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Long-term Care

Actuarial Issues in Designing Voluntary Federal-Private LTC Insurance Programs

AMERICAN ACADEMY *of* ACTUARIES

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The American Academy of Actuaries established the Committee on Long-term Care, a group of experts in the field of financing long-term care, and charged it with providing the public an independent review of actuarial issues affecting long-term care insurance plans. The Committee monitors and comments on developments in this area at both the federal and state levels and works with regulators and policy makers to assist in developing public policies in connection with long-term-care insurance plans.

This monograph focuses on actuarial issues in federal initiatives to expand LTC insurance coverage using the existing private LTC insurance system as a vehicle. The monograph discusses a broad array of program design choices that could lead to very different levels of eligibility and participation.

The Committee neither endorses nor opposes such initiatives, nor does it view them as complete solutions to the problem of caring for the frail elderly. The Committee strongly recommends, however, that any proposals of this type that are developed be based on sound actuarial principles and fully consider the actuarial issues raised in this monograph.

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This monograph is dedicated to the memory of Harold L. (Hal) Barney, who chaired the Academy Committee on Long-term Care and was responsible for the development of this monograph. Hal provided strong leadership and direction to the work of the LTC Committee. He will be missed for his depth of knowedge, inspiration, and amiable presence.

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Executive Summary

The National Academy on Aging estimated that 7.3 million elderly Americans were in need of long-term care (LTC) in 1997. Yet, only about 6–7 percent of the 34.2 million elderly in the U.S. currently own LTC insurance. This circumstance has future implications for the Medicaid and Medicare programs, which currently cover about 55 percent of LTC costs.

Concurrently, there is no simple way to measure LTC costs because no one source tracks all costs. However, in 1995 the costs resulting from the services of LTC providers amounted to $106.5 billion, reflecting a two-fold increase in real LTC costs for each decade since 1970. Clearly, LTC is a costly and growing area.

As the population ages, the need for LTC coverage becomes ever more apparent. In order to provide for this increased need, a voluntary federal-private LTC insurance program could be considered a viable option within a more comprehensive framework involving multiple programs. Access, financing, plan design, marketing, administration, and regulation are key factors in the design of such a component program.

Access

• Access to a voluntary federal-private LTC insurance program must be consistent with the overall goals of the program. While universal access is at one extreme of possible choices, the implementation of a workable voluntary federal-private LTC insurance program will likely involve some restrictions on eligibility. Areas where restrictions might be considered include: the participant's legal status; age at application; functional status; and financial status.

• Coordination with eligibility for other federal programs providing LTC benefits will also be necessary. The design of the voluntary federal-private insurance program should be carefully coordinated with existing federal programs, particularly, Medicaid and Medicare.

• Medicare was not intended to be an LTC program but, due to the lack of a sharp line between acute and long-term care, it has evolved to the point where it now covers nearly 20% of LTC costs. The continued movement of Medicare into the LTC area will exacerbate the already difficult financing problems projected for this program.

Financing

• From a financial perspective, voluntary federal-private LTC insurance has two primary objectives: (a) to provide the means for individuals to save at after-tax rates greater than increases in the cost of LTC services; and (b) to pool their savings through insurance with those of others subject to the same risks. Since most LTC expenses occur very late on the life span continuum, through the power of compound interest it is possible to pay for a large proportion of the benefits needed; this is a particularly important consideration.

• Widespread participation in a voluntary program is attainable only when individuals perceive a positive relationship between the benefits of participation and the individual's cost to participate in the program. Congress might consider reforming current tax policy to encourage participation in a voluntary federal-private LTC insurance program.

Plan Design

• A fundamental question in structuring a voluntary federal-private LTC insurance program is deciding whether LTC insurers can continue to have nearly unlimited freedom in plan design, or whether a small number of standardized plan designs might more readily accomplish the goals of the program. Standardization in LTC plan design is currently nonexistent.

• Flexibility is critical because the LTC delivery system and the LTC insurance market are in a state of rapid evolution. Plan designs, benefit triggers, and provider definitions have and will continue to change as insurers gain expertise and as care delivery evolves.

• Greater simplicity would help consumers make choices about carriers and plan design options. Greater simplicity would also help the regulation of this product.

Marketing

• A voluntary federal-private LTC insurance program could be marketed to the public either by the participating insurers or by an agency of the federal government. Effectiveness in encouraging participation in the program and the ability to meet marketing costs per insured life are objectives for both marketing approaches.

• The expected level of participation in the program and the costs to market the program can have a significant impact on the program's financial viability and risk characteristics. In addition, the marketing of a voluntary federal-private LTC insurance program may be further complicated by the availability of both voluntary federal-private and other LTC insurance programs to consumer buyers.

Administration

The range of options that could be considered in the administration of a voluntary federal-private LTC insurance program is as broad as the range of possible programs that could be instituted. A designated government agency could assist in the administration of an LTC insurance program in several ways and at several levels of involvement. For example, the agency could:

• Provide educational material to eligibles and/or participants. Dissemination of such material would be a critical success factor to any LTC insurance program.

• Function as a mechanism for participating carriers to reach eligibles.

• Assist in developing LTC insurance regulations and in determining eligible insurance carriers.

In addition, the agency could help establish and maintain consumer confidence in the program by monitoring insurer experience and addressing consumer complaints and concerns.

Regulation

Regulation by either the federal or state government or some combination of both may impact voluntary federal-private LTC insurance product design, administration, and consumer interest.

• A voluntary federal-private LTC insurance program could be regulated solely at the federal government level, solely at the state level, or by some combination of federal and state authorities.

• The question of how the program will be regulated should be considered in the program's initial development.

This monograph describes the major actuarial issues involved in developing a voluntary federal-private LTC insurance program. It is does not address the public policy implications of these issues or recommend specific plan designs. This information will be of assistance to legislators, congressional staff, other policy makers, and other parties interested in designing such an LTC insurance program.

Developing a clearly articulated statement of goals is a logical first step in the design of a voluntary federal-private (VFP) LTC insurance program. Given the range of options identified, these goals will help define the ultimate design of such a program.

Designing a VFP LTC insurance program is a complex task. Much of the complexity derives from the voluntary nature of the program. Once the decision is made that participation in the program will be a voluntary choice, then all of the issues described above become relevant. What is perhaps surprising is that not all voluntary programs are the same, or even similar. The range of options identified above indicates that there are numerous ways to design a voluntary program that would be consistent with specific federal policy objectives. This suggests that a first step in the design of a VFP LTC insurance program could be to develop a clearly articulated statement of the program's goals. This statement could then be matched against each issue to narrow the options to a set consistent with those goals. These sets could then be matched across issues for coherency, eliminating contradictory or inconsistent choices, to array all alternative program designs consistent with the stated goals. Choices among these options would then depend on further analysis of their public policy and actuarial implications. The Academy Committee on LTC could assist with the latter assessment.

Introduction

This monograph focuses on actuarial issues in federal initiatives to expand long-term care (LTC) insurance coverage using the existing private LTC insurance system as a vehicle. The monograph was prepared to respond to questions from legislators, congressional staff, and others developing proposals to deal with the financing of LTC in an aging population. The development of this monograph should not be interpreted as an endorsement of proposals of this type as the most appropriate solution to the LTC financing issues facing the U.S. Instead, it is the view of the Academy Committee on LTC that there exist many different possible forms of solutions to these issues, and that the choice of which is the most appropriate is a public policy issue. The Committee does endorse the use of sound actuarial principles in developing all alternative proposals, and its intent in this monograph is to clearly identify the actuarial issues that should be addressed in designing voluntary federal-private LTC insurance programs that build on the existing private LTC insurance system.

Given this limited scope, the approach of the Committee in writing this monograph was to:

• define the problem within the context of existing LTC financing systems,

• present a framework for the design of legislative proposals that might supplement existing public and private plans, and

• identify issues that must be addressed and discuss their actuarial implications.

It is not within the scope of this monograph to discuss the public policy implications of these issues, nor to recommend specific plan designs. The Committee's view is that legislators, congressional staff, and other policy makers should develop specific plan designs. This monograph is intended to be of assistance in those efforts. A continuing role of the Committee will be to respond to specific proposals that may be developed, with an independent and impartial review of their actuarial implications.

Below are three very different approaches to federal involvement in the financing of LTC:

• A mandatory federal LTC insurance program could be instituted. Such a program was proposed by the Clinton administration in the 1993 Health Security Act as a program of state-run block grants with federally determined budget caps. The American Academy of Actuaries Long-term Care Workgroup reviewed the actuarial issues in that program in 1994 (see No. 16 in the Academy Monograph Series on Health Care Reform).

• A voluntary federal LTC insurance program could be instituted which would be designed, marketed, and administered by the federal government or its contracted vendors, to the exclusion of private insurance. The federal government would contract directly with participants insured under the program.

