Who Purchases Long-Term Care Insurance. Working Paper, Urban Institute. 2011; <http://www.urban.org/publications/412324.html>. Accessed November 2012.
5. Life Insurance Manufacturers' Research Association (LIMRA). Data on Number of Policies Sold and Average Premiums. 2010.
6. Krunreuther H, Meyer R, Zeckhauser RP, Slovic P, Schwartz B, Schade C, Luce MF, Lippman S, Krantz D, Kahn B, Hogarth R. High Stakes Decision-Making: Normative, Descriptive and Prescriptive Considerations. *Marketing Letters*. 2002; 13(3): 259-268.
7. CalPers. CalPers Long-Term Care Program: Special Constituent Meeting 2010 Rate Increase. Presentation December 2, 2009. Sacramento, CA.
8. Friedemann ML, Newman FL, Seff LR, Dunlop BD. Planning for Long-Term Care: Concept, Definition, and Measurement. *The Gerontologist*. 2004; 44(4):520-530.

9. Sorenson S, Pinquart M. Developing a Measure of Older Adults' Preparation for Future Care Needs. *International Journal of Aging and Human Development*. 2001; 52(2): 137-165.
10. Metlife Mature Market Institute. Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. 2011; <https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf>. Accessed November 2012.
11. Kaiser Family Foundation. The Public's Views on Long-Term Care. KFF Public Opinion Spotlight, July 2005.
12. Stum M. Financing Long-Term Care: Examining Family Decision-Making to Help Inform Policy and Practice. Working Paper, University of Minnesota, Department of Family Social Science. 2005.
13. Finkelstein A, McGarry K. Multiple Dimensions of Private Information: Evidence from Long-Term Care Insurance. *American Economic Review*. 2006; 96(4): 938-958.
14. CalPers. CalPers Long-Term Care Program: Special Constituent Meeting 2010 Rate Increase. Presentation December 2, 2009. Sacramento, CA.
15. LifePlans, Inc. A Profile of Declined Long-Term Care Insurance Applicants: A View of Selected Socio- Demographic Characteristics. Prepared for the Office of Disability, Aging, and Long-Term Care Policy; Office of the Assistant Secretary for Planning and Evaluation; Department of Health and Human Services, Washington, D.C. December 2010.
16. Cutler DM. Why Don't Markets Insure Long-Term Risk. 1996; http://scholar.harvard.edu/files/ltc_rev_0.pdf. Accessed November 2012.
17. Brown JR, Finkelstein A. The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market. *American Economic Review*. 2008; 98(3): 1083- 1102.
18. Life Insurance Manufacturers' Research Association (LIMRA). Data on Number of Policies Sold and Average Premiums. 2010.
19. Minnesota Management and Budget. The Public Employee Long-Term Care Insurance Program Study. 2010; <http://archive.leg.state.mn.us/docs/2010/mandated/100170.pdf>. Accessed November 2012.
20. Burns B. Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers. AARP Public Policy Institute Issue Paper. 2006.
21. Elbel B, Schlesinger M. How Much Choice? Nonlinear Relationships Between the Number of Plan Options and the Behavior of Medicare Beneficiaries. Working Paper, Yale University. 2006.
22. Strombom BA, Buchmueller TC, Feldstein PJ. Switching Costs and Health Plan Choice. *Journal of Health Economics*. 2002; 21: 89-116.
23. Frank RG, Lamiraud K. Choice, Price Competition and Complexity in Markets for Health Insurance. *Journal of Economic Behavior and Organization*. 2009; 71:550-562.
24. Abaluck J, Gruber J. Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program. *American Economic Review*. 2011;101(4):1180-1210.