• A voluntary federal-private (VFP) LTC insurance program could be instituted. Such a program could involve voluntary participation of individual enrollees in private LTC insurance plans with some level of federal oversight and participation. Because private LTC insurance already exists in the U.S., and the tax status of qualified LTC insurance policies was substantially clarified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it might appear that the U.S. already has a viable VFP LTC insurance program in place. Unfortunately, at this time, private LTC insurance covers only a small percentage of the population currently in need of LTC services.

Stimulating voluntary participation in LTC insurance programs, whether private or public, has been suggested as a viable approach to reducing the funding problems present in the Medicaid and Medicare programs. To the extent LTC services could be paid for by those participants using the prefunding mechanism of a voluntary program, the necessity to use tax revenues would be reduced.

This monograph discusses only the actuarial implications of a VFP LTC insurance program involving private insurers and does not deal with either a mandatory program or exclusively federal program. Proponents of all three types of programs, however, need to consider these issues in some way. Legislators and congressional staff can design many variations of a VFP LTC program depending upon the degree to which the federal government is involved in its operational components.

The actuarial issues are grouped into six areas:

• **Access**—What restrictions, if any, would be placed on access to the program? Would the voluntary nature of the program extend to allowing insurers to reject applications through an underwriting process? What provisions would be made for persons who either fail to apply or are rejected through underwriting? How would VFP LTC insurance interact with Medicaid and Medicare?

• **Financing**—What would be the most effective funding mechanisms? How would the funds be invested? What alternative uses of the funds would be permitted? What tax incentives, if any, would be included to stimulate participation? What limits would be placed on contributions?

• **Plan Design**—What restrictions, if any, would be placed on the designs of the plans? What are appropriate minimum standards?

• **Marketing**—Which segments of the eligible population should be targeted? What impact would underwriting have on the price and affordability of the coverage? Should the existing private sector distribution methods be used for a VFP LTC insurance program?

• **Administration**—Recognizing the multitude of services necessary, e.g., premium collections, policy issuance, benefit payments, etc., which services are best accomplished by the private or public sectors? How would contracted benefits be administered to manage the cost of LTC and deliver appropriate care?

• **Regulation**—How would existing state regulation fit within an expanded federal-private program? What impact would more federal regulation have on the existing private system?

These and other important questions should be considered by legislators, congressional staff, and other policy makers in any proposals that may be developed for a VFP LTC insurance program.

Designing an insurance program requires an understanding of the interactions among the issues that must be addressed. For example, one important consideration in the design of any voluntary insurance program is the impact of underwriting on affordability and participation. The level of premiums will depend on the extent to which the applicants are healthy and not in current need of LTC services at the time of enrollment. Willingness to participate will depend on the level of premiums (i.e., affordability). The percentage of the population eligible to participate (i.e., accessibility) will be defined by the level of good health required at the time of application. Unless good balance is achieved between affordability and accessibility, a voluntary program will fail to achieve a high level of participation.

This monograph contains three sections:

• A **Background Section** provides basic information on the current and future size of the LTC disabled population and cost of LTC services in the U.S. The impact of population aging and the role of prefunding are identified and discussed in the context of LTC (beginning on page 5).

• An **Issues Section** provides both an overview and detailed discussion of issues in the six areas identified above. To the extent that these issues are relevant to the existing private LTC insurance industry, the experience of this industry is described. Some similarities of goals within a VFP LTC insurance program and the existing private LTC insurance industry include (a) voluntary participation, (b) prefunding of benefits, and (c) affordability (beginning on page 9).

• A **Conclusion Section** recommends that a clearly articulated statement of program goals be developed as a logical first step in designing specific VFP LTC insurance proposals. This would facilitate a coherent and consistent treatment of all actuarial issues that impact on program design (page 22).

Background

A prerequisite to designing a VFP LTC insurance program that will successfully meet the LTC needs of the U.S. population is an understanding of those needs and how existing programs fail to meet them. This section provides background to assist readers unfamiliar with LTC to get a quick overview of these topics.

LTC is a wide range of health and social services.

Long-term care, or LTC, is a wide range of health and social services that may include adult day care, custodial care, home health care, hospice care, intermediate care, respite care, and skilled nursing care. LTC is generally necessitated by the development of chronic disability, which may result from a variety of medical conditions such as cancer, heart disease, chronic lung disease, arthritis, osteoporosis, stroke, Parkinson's disease, AIDS, and Alzheimer's disease and other forms of dementia. It is the chronicity of the disability that distinguishes LTC from acute care. Thus, LTC does not generally include short-stay hospital care.

LTC recipients can be classified in a variety of ways.

Many classification systems of people in need of LTC services exist today. Two widely used systems are described below:

First, the classification system used in the National Long-term Care Survey (NLTCS; Manton et al., 1997) classifies LTC recipients according to whether a person is resident in an LTC institution or in a non-institutional community setting. The latter are further classified according to the number of basic activities of daily living (ADLs) for which help is required, or, if none, according to the number of more complex instrumental activities of daily living (IADLs) for which help is required. At least one of these activity-limitations must last or be expected to last 90 days or longer in order for the person to be classified as LTC-disabled in the NLTCS.

Seven basic ADLs are measured in the NLTCS: bathing, dressing, toileting, transferring, eating, continence, and inside mobility. Tabulations in the NLTCS typically delete continence from the basic ADL list. Nine IADLs are measured in the NLTCS: housework, laundry, cooking, grocery shopping, outside mobility, travel, money management, taking medications, and telephoning.

The NLTCS tabulation rules result in a hierarchical classification ranging from IADL to ADL to institutional LTC needs, which are roughly related to the severity of the underlying disability. Severely disabled persons are often defined as persons with three to six ADL limitations or institutionalized persons (although some institutionalized people are limited in less than three ADLs). Persons with one to two ADL limitations or any number of IADL limitations are then classified as mildly disabled.

Second, the classification system introduced by HIPAA was designed to focus primarily on severely disabled persons, and also introduced specific criteria for dealing with cognitive impairments that are not associated with ADL limitations. To gain the advantages of tax-qualified LTC coverage under HIPAA, a person can be eligible for LTC insurance benefits only if a licensed health care practitioner certifies that the individual satisfies one of three criteria (triggers):

- ADL Trigger—the individual is unable to perform without substantial assistance from another individual at least two out of six ADLs for at least 90 days due to a loss of functional capacity; or

- Similar Level Trigger—the individual has a level of disability similar to the level in the ADL Trigger; or

- Cognitive Impairment Trigger—the individual requires substantial supervision to protect him/herself from threats to health and safety due to severe cognitive impairment.

Such persons are defined as chronically ill individuals by HIPAA and it is clear from the wording of the ADL Trigger that chronicity is an integral part of the definition. Thus, HIPAA provides favorable tax treatment for certain types of LTC insurance policies provided that a health care practitioner certifies the individual will need assistance for at least 90 days.

HIPAA deletes inside mobility from the ADL list used by the NLTCS and allows insurers to delete one of the remaining six ADLs. Thus, in practice, the ADL Trigger may become two of five ADLs—which is more severe than two of six ADLs—thereby allowing insurers the option of using more stringent benefit qualifiers. HIPAA does not specifically mention IADLs in defining LTC benefit triggers, but it is likely that persons who are so severely impaired that they satisfy the cognitive impairment trigger would have difficulty with at least some of the IADLs. It is also possible that certain combinations of ADLs and IADLs could satisfy the Similar Level Trigger, but that option has not been clarified in the current regulations of the IRS.

The private LTC insurance market is small but is growing rapidly.

The Health Insurance Association of America (HIAA, 1998) reports that the cumulative number of LTC policies sold increased from 815,000 at year-end 1988, to 2.93 million at year-end 1992, to 4.96 million at year-end 1996. With recent sales growth at 14 percent per year, this projects to about 6.5 million LTC policies sold by year-end 1998.

Currently there are about 3.5–3.7 million in-force LTC insurance policies.

Estimates of the number of in-force LTC insurance policies are less certain. HIAA (1998) reports that individual and group-association sales represent 80 percent of all cumulative sales, with an average issue age of about 67 years. The remaining 20 percent are attributable to employer-sponsored LTC plans (13 percent) and life insurance LTC riders (7 percent),

each with an average issue age of about 42 years. Bodnar (1995) presents statistics on the number of in-force policies for the individual and group market (which includes both group-association and employer-sponsored plans, but not life riders) for year-end 1992 and 1993; these are about 54–57 percent of the HIAA cumulative sales numbers for the same types of policies. The differences are attributable to lapses, policy replacements, and deaths. Application of these lapse rates to the estimated 6.5 million LTC policies sold by year-end 1998 yields an estimate of 3.5–3.7 million LTC policies currently in force.

About 60–64 percent of all in-force LTC policies are currently owned by the elderly.

Estimates of the percentage of in-force policies owned by the elderly are even less certain. Bodnar (1995) reports that 65 percent of policies issued in the individual market in 1994 were to purchasers aged 65 and older, with an average issue age of 68. This agrees closely with the average issue age of 67 reported by HIAA (1996) for the combination of individual and group-association sales in 1994. Bodnar's lapse rates suggest that the average duration of ownership is about three years, implying that 75–80 percent of the individual and group-association policies are owned by persons currently age 65+. Because these types of policies account for almost all policies held by the elderly, this suggests that about 60–64 percent of all in-force LTC policies are owned by persons currently age 65+.

About 6–7 percent of the elderly currently own in-force LTC policies.

Taken together, these factors suggest that there are currently about 2.1–2.4 million elderly with in-force LTC policies, representing about 6–7 percent of the 34.2 million elderly. This estimate compares with Wiener's (1996) estimate of 4–5 percent in mid-1996, and implies an overall growth of about 14–18 percent per year in the proportion of elderly with in-force LTC policies.

The National Academy on Aging (1997) estimated that up to 13 percent of the elderly could have owned in-force LTC policies in 1995. This estimate was also based on the HIAA cumulative sales reports, but the estimate did not reflect any of the downward adjustments described here.

LTC is a costly and growing area.

There is no simple way to measure LTC costs because no one source tracks all costs. In the National Health Accounts (NHA), LTC includes spending for care received through free-standing nursing homes and home health agencies. Levit et al. (1996) suggest that these costs include only about 90 percent of actual LTC expenditures, and this does not account for the enormous amount of LTC provided without charge by family members in the U.S. Figure 1 (page 24) displays LTC costs from the NHA from 1960 to 1995, in constant 1995 dollars. The 1995 cost was $106.5 billion and this reflects a doubling of real LTC costs each decade since 1970. Clearly, LTC is a costly and growing area.

Medicaid and private out-of-pocket funds pay for most LTC.

Figure 2 (page 25)displays the distribution of expenditures for services of LTC providers by the sources of funds in the 1995 NHA. Public funds pay for 57 percent; private funds 43 percent. Medicaid is the largest public source (37 percent of all funding), Medicare is second (18 percent). Private funds are primarily out-of-pocket (32 percent). Most significantly, private health insurance (which includes LTC insurance) pays 6 percent.

Most persons in need of LTC are elderly.

The National Academy on Aging (1997) estimated that 12.8 million Americans were currently in need of LTC. The age breakdown of these estimates, however, gives two very different pictures of the problem.

First, direct stratification of the LTC estimates by age yields 420,000 children aged 0–17 years (3 percent); 5.09 million adults aged 18–64 years (40 percent); and 7.33 million adults aged 65+ years (57 percent). Most persons in need of LTC are elderly, but a significant number of nonelderly are also in need.

Second, one can estimate the fraction of the total population in each age group in need of LTC. To do so, the Committee used the U.S. Census Bureau population projections for 1995 (Day, 1996) to estimate LTC prevalence rates of 0.6 percent, 3.2 percent, and 22 percent, respectively for ages 0–17, 18–64, and 65+. Thus, the elderly are at a risk level seven times larger than that of the working-age population.

The elderly populations LTC needs increase dramatically with age.

This is shown in Figure 3 (page 26), where the LTC prevalence rates for 1982 and 1994 are displayed by age and severity of disability. The figure shows the overall prevalence of LTC disability is composed of a relatively low rate for age 65–74 (11–14 percent), an intermediate rate for age 75–84 (26–31 percent), and a high rate for age 85+ (59–64 percent). The age increase is even steeper for severe LTC disability (defined as institutional or three-plus ADLs) rising from about 5 percent at age 65–74 to better than 40 percent at age 85+. The steepest age increase is for institutionalization, rising from under 2 percent at age 65–74 to 24–26 percent at age 85+. In each case, the 1994 rate is lower than the 1982 rate.

Middle-aged persons also face increasing LTC risks with age.

Institutionalization is a small but increasing risk prior to age 65. For example, at age 45–54 the prevalence is about 0.2 percent; and at age 55–64, about 0.4 percent (Hing et al., 1989). These estimates can be combined with ADL/IADL prevalence rates from the National Health Interview Survey to obtain overall LTC prevalences of 3.7 percent at age 45–54 and 6.6 percent at age 55–64 (LaPlante and Carlson, 1996).

McNeil (1993) studied the effect of expanding the ADL/IADL criteria to include:

- wheelchair use for six-plus months;

- Medicare or SSI enrollment prior to age 65;
- inability to work a job or housework; and
- selected conditions such as Alzheimer's disease, senility, dementia, mental retardation, cerebral palsy, or autism.

These criteria resulted in an overall disability prevalence estimate of 8 percent for age 15–64; with estimates of 11 percent and 21 percent for ages 45–54 and 55–64, respectively. To the extent that these criteria are predictive of immediate or later need for LTC, they indicate the size of the population that might not be eligible to purchase LTC insurance. It is significant that the rate doubles from age group 45–54 to 55–64. This suggests that encouraging enrollment at younger ages will increase the percentage of the population that will be insurable. These estimates are consistent with an LTC underwriting rejection rate of 12–23 percent at age 65 (Murtaugh et al., 1995).

Population aging will significantly increase the need for LTC.

Population aging is a demographic phenomenon in which the composition of the population shifts to older ages. From 1995 to 2040, the Social Security Administration (SSA) projects a 5.4 percent increase in the population aged 0–19 years, a 24 percent increase at age 20–64, and a 115 percent increase at age 65+ (Bell and Kumar, 1996). Applying these rates of growth to the LTC prevalence estimates cited above (i.e., 420,000, 5.09 million, and 7.33 million, respectively) yields a total of 22.4 million persons in need of LTC in 2040, with 443,000 aged 0–17 (2 percent), 6.3 million aged 18–64 (28 percent), and 15.6 million aged 65+ (70 percent). Thus, the LTC population could increase by 75 percent (from 12.8 to 22.4 million people) over the next 45 years, with most growth at older ages.

Actually, the estimated increase should be modified to reflect the effects of two additional, partially offsetting, factors. First, it is necessary to account for the changing age composition within the elderly population aged 65+. This is because the risk of LTC is highest at the oldest ages. Figure 4 (page 27) shows the growth of the elderly LTC population based on applying age-specific LTC prevalence rates for seven five-year age groups (i.e., ages 65–69, 70–74, 75–79, 80–84, 85–89, 90–94, and 95+; summarized in Figure 3) to SSA projections, with the 1994 rates applied to years 2000 and beyond. With this adjustment, the projected LTC population increases from 12.8 to 24.6 million people by 2040—an increase of 92 percent.

Second, it is necessary to account for expected continued reductions in age-specific LTC prevalence rates among the elderly in future years. A decline of 0.6 percent per year is consistent with the decline at age 85+ in Figure 3 for the period 1982–94, and also with the decline for chronic health conditions calculated by Fogel and Costa (1997) for age 65+ for the period 1910–88. Figure 4 (page 27) shows the impact of a reduction in age-specific LTC prevalence rates among the elderly of 0.6 percent per year after 1994. In this case the projected LTC population increases from 12.8 to 20.3 million. Together, the two adjustments imply an increase of 60 percent (not 75 percent) in the total LTC population between 1995 and 2040. This calculation reflects the growth in the burden of LTC on the working population (which is projected to grow only 24 percent over the same period).

To determine the burden of LTC on the financing of a VFP LTC insurance program, it is necessary to project the growth of severe LTC disability among the elderly because the severely disabled will account for most of the expenditures. These projections are shown in Figure 5 (page 28). If the prevalence rates underlying Figure 3 remain constant (as in the first adjustment above), then the severely LTC disabled elderly population would increase from 3.9 million in 1995 to 9.8 million in 2040 (a 150 percent increase—significantly more than double); if the prevalence rates decline 0.6 percent per year (as in the second adjustment above), then the 2040 estimate would still be 7.4 million (a 90 percent increase—almost double today's number.) The second estimate is preferred, the absolute increase of 3.5 million is large, and the relative increase of 90 percent is much larger than the 60 percent estimated for all LTC statuses combined. Thus, this calculation shows the increased burden of LTC that would be financed by a VFP LTC insurance program.

Population aging will significantly increase the cost of LTC.

These factors suggest that the aggregate real burden of LTC will almost double by 2040 while SSA projects the working-aged population to increase less than 25 percent. Thus, there will be continuing pressure on the current pay-as-you-go means-tested public programs such as Medicaid and non-means-tested public programs such as Medicare to increase LTC expenditures faster than revenue growth. These pressures will add to similar pressures already recognized by the Board of Trustees of the Social Security and Medicare programs in their annual reports to Congress.

As a consequence, it will be difficult for the public sector to maintain its current share of LTC expenditures without significant tax increases. This suggests that the private sector may retain, or possibly increase, its share in terms of out-of-pocket expenditures, private LTC insurance, or informal (unpaid) care.

An increase in private LTC insurance could help meet those costs.

One strategy that has been considered to promote an increase in the private sector's share of LTC expenditures is federal involvement in the private LTC insurance market. The use of a private LTC insurance mechanism means that the private sector, not the federal government, could bear the financial risks associated with future costs of LTC for groups of insureds. The voluntary acceptance of those financial risks by private insurers characterizes one approach to designing VFP LTC insurance programs.