25. America's Health Insurance Plans (AHIP). Results from 2010 Survey of Long-Term Care Insurance Buyers and Non-Buyers. 2010. Washington, D.C.
26. Bhargava S, Manoli D. Why Are Benefits Left on the Table? Assessing the Role of Information, Complexity, and Stigma on Take-up with an IRS Field Experiment. UCLA mimeo. 2011.
27. O'Brien, J. United States Office of Personnel Management. The Future of Long-Term Care: Saving Money by Serving Seniors. Testimony before the United States Senate Special Committee on Aging; April 18th, 2012; Washington, D.C.
28. National Association of Insurance Commissioners (NAIC). Tabulations from state insurance commissioner filings in 2010.
29. Thomas K, Rice T. Evaluating the New Medigap Standardization Regulations. *Health Affairs*. 1992; 11(1):194-207.
30. Metlife Mature Market Institute. Market Survey of Long-Term Care Costs: The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. 2012; <http://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf>. Accessed November 2012.
31. Bird S, Kurowski W, Dickman G, Kronberg I. Integrated Care Facilitation for Older Patients with Complex Care Needs Reduces Hospital Demand. *Australian Health Review*. 2007; 31(3): 451-461.
32. Fisher H, McCabe S. Managing Chronic Conditions for Elderly Adults: The VNS Choice Model. *Health Care Financing Review*. Fall 2005; 27(1): 33-45.
33. Grabowski D, Bramson, J. State Initiatives to Integrate the Medicare and Medicaid Program for Dually Eligible Beneficiaries. *Generations*. 2008; 34(3): 54-60.
34. Kane RL, Homyak P, Bershadsky B, Flood S. Variations on a Theme Named PACE. *The Journals of Gerontology: Series A: Biological Sciences and Medical Sciences*. 2006; 61(7): 689-694.
35. Béland F, Bergman H, Lebel P, Clarfield M. A System of Integrated Care for Older Persons with Disabilities in Canada: Results from a Randomized Control Trial. *The Journals of Gerontology; Series A: Biological Sciences and Medical Sciences*. 2006; 61A(4): 367-374.
36. Brammli S, Waitzberg R. Israel's Private Long-Term Care Insurance Market. Myers-JDC-Brookdale Institute. Jerusalem, Israel. 2011.
37. Cutler DM. Why Don't Markets Insure Long-Term Risk. 1996; http://scholar.harvard.edu/files/ltc_rev_0.pdf. Accessed November 2012.
38. Lankford K. Long-Term Care Rate Hikes Loom. *Kiplinger Personal Finance*. 2011; <http://www.kiplinger.com/magazine/archives/longtermcare-rate-hikes-loom.html>. Accessed November 2012.
39. Life Insurance Manufacturers' Research Association (LIMRA). Data on Number of Policies Sold and Average Premiums. 2011.
40. Krunreuther H. Mitigating Disaster Losses through Insurance. *Journal of Risk and Uncertainty*. 1996; 12:171-187.

41. Cohen M, Kaur R, Darnell B. Exiting the Market: Understanding the Factors Behind Carriers' Decision to Leave the Long-Term Care Insurance Market. Draft Report provided to the Office of Disability, Aging, and Long-Term Care Policy; Office of the Assistant Secretary for Planning and Evaluation; Department of Health and Human Services, Washington, D.C. 2013.
42. CalPers. The CalPers Long-Term Care Insurance Experience. 2010.
43. Stum MS, Zuiker VS, Pelletier E, Hope L. To Buy or Not to Buy: Examining Long-Term Care Insurance Decision-Making From the Employee Perspective. Research Report from the Department of Family Social Science at the University of Minnesota, St. Paul. December 2001.
44. CalPers. The CalPers Long-Term Care Insurance Experience. 2010.
45. Minnesota Management and Budget. The Public Employee Long-Term Care Insurance Program Study. 2010; <http://archive.leg.state.mn.us/docs/2010/mandated/100170.pdf>. Accessed November 2012.
46. Johnson RW, GT Mermin. Long-Term Care and Lifetime Earnings: Assessing the Potential to Pay. Working Paper, Urban Institute. 2008.
47. Mermin GT, Zedlewski SR, Toohey DJ. Diversity in Retirement Wealth Accumulation. Brief Series No. 24, Urban Institute. 2008.
48. America's Health Insurance Plans (AHIP). Who Buys Long-Term Care Insurance in 2010-2011? 2012; <http://www.ahip.org/WhoBuysLTCInsurance2010-2011/>. Accessed November 2012.
49. Pincus J, Wallace-Hodel K, Brown K. The Size of the Employer and Self-Employed Markets without Access to Long-Term Care Coverage. <http://www.thescanfoundation.org/size-employer-and-self-employed-markets-without-access-long-term-care-coverage-options>. Accessed March 2013.
50. Mercer. Mercer National Study of Employer-Sponsored Health Plans. 2010.
51. Johnson EJ, Goldstein D. Do Defaults Save Lives? *Science*. 2003; 302:1338-1339.
52. Thaler R, Benartzi S. Save More Tomorrow: Using Behavioral Economics to Increase Employee Saving. *Journal of Political Economy*. 2004; 112(1):S164-S187.
53. Thaler R, Sunstein C. *Nudge: Improving Decisions About Health, Wealth and Happiness*. New York: Penguin; 2009.

For more information contact:**The SCAN Foundation****3800 Kilroy Airport Way, Suite 400, Long Beach, CA 90806****www.TheSCANFoundation.org****(888) 569-7226 | info@TheSCANFoundation.org**** Follow us on Twitter  Find us on Facebook**