A distinguishing feature of existing private LTC insurance is the prefunding of LTC expenses. Under prefunding, revenues are matched to expenditures through a set of actuarial calcula-

tions that yield, for each individual, the constant amount of money (i.e., a level or flat premium) that individual needs to set aside each year in order to meet his or her expected lifelong LTC costs. Figure 6 (page 29) illustrates the typical pattern of increasing claim costs with age. Prefunding is essential to the design of affordable LTC policies since LTC expenditures mostly occur at the oldest ages. In general, the younger the age at which a policy is issued, the lower the level premiums. Thus, prefunding is an effective strategy to deal with LTC costs of an aging individual.

Less commonly recognized, prefunding may also be effective in dealing with LTC costs in an aging population. It may resolve the problem of divergence between expenditures and revenues that occurs in a pay-as-you-go system when the number of beneficiaries increases faster than the number of persons contributing funds. To the extent that only a portion of the population participates in prefunded LTC insurance plans, prefunding can represent only a partial solution to this problem. The larger the portion participating, however, the closer one gets to a complete solution.

Because private LTC insurance already exists in the U.S. as a working voluntary prefunded system, it makes sense to consider design issues for any new VFP LTC insurance program in the context of the existing system. A short-term goal of federal involvement could be to stimulate the voluntary participation of large segments of the population in private LTC insurance plans; a long-term goal could be to increase the ability of program participants to fund their own LTC costs. Nonetheless, because participation would be voluntary and may not be affordable or accessible to all segments of the population, there may be a continuing need for LTC services provided through Medicaid and Medicare. Thus, a VFP LTC insurance program may only be a partial solution to the LTC needs of the U.S. population; but some proponents feel it would be a significant first step. The remainder of this monograph discusses actuarial issues involved in designing such a program.

Actuarial Issues in Program Design

I. ACCESS

Overview

Access to a VFP LTC insurance program must be consistent with the overall goals of the program. While universal access is at one extreme of possible choices, the implementation of a workable VFP LTC insurance program will likely involve some restrictions on eligibility. Areas where restrictions might be considered include the participant's legal status, age at application, functional status, and financial status. Coordination with eligibility for other federal programs providing LTC benefits will also be necessary.

Underwriting screens control the access to insurance programs in order to ensure premium adequacy for the appropriate class of insured. Private insurance has standards that historically have varied but have become more uniform in recent years. Between the extremes of guaranteed issue and extensive underwriting, the VFP LTC insurance program could construct a set of standards that achieve the desirable level of participation.

The design of the VFP LTC insurance program should be carefully coordinated with existing federal programs, particularly Medicare and Medicaid. Medicare was not intended to be an LTC program but, due to the lack of sharp line between acute and long-term care, it has evolved to the point where it now covers nearly 20 percent of LTC costs. The continued movement of Medicare into the LTC area will exacerbate the already difficult financing problems projected for this program. Medicaid, in contrast, was designed to cover LTC costs for qualified individuals who meet specified limits on income and assets. Thus, Medicaid serves as a safety net for individual Americans who are unable to meet their LTC costs. One goal of a VFP LTC insurance program could be to increase the projected numbers of persons who can meet their LTC costs by substituting a planned predictable series of VFP LTC insurance premiums for the unplanned and unpredictable consequences of catastrophic LTC expenditures. Careful evaluation of the impacts of various design options on the size of the Medicaid eligible population will be essential to program coordination.

1. Eligibility/Target Market

Who will have access to the program? One rationale for federal involvement in voluntary LTC financing could be to stimulate increased participation of the U.S. population in LTC insurance plans. Other important goals may be increased consumer protection and reduction of the LTC cost burden on federal and state programs. It is important to clearly articulate the program's goals and to ensure that the access provided is consistent with those goals.

Four component issues that have to be addressed with respect to an applicant's eligibility are the applicant's: (1) legal status; (2) age; (3) functional status; and (4) financial status.

Legal status refers to restrictions based on residency and citizenship. Perhaps the broadest definition of eligibility would include all citizens and all legal residents of the U.S. Because these statuses can change over the life of an applicant, and because many proposals would be funded by applicant contributions, the impact of different cutoffs of eligibility based on legal status should be carefully evaluated.

Applicant's age refers to the attained age of the applicant at the time he or she initially joins the program. It is in the nature of LTC insurance that the average annual costs of benefits increase sharply with age. Thus, insurance costs, computed on a level premium lifetime basis, are significantly lower for policies issued at younger ages (see Figure 6, page 29). It appears desirable to encourage, rather than discourage, younger applicants, and the impact of a lower age cutoff should be carefully evaluated.

The impact of an upper age cutoff is different. To the extent that one can defer the decision to participate in a VFP LTC insurance program indefinitely, there is reduced motivation to apply at younger ages. A firm upper age cutoff would require a clear decision on the part of each person reaching that age. There are existing precedents in federal law for age-based cutoffs. For example, contributions to traditional tax deductible IRAs are not permitted beyond age 70.5 years.

Functional status refers to an applicant's ability to perform a basic set of activities of daily living (ADLs; defined in HIPAA) or a more complex set of activities (called IADLs), and the presence or absence of cognitive impairment. Functional status interacts with the related issue of underwriting. Individuals who are receiving disability benefits through a government program at the time of application represent a particularly costly group. The plan should clearly indicate whether these individuals would have access to the program as their inclusion will have a significant impact on the cost of coverage to all participants. Many such individuals could be classified as disabled for the purposes of one government program such as SSI or SSDI, but as non-disabled for the purpose of eligibility for VFP LTC insurance participation.

Financial status refers to an applicant's income and assets. These change over the life of an applicant. Should there be some minimum amount of income or assets required before one is allowed to join the program? Because the prefunding of LTC itself generates an asset, should persons who are receiving means-tested assistance through federal or state programs such as SSI or Medicaid be permitted to joint the program? If so, should their accumulated LTC funds be counted as assets in determining their continued eligibility for these means-tested programs? Does it make sense for someone who would be immediately eligible for Medicaid LTC services to join a

private LTC insurance plan?

In resolving eligibility issues, it will be important to ensure that the choices here are carefully coordinated with choices made in response to other issues such as underwriting and the interactions with Medicaid and Medicare.

2. Underwriting

Along with eligibility for coverage, underwriting is an essential access issue relating to a VFP LTC insurance program. Based on information available, underwriting is the process by which an insurer accepts the applicant's risk. This determination follows a set of standards that is consistent with the price of the coverage.

Historically, the underwriting standards for private LTC insurance can be characterized as diverse. They range from guaranteed issue to extensive assessment of medical history as well as in-person health interviews. They vary between the individual and group markets, and within the group market, between employer-sponsored and other group-association plans. Because LTC needs increase significantly as people age, underwriting requirements are typically more extensive for older applicants than younger applicants. Partly because of the discretionary access to LTC services by the individuals and partly due to competitive pricing pressure, underwriting standards for individual LTC insurance in recent years appear to gravitate towards a more refined and thorough process. Current underwriting requirements may include medical, functional, and lifestyle questions on the application, physician statements, medical records, face-to-face health interviews, cognitive tests, and telephone interviews. For group insurance, actively-at-work status is the typical minimum requirement for employees. Short form medical questionnaires are common for the spouses of employees. Full underwriting, similar to that for individual insurance, is typical for retirees.

The fundamental underwriting issue for a VFP LTC insurance program lies in the balance between the affordability of premiums and the desire for wide accessibility. The very nature of a voluntary program means that coverage will not be elected by a typical cross-section of the population. When underwriting standards are set liberally, a disproportionate number of unhealthy individuals find it more attractive to apply. As a result, per-participant benefit costs rise and premiums can become so high that healthy individuals will not participate and only unhealthy lives, who are predisposed to claim, will choose to participate in such a voluntary plan. With little spread of risk, the program would be unworkable. Conversely, the more restrictive the underwriting standards, the healthier the group of insureds will be. This translates into lower claim costs and lower premiums. The coverage is then affordable to more people even though those in poor health will not be covered. Underwriting criteria are therefore the mechanisms for attracting the acceptable level of participation with the appropriate price. The full range of possible underwriting criteria is discussed below.

A fully underwritten plan may have standards similar to those for current private insurance programs seeking healthy lives at time of application. Premiums would be competitive with comparable private plans and affordable as well. On the other hand, a significant number of applicants would be declined. The current decline rate for individual insurance is in the neighborhood of 10–20 percent. It can be lower for actively working employees or higher for older retirees in group plans. With limited participation, future savings for Medicare and Medicaid may be lessened if lower premiums do not attract more applicants.

To increase participation, the underwriting standards could be relaxed. An approach that is similar to group insurance would use simplified underwriting requirements together with a long period for which preexisting conditions would be excluded from coverage. For actively-at-work applicants, perhaps only a few health conditions would need to be met while benefits would not be paid for medical conditions that existed perhaps up to two years before application. An advantage of such a simplified underwriting approach is ease of initial administration of the plan. Additionally, fewer applicants will be rejected than in a fully underwritten plan, but still, not all will have coverage. A disadvantage is that in order to cover the higher costs of less healthy insureds, premiums would have to be higher than if full underwriting of applicants were used.

An alternative underwriting standard would allow every applicant to be accepted for coverage. To prevent people from waiting until an immediate need for LTC benefits arose, unhealthy applicants would only be allowed to purchase a policy with minimal benefits such as a two-year nursing-home-only policy with a 180-day elimination period. This policy could be offered in conjunction with an exclusion from receiving benefits due to specific preexisting medical conditions of the insured. Even with such restricted benefits, premiums for the unhealthy insured may well be quite costly—making them not covered. Furthermore, the benefits may not meet their needs and therefore may not reduce reliance on Medicare and Medicaid. Healthy insureds may be required to share a portion of the costs of the unhealthy insureds through higher premiums for all participants. One way to spread the risks associated with accepting less healthy applicants is to create a risk pool among insurers. A risk pool does not eliminate the higher costs associated with higher risk individuals; it merely spreads them over other healthier insureds. This can make the cost of insurance less attractive to some healthy insureds, thereby reducing participation in a voluntary program.

A fully guaranteed issue, voluntary plan, with no differentiation in benefits or premiums among all participants, would surely attract a disproportionate number of unhealthy insureds. The insurance mechanism would not exist, as the correct premiums would be prohibitively expensive. As an alternative, a long waiting period of, say, 10 years, may be used to mitigate the anti-selection. Thus the participants would sign up and pay premiums for 10 years before any claims could be filed, with premiums returned with interest for those who died during the 10-year waiting period. This approach could maximize participation while providing meaningful benefits with reasonable premiums.

There is no single, perfect answer. However, given the

premise that individual equity can be compromised for the good of the entire participant population, a reasonable set of underwriting standards could be formulated to satisfy the participation criteria. In order to keep premiums affordable, underwriting could employ a combination of medical, functional, and cognitive screens as well as waiting periods and exclusions.

3. Program Interactions

If the federal government chooses to develop a VFP LTC insurance program, then it will be critical to ensure that the structure and design of that program are carefully coordinated with the structure and design of existing federal programs that impact the same populations. Not only must the programs be coordinated but the general public must be informed about the nature of this coordination and their individual responsibilities to act at appropriate points in time to achieve the goal of adequate financing for LTC services for current and future generations of Americans.

Two programs are particularly relevant to this task: Medicare and Medicaid. Most Americans are aware of these programs but there is a general lack of information, especially among working-age persons, about how they are financed and what types of LTC services are covered. Many are surprised to learn that Medicare is an acute care program never intended to be an LTC program.

In actuality, as Welch et al. (1996) point out, Medicare's home health care visits are used primarily to provide long-term care. Sixty-one percent of Medicare covered home health care visits in 1993 were to enrollees who received home health care for six months or more. The home health program is growing rapidly, from $1.9 billion in 1988 to $15.4 billion in 1995 (HCFA, 1997). The Congressional Budget Office (Rudowitz, 1997) projected expenditures of $19.5 billion in 1997, with an increase to over $44 billion in 2007. The Balanced Budget Act of 1997 imposes some restrictions on this program in an attempt to curb its growth, as well as shifting the financing of a significant amount of home health care from Part A to Part B of the Medicare Program. The shift focuses on home health services that do not follow a hospital or skilled nursing facility stay, and thus are more clearly identifiable as potential LTC services. It is possible for some of these services to overlap the covered services in a VFP LTC insurance plan, raising two questions: (1) Should Medicare continue as the primary payer?, and (2) Should private insurers anticipate a change in Medicare's secondary payer policy?

The rapidity of the growth of the Medicare home health program should serve as a warning that the line between acute and long-term care is not always as sharp as program designers would like. This raises two questions: (1) How confident are today's designers of LTC financing plans that they can anticipate the nature and delivery of LTC services in 30, 40, or 50 years?, and (2) How stable is the line between acute and long-term care? Does it make sense to use radically different financing mechanisms or would an integrated coverage and financing mechanism be more coherent?

Unlike Medicare, it is the explicit intent of Congress that the Medicaid program covers the costs of institutional LTC services for qualified individuals. Thus, Medicaid pays nearly 50 percent of current costs of nursing home care. In addition, the states, through the standard Medicaid home health and personal care programs and the innovative Medicaid waiver programs, have implemented a broad range of home and community-based (HCB) LTC services. The expenditures for these services in fiscal 1996 amounted to about $10.8 billion (AARP, 1998a).

Eligibility for Medicaid HCB LTC services varies by state and, in general, is tied to the income levels for the federally funded Supplemental Security Income (SSI) Program. In 1995, this was limited to $478 per month income and $2,000 in countable assets; or, for a couple, $707 per month income and $3,000 in countable assets (AARP, 1995). Eligibility for Medicaid nursing home benefits is more generous, in recognition of the fact that nursing home costs can easily exceed $3,000 per month. Indeed, these costs are so expensive that about 40 percent of patients admitted to nursing homes are eligible for Medicaid assistance at the time of admission; and about 30 percent of those who enter as private-pay patients convert to Medicaid-pay status during their stay (Wiener et al., 1996). Thus, there is a tremendous disincentive for persons with low or moderate income to purchase private LTC insurance and instead to rely on the high probability of Medicaid eligibility. Removing these disincentives will be an important aspect of a successful VFP LTC insurance program.

Demonstrations of how this might be done are being conducted in four states—California, Connecticut, Indiana, and New York—through their partnership policies programs (*Consumer Reports*, 1997). These are special LTC insurance policies that protect specified amounts of assets from being counted against Medicaid eligibility thresholds. For example, to protect an additional $100,000 in assets above the usual $2,000 limit, one would purchase an approved partnership policy with a benefit cap of $100,000. This type of policy could be targeted to people with assets of, say, $30,000–100,000, people who would spend down to Medicaid eligibility in one to three years of nursing home confinement without such insurance protection. The success of these programs suggests the desirability of developing similar programs in other states, or of considering alternative methods of achieving the same goal.

For many Americans, the Medicaid program is their *de facto* form of LTC insurance. The success of a new VFP LTC insurance plan could depend on appropriate coordination with this program, or a modified version.

There is a difficult trade-off that must be made between affordability and accessibility; and the result of this trade-off is that those individuals who cannot meet the underwriting standards in effect at the time of their application may be denied access to the VFP LTC insurance program, through no fault of their own. While it may be true that these same persons would be denied access to LTC insurance in today's private market, the fact that VFP LTC insurance is a federal program means that the disposition of these cases will have to be carefully considered. Will they be provided LTC services through Medicaid and Medicare? Will they have access to

other federal programs? Is the federal government willing to subsidize the cost of those persons' LTC insurance, and, if so, how will the subsidies be funded? Finally, will persons who could have purchased VFP LTC policies, but chose not to participate, be eligible for similar benefits under Medicaid or Medicare?

II. FINANCING

Overview

From a financial perspective, voluntary LTC insurance has two primary objectives: (a) to provide the means for individuals to save at after-tax rates greater than increases in the cost of LTC services; and (b) to pool their savings with those of others subject to the same risks through insurance. Since most LTC expenses occur very late in the life span, i.e., after age 85, the power of compound interest to pay for a large proportion of the benefits needed from investment income is a particularly important consideration. For purchasers at age 35, nearly all of the benefits will be paid for from investment earnings. At age 50, an age at which many first become aware that they may have such needs, over half of the benefits of a typical individual LTC policy can be paid for from investment earnings, and over 80 percent with an employer-sponsored group policy. Even as late as age 70, a substantial proportion of the cost can be met from investment earnings: 30 percent in an individual policy and 60 percent in a group policy.

Widespread participation in a voluntary program is attainable only when individuals perceive a positive relationship between the benefits of participation and the individuals costs to participate in the program. Tax consequences of participation affect individuals' costs and to a lesser degree their perception of the value of the benefits. Tax policy has been shown to have a significant impact on participation rates under 401(k)s and IRAs in the past and can be expected to have effects on participant rates for a VFP LTC program.

1. Investment of Funds

1a. Importance of Investment Income to Support LTC Benefits

Effective LTC programs can be designed that provide insurance from relatively young ages when the possibility of needing LTC services is minimal or that defer the inception of the pooling function of insurance to ages closer to the years during which frailty is a significant risk. For example, an effective design would provide tax-favored vehicles, in which savings can occur, to be used to fund LTC insurance at the normal retirement age (i.e., currently age 65, but scheduled to increase to age 67).

In general, the prefunding of LTC benefits has two primary objectives:

- to provide the means for individuals to save for the care they will need in their frail elderly years; and
- to enhance the purchasing power of savings in terms of the LTC benefits that can be funded.

From the perspective of the economy as a whole, prefunding can smooth out the fluctuations in the ratio of frail to working-age populations. In addition, an economy that has arranged to prefund the costs of aging will have more capital and the aging persons will be important owners of capital, benefitting from the fact that capital is productive.

From the perspective of individuals, the power of compound interest to produce far more purchasing power is the most important consideration. Since most LTC expenses occur very late in the life span (e.g., after age 85), the power of compound interest to pay for a large proportion of the benefits needed from investment income is a particularly important consideration. For purchasers at age 35, nearly all of the benefits will be paid for from investment earnings. At age 50, an age at which many first become aware that they may have such needs, over half of the benefits of a typical individual LTC policy can be paid for from investment earnings, and over 80 percent with an employer sponsored group policy. Even as late as age 70, a substantial proportion of the cost can be met from investment earnings: 30 percent in a typical individual policy and 60 percent in a group policy. Thus the key to funding the most LTC benefits from the amounts contributed by participants is to maximize the investment return net of expenses and taxes.

Figure 7 (page 30) shows, according to age at issue, the proportion of the outlays that can be paid from investment income by a comprehensive employer-sponsored group LTC policy with lifetime inflation protection and nonforfeiture benefits, assuming a real investment earning rate of 3 percent relative to the rate at which the benefits are increased. As can be seen, the earlier the funding begins, the higher the proportion that will be earned from investment income. In fact, at issue ages below 35, nearly all of the cost of the policy is paid from investment earnings. Similarly, Figure 8 (page 31) shows the proportions of outlays that can be paid from investment income by a similar individual LTC policy sold through agents. The differences reflect the higher acquisition and maintenance costs of the individual market.

Since the object is to purchase LTC services, of which the primary economic input is wages, the effect of prefunding is measured best by examining policies that provide for benefits that will increase with the wages of nursing home and home health agency employees. In LTC insurance policies, this means that benefits must rise as fast as the wages of nursing home and home care agency employees. This is accomplished through provisions, known as inflation protection, that raise benefits by a certain percentage each year, intended to provide for the likely long run rate of inflation in the cost of nursing home and home care services. To meet this need, the National Association of Insurance Commissioners (NAIC) has promulgated model state laws that require insurers to offer benefits that increase at a (compounded) annual rate of at least 5 percent. Premiums for inflation-protected benefits are substantially higher than premiums for non-inflation-protected bene-

fits, which generally results in lower participation rates.

Also from a public policy perspective, a relevant issue is nonforfeiture benefits. Without nonforfeiture benefits, premiums paid by most purchasers accrue to the sole benefit of the few who persist until the advanced ages at which most LTC services are needed. At the lapse rates typically found in LTC insurance, only a small fraction of those who originally purchased coverage are expected to retain coverage to the time they will be eligible to receive benefits. The cost of coverage (premiums) for policies with nonforfeiture benefits is higher than for policies without nonforfeiture benefits, which could result in lower participation rates.

1b. Deferred Insurance Model

Voluntary LTC insurance can be provided under two very different approaches to the savings (or prefunding) and insuring functions:

- lifetime insurance policies, which are purchased at the age at which funding begins; and

- separate savings and insurance instruments.

The former approach is common in today's policies. A policy is typically sold at a premium that is based on the age of the applicant and that does not increase after issue (except for inflation, if that option is purchased). The insurer bundles the savings and LTC insurance components of the policy and assumes the risks of benefit costs and investment return.

The latter approach may be called the deferred insurance model. Under this approach, savings are accumulated in a pure savings medium (e.g., dedicated mutual funds, savings accounts, etc.), until a conversion age (e.g,. normal retirement age for Social Security benefits), at which time they are used to purchase a paid-up LTC insurance policy. The conversions may be offered in a number of ways, ranging from guarantees offered by the investment companies offering the savings instruments to a regulated forum that would be operated in a manner similar to the Federal Employees Health Benefits Program and some state purchasing alliances. The general advantages of this approach are that a wide variety of savings instruments can be offered, including many that have lower administrative expenses than faced by insurance companies. Most savers are already familiar with similar instruments (e.g., IRAs, Roth IRAs, 401(k)s, Keogh plans, etc.), which can provide competition to savings plans offered through insurers. Further, under current taxation, other savings methods have tax advantages over accumulations by insurance companies. Under this approach, the individual may retain some of the investment risk while the insurer carries only the risk of benefit costs for some period of time while savings accumulate.

There may be ways to encourage greater savings rates at earlier ages, if there are other potential uses for the savings besides purchase of LTC insurance. Under the deferred insurance model, it is feasible to provide either the savings or insurance functions through private or public programs. In this monograph, however, we will be concerned only with private approaches.

2. Alternative Uses of Funds

2a. Relevance of Alternative Uses

A successful VFP LTC insurance program that will encourage adequate funding for LTC needs will have two general functions:

- accumulation of funds during working and early retirement years; and

- pooling of funds from different individuals to provide more funds for those whose needs turn out to be greatest.

Either a lifetime insurance policy or deferred insurance approach must provide both of these functions.

Because the financial burden of paying for LTC is concentrated in the last years of life, funding LTC for all but the wealthy requires the accumulation of funds when the needs for expenditures are lower, preferably during years of employment and peak lifetime earnings. Experience has demonstrated, however, that it is difficult to persuade a large proportion of the population that the potential cost of LTC is a significant risk to them, especially those under age 65. As persons approach retirement, however, and gain personal experience with frail elderly relatives and friends, the general perspective changes. For these reasons, many who would not have been willing to save for LTC needs when they were younger change their priorities as they approach retirement years.

Since it is difficult to persuade a large proportion of the population that they should save for their frail years, and because the extent of the savings needed is difficult to predict, some proposals would permit other uses of accumulated funds. The hope is that the prospect of alternative uses would motivate a stronger savings stream, with the possibility of diverting the savings to purposes that appeal more to younger adults than LTC. As their appreciation of the need changes, however, they may be willing to apply the savings to the use for which they were nominally intended. Similarly, if there are accumulations that can be used for multiple purposes, there is the potential for individuals to divert them to prefunding LTC during their early retirement years when most persons can meet the underwriting tests for LTC insurance.

For these reasons, alternative potential uses of accumulations can constitute an important dimension of public policy intended to encourage the voluntary participation in either a traditional lifetime LTC insurance policy or under a deferred insurance approach.

2b. Potential Alternative Uses

Alternative uses that may be considered include the following:

Death Benefits

A death benefit may assure persons saving for LTC needs that the savings will not all be lost if they do not live long enough to reach the ages at which most frailty occurs.

Catastrophic Health Expenses

All or a major portion of the accumulation could be used to pay for catastrophic medical care, without significantly undermining the policy goal of saving for LTC. Most of those who have a catastrophic illness will not survive to old age, or if they do they will not have income to continue accumulating funds for LTC.

Use of funds could be restricted to situations in which paying for such expenses would produce a financial emergency (e.g., force participant to sell home, take children out of college, etc.).

Disability Income

Permitting use of accumulated funds for disability income should not undermine the policy goals noted above nor lead to biased selection, for reasons similar to those given above. However, since disability income can be obtained from a range of other sources, both public and private, it may be necessary to coordinate the benefit amounts to maintain the integrity of the LTC program.

Paying for LTC for Other Family Members (e.g., Parent, Sibling, etc.)

Part or all of the accumulation could be used to pay for LTC for immediate relatives (parents, aunts, uncles, siblings, etc.). Although such diversion would undermine the policy objective of providing for LTC needed by participants, the diversion would itself purchase needed LTC. Provided that such use was elected more than five years before a conversion age, permitting this use would not produce significant biased selection.

Retirement

Permitting use to supplement retirement funds might provide a significant inducement for participation at younger ages (e.g., between age 40 and age 65, when people tend to be more conscious of retirement needs than of LTC needs). Allowing funds to be used for retirement, however, could undermine savings for the primary goal of funding LTC. Nevertheless, additional savings, intended to increase income during retirement, would be available as the participant reaches those ages at which the prospect of needing LTC will appear more relevant.

There would also be significant potential for biased selection if a large proportion of those in good health elected additional retirement income, leaving a higher proportion of those with immediate needs for LTC in the purchasing pool. If the election were made more than five years in advance of a conversion age, however, the impact of biased selection would probably not require significantly lower benefits at the conversion age. Both the policy and biased selection problems could also be addressed by limiting the proportion that could be used for retirement income. The primary problem would then be competition with other types of retirement income savings accounts already offered with tax advantages, such as defined contribution pensions, 401(k)s, Keogh plans, IRAs, etc.

Unemployment Support

Given that the absence of steady employment is likely to indicate that individuals are unlikely to save enough to fund their LTC needs, part of the accumulation might be used to provide some income during sustained periods of unemployment, especially at older ages.

Education, Primary Home Down Payments, Etc.

Part or all of the accumulation could also be used to pay for continuing education, down payments on housing, etc.—with restrictions comparable to those imposed on similar use of 401(k) accounts.

2c. Limitations on Alternative Uses

With the exceptions of death and catastrophic illness, permitting alternative uses of funds will affect the design of the VFP LTC insurance program in important ways. Individuals presumably will make the choices that are financially most advantageous to them, given their health and other needs besides LTC. To the extent that individuals have choices such as whether to apply the funds to LTC or additional retirement benefits, those choosing additional retirement benefits can be expected to have much lower LTC needs, and those choosing LTC much higher and more immediate needs. Thus, choices may require underwriting to occur at the ages at which choices can be made. To the extent that restrictions are imposed, some who saved will find themselves excluded from applying the funds for the primary objective for which they saved.

3. Tax Treatment

Tax policy is a frequently used tool to motivate (or discourage) societal behavior in keeping with social goals. If one objective of a VFP LTC insurance program is to foster widespread insurance coverage of the future elderly, then tax policy will need to be consistent with that goal. One reason frequently cited for the limited growth of private LTC insurance over the past 10 years has been the previously unclear tax consequences surrounding LTC insurance policies. Issues include the tax deductibility of premiums paid by an individual or by an employer, taxation of benefits paid, and insurance companies taxes on the inside build-up of reserves.

Many important tax issues were addressed in HIPAA, which established requirements for qualified long-term care insurance contracts. Under LTC contracts that meet the HIPAA definitions for qualification, benefits are not included in income and certain LTC expenditures for services are deductible from income (as any other medical care expenditures). Also, premiums are generally treated as any other

health insurance premium for tax purposes (except premiums for LTC policies cannot be part of an employer's cafeteria plan; IRC Section 125).

One way to spur more widespread coverage in a VFP LTC program is to effectively reduce the cost of the insurance policy through tax advantages or subsidies. Almost 100 percent of eligibles participate in Medicare Part B due in large part to the substantial subsidy (over 75 percent) of the premiums through general revenues. Less direct, but also effective, has been the tax deductibility of some premiums and contributions which has led to widespread participation in private retirement plans, 401(k)s, IRAs, and other health insurance programs that accumulate savings or pool the risks for a future need, thereby diminishing the likelihood of individuals needing to rely on public support when the need arises.

It is reasonable to conclude that favorable tax treatment of LTC contributions would significantly impact the participation rates in any proposed VFP LTC program. Favorable tax treatment effectively reduces the cost to the individual who is making the voluntary decision to participate. Forty-three percent of respondents to a recent non-buyer survey on LTC insurance cited cost as the main reason for not purchasing an LTC policy (Cohen et al., 1993). Also, favorable tax treatment combined with the federal oversight implicit in a federally legislated program would further promote the perceived importance and need for such coverage. Twenty-seven percent of respondents to the same survey of non-purchasers cited a lack of adequate policies and an unclear governmental role as the main reasons for not purchasing an LTC policy (Cohen et al., 1993).

Favorable tax treatment can take numerous forms, the appropriateness of each depending on the public/private program's goals and designs. The tax treatment can range across the following spectrum (not necessarily all inclusive):

l) General revenue subsidies of some or all costs (as in the case with Medicare and Medicaid).

2) Tax credits based on premiums or contributions.

3) Tax deductibility of premiums or contributions.

4) Tax-deferred or tax-free build-up of funds to pay LTC premiums at a later date.

5) Tax exempt receipt of benefits.

Related program design issues include the following:

1) Are there maximum limits on the amounts that can be contributed to the LTC plan?

2) For what purposes other than LTC might any funds accumulated for prefunding the future costs of LTC be used by individuals?

3) What taxes or penalties would be incurred on withdrawal of funds for LTC or for other purposes (if permitted)?

4) What are the tax consequences to the individual of interest earned on the reserves (the inside build-up)?

Quantification of the impact of favorable tax treatment is difficult since the likely impact is dependent on a range of characteristics in the final program design. The survey used by Cohen et al. (1993) found that 20 percent of non-purchasers would have purchased a LTC policy if the premiums were fully tax deductible. Since these estimates refer to private LTC insurance outside the scope of a federally sponsored or endorsed program, 20 percent might be considered a lower bound range of the impact. It is also significant that the query involved full tax deductibility. HIPAA allows tax deductibility as an itemized medical expense subject to the 7.5 percent AGI floor.

If the VFP LTC insurance program involves an accumulation plan below age 65, one can gain insight into the impact of favorable tax treatment by analyzing participation rates for IRAs and 401(k)s in the mid-1980s. IRAs effectively began with the Economic Recovery Tax Act 1981. The proportion of tax filers making IRA contributions rose from 12.6 percent in 1982 to 15.9 percent in 1986, and then with the Tax Reform Act of 1986 fell to 6.8 percent in 1987 (Poterba et al., 1994). Thus, the relative decline in participation (-57 percent) was substantial. The decline would appear to be due to the loss of favorable tax treatment for IRAs for couples with incomes above $30,000.

The Revenue Act of 1978 initially established 401(k)s. The rules were clarified by the Treasury Department in 1981 and the contribution limits were reduced (from $30,000 to $7,000) and indexed by the Tax Reform Act of 1986. Poterba et al. (1994) report that eligible employees with a 0 percent match rate by their employers participate at a 49.5 percent rate. The participation rate peaks at 98.6 percent for employer match rates of 100 percent. On average over 60 percent of eligible employees take advantage of 401(k)s. A significant finding in Poterba et al. (1994) is that the IRA and 401(k) contributions created new savings that would not have occurred in the absence of these tax favored programs.

An important distinction between traditional IRA/401(k) tax treatment and full tax deductibility for accumulated LTC funds under a VFP LTC program is the tax treatment after retirement or, if the design includes a savings component followed by insurance coverage, at the time of conversion from savings to LTC insurance. For traditional (not Roth) IRAs and 401(k)s, tax is incurred as the funds are distributed. For the VFP LTC program with a savings component preceding the insurance purchases, this would correspond to taxing the premiums paid to the LTC insurer in the post-conversion period. If these taxes were not levied, then the tax treatment of the VFP LTC program would be more favorable than for IRAs and 401(k)s, with a resulting increase expected in the participation rates.

The primary disadvantage of favorable tax treatment is that

it could reduce Treasury revenues. Also, some critics will claim that such tax treatment favors the wealthy. While estimating Treasury impacts is beyond the scope of this monograph, it is worth noting that at age 40, the annual amount needed to be set aside for long-term care is relatively small since there is a long time to accumulate funds prior to most LTC needs. This allows for more contributions to accumulate as well as inducing a more pronounced effect of compounding interest. At age 40, reasonable policy premiums might be around $25 per month, whereas the same policy might be 10 times that amount if purchased at age 75, based on the prototypical premium used by Wiener et al. (1994, p. 49) for a $60/day, inflation protected, four-year benefit period policy. The tax impact is less at the lower ages, when earnings are generally lower, as are the costs of insurance.

While it is true that favorable tax treatment favors the wealthy, the very wealthy are more likely to self-insure their LTC risks as a normal household expense. It is middle-income Americans who are most exposed to impoverishment from LTC needs and most likely to end up with care highly subsidized by general revenues through Medicaid if an extended period of disability occurs. Encouraging these Americans to set aside funds for LTC could ultimately reduce their possible future reliance on other fully subsidized programs.

4. Contribution Limitations

Limitations on premiums or contributions are warranted when such amounts would result in excessive tax advantages for the participants. Tax advantages should serve only to encourage participation. HIPAA allows for premium deductibility and tax-free benefits for qualified LTC insurance. Any contribution limitation on the VFP LTC insurance program should be coordinated with the provisions of HIPAA.

The nature of the limitations will depend on the specific tax incentive as well as the plan design. If the premiums are deductible and the policy has no fund accumulation, the limitations in HIPAA can apply with or without modification. Under HIPAA, the amount of deduction is limited by a schedule of maximum annual premiums that varies by attained age. An example of a modification is to allow premium deduction without regard to the 7.5 percent medical expense threshold. If the tax incentive is in the form of a tax credit, such credit can also be subjected to a fixed maximum amount.

If the policy has a fund accumulation period, premium limitations must account for the flexible nature of the policy. For the same premium level, such a policy can emphasize accumulation or protection. A maximum premium can be determined using a minimum interest rate and a maximum long-term care risk charge schedule. This concept has been used in the definition of life insurance for income tax purposes.

Clearly, contribution limitations affect the attractiveness of the VFP LTC insurance. Any proposed contribution limitations must balance the desire to attract participants with the potential loss of tax revenue.

III. PLAN DESIGN

Overview

A fundamental question in structuring a VFP LTC insurance program is deciding whether LTC insurers can continue to have nearly unlimited freedom in plan design, or whether a small number of standardized plan designs might more readily accomplish the goals of the program. Currently, it is rare to find an identical LTC product offered by two different insurance companies. A VFP LTC insurance program could place no additional restrictions on plan designs or could establish a set of standardized benefit designs as was done for Medicare supplement products. The opposing arguments can be boiled down to simplicity versus flexibility. Flexibility is critical because the LTC delivery system and the LTC insurance market are in a state of rapid evolution. Benefit designs, benefit triggers, and provider definitions have changed and will continue to change as carriers gain expertise and as care delivery evolves. Carriers typically introduce new plans about every two years or so to react to new product design demands. On the other hand, greater simplicity would help consumers in making choices about carriers and plan design options. Greater simplicity would also help the regulation of this product.

Standardization

When structuring a VFP LTC insurance program, a fundamental question arises: whether LTC insurers could continue to have nearly unlimited freedom in plan design, or whether a small number of standardized plan designs would better accomplish the goals of the program. The opposing arguments can be boiled down to simplicity and comparability versus flexibility and innovation.

All currently marketed LTC policies must contain benefits and benefit eligibility criteria that meet minimum standards that vary by state. Tax-qualified plans must also meet certain additional criteria. Both state and tax-qualified standards leave ample room for insurance companies to design unique products. It is rare to find an identical LTC product offered by two different insurance companies. A VFP LTC insurance program could place no additional restrictions on plan designs or could establish a set of standardized benefit designs as was done for Medicare supplement products.

The current state of variations of benefit designs is a result of several factors, a few of which are discussed here. One factor is the dynamic nature of the LTC delivery system. During the last decade, nursing home utilization has decreased while utilization of lower levels of care has increased. These lower levels of care are provided primarily in the home or community and include homemaker services, home health aid services, personal care services, adult day care, habilitation services, respite care, transportation, in-home support services, meal services, communication services, minor home modifications, assisted living services, and care management services. LTC insurance products have evolved in reaction to this. If implemented, standardized plan designs could limit the mar-

ket's ability to keep pace with LTC delivery changes.

A second factor contributing to the variety of plan designs is evolving loss experience. LTC insurance is still a relatively new product. As carriers gain experience with the product, they are discovering and implementing plan designs that give them the most control over risk and/or give attractive benefit options to consumers.

A third factor is a desire by many carriers to offer a unique product that can differentiate them in the marketplace. Implementation of standardized plan designs would restrict the ability of carriers to offer creative products for marketing reasons or in reaction to evolving experience.

Plan design differences among carriers can make comparison-shopping difficult for consumers. In addition to choosing a carrier, consumers must also typically choose an appropriate daily benefit level, benefit period, and elimination period. They may also have to choose among several optional provisions and benefits such as home health care, benefit inflation protection, and nonforfeiture benefits. In most cases, a specialized insurance agent explains these options to the consumer during the sales process. Implementation of standardized benefit designs could simplify the decision process. Consumers could more easily compare premium rates for basic benefits and optional benefits offered by different carriers. Direct price comparisons might result in carriers lowering commissions in order to provide the most competitive premium rates. On the other hand, consumers would not be able to select some plan designs that might have more effectively met their unique situation or needs.

Standardization could simplify regulation. Policy language could be standardized and result in easier review of policies by regulators for compliance purposes. The rate-filing and experience monitoring processes would be easier for both regulators and carriers. However, regulators would lose their current ability to approve new or more flexible policy designs.

Standardized plans would have to compete with non-standardized plans unless the non-standardized plans were prohibited. Non-standardized plans could be more creative and take advantages of new developments. This would make standardized plans less attractive to consumers. As an alternative to standardized plans, some minimum standards, such as those used to define tax-qualified plans could be used. This would provide some standardization with some flexibility

In defining standardized plans or other minimum standards for eligible plans, note that several design options would require further consideration. These items include premium structures, benefit bases, and benefit triggers.

Within a VFP LTC insurance plan, options for premium structures could vary in the pre-conversion and post-conversion periods. During the pre-conversion period, premiums could be issue-age rated, attained-age rated, or community rated. Issue-age rating would require prefunding during the pre-conversion period and would be the riskiest structure for insurance carriers to price. Although community rating would be the simplest to administer, it would be unfair to companies with older-age risk pools. During the post-conversion period, single and limited pay structures, as well as lifetime level premiums could be used. Under a single or limited pay structure, consideration should be given to where the unused portion of the policy's fund would be held if the insured changes carriers.

In developing benefit bases, several options would be available. If a usual, reasonable, and customary (URC) basis were used without limit on daily maximums, the plans would have built-in inflation protection. However, the level premiums required to fund this benefit would be relatively high. Also, LTC charges vary greatly by geographic area. This would require research on charges by area for pricing and claim processing purposes. Benefits that are paid out using an indemnity basis are simple to administer and less risky to price. However, indemnity benefits do not protect against inflation and consideration should be given to the advantages and disadvantages of requiring inflation protection in some form.

The options for benefit triggers for plans within a VFP LTC program could be coordinated with the requirements imposed by HIPAA (see Background section, page 5). One major area of potential innovation is within HIPAA's Similar Level Trigger. For example, AARP (1998b) reports that the level of disability associated with five to six IADLs is comparable to that of persons with two-plus ADLs. This suggests that innovative LTC insurance plans could be developed with benefit triggers that explicitly take account of IADL limitations, and yet satisfy the requirements of HIPAA. Thus, an important design issue for a VFP LTC program is whether it will be more or less flexible than HIPAA in its allowable sets of benefit triggers.

A review of the effects that standardization had on the Medicare supplement market may help in anticipating the effects of standardization on a VFP LTC insurance market. As a result of standardization, consumers are now able to directly compare premium rates for standard Medicare supplement benefits. In reaction to this, many carriers changed to attained-age rating scales that make premiums at younger ages appear more attractive. This in turn lowered the average dollar amount of commissions paid to agents. It should be noted that standardization had little effect on the number of carriers in the market or the size of the market. Also, the carriers that tend to offer the lowest premium rates are not necessarily those that have the highest sales volumes. This indicates that consumers consider factors other than, or in addition to, premium rate levels when choosing carriers. Examples of these other factors may include a company's A.M. Best rating and company reputation.

It is possible that standardization of LTC products would have different results from those observed in the Medicare supplement market. Many state regulations prohibit attained age rating beyond age 65. This would prevent an overall change in rating structures like that in the Medicare supplement market. Also, Medicare supplement insurance has been a much less dynamic product than LTC insurance. The Medicare benefit structure has not changed significantly from year to year, so there was little chance that the standardized plans would require significant change. It remains to be seen

how stable that situation will be as Medicare moves toward greater use of managed care in future years. On the other hand, the LTC delivery system has been and currently is in a state of rapid evolution. Standardized plans could become outdated in a few years unless an ability to modify their definitions existed.

IV. MARKETING

Overview

A VFP LTC insurance program could be marketed to the public either by the participating insurers or by an agency of the federal government. Marketing support and public solicitation may be performed by individual insurance agents, an agency of the federal government, an insurance industry trade association, employers and other affinity groups, or through direct contact with potential applicants via mail, television, radio, the Internet, and other mass marketing media. Each approach to marketing has advantages and disadvantages, especially with regard to effectiveness in encouraging participation in the program and on the marketing cost per insured life. In turn, the expected level of participation in the program and the costs to market the program can have a significant impact on the programs financial viability and risk characteristics. In addition, the marketing of a VFP LTC insurance program may be further complicated by the availability of both VFP and non-VFP programs to consumer buyers.

Options

This section discusses the pros and cons of the various approaches that could be taken toward the marketing of VFP LTC insurance plans, from the individualized agent approach to the employer group sale approach to the possibility of a government agency marketing the plans directly to the public. The issues of cost (to insurers, and ultimately to consumers), consistency, and credibility of the message delivered, and appropriateness of sales tactics are addressed. In addition, the marketing implications of the availability of both non-VFP LTC insurance and VFP LTC insurance plans to consumers are addressed.

A primary goal of a VFP LTC insurance program could be to promote widespread coverage for private LTC insurance benefits. The program's ability to achieve this goal will depend, in large part, on how effectively it is marketed to the American public. In designing the marketing strategy, a number of issues need to be addressed.

Who should provide marketing support?

Who will provide the marketing support (answering questions, giving advice on benefit levels/options to elect, etc.) for the plans offered under a VFP LTC insurance program? This support should include educating potential participants about the risk of needing LTC, the cost of LTC services, and the value of LTC insurance in light of continuing financial constraints on Medicare and Medicaid.

One possibility would be for an agency of the federal government, such as HCFA, SSA, or a newly created agency, to do the marketing. The advantages of this marketing approach are several:

- all potential participants would receive the same, consistent message;

- inappropriate and misleading sales practices and materials would be more easily controlled;

- it would be more efficient, thereby reducing the cost of coverage to the public; and

- the information may be perceived by consumers as more objective and credible, and therefore could promote higher levels of program participation.

On the other hand, this approach would have the following disadvantages:

- it would lead to significant increases in federal staffing and bureaucracy;

- it would increase the likelihood that plan provisions would need to be standardized in order to facilitate product training;

- it may not be acceptable to those LTC insurance carriers that are uncomfortable with federal employees answering questions and making representations about their LTC insurance plans; and

- it would remove the incentive of profit-driven competition for sales.

An alternative marketing approach would be for each participating insurer to market its own products. Private insurers would know their own products well and would likely be more responsive to product specific inquiries. They would also be able to distinguish themselves with their own unique marketing approaches. One disadvantage of this approach would be greater complexity and potential consumer confusion due to differences in each participating insurer's plan design (if not standardized), application and underwriting procedures, guidelines, and terminology. Furthermore, the marketing message may lack the credibility and objectivity that a message from a federal agency would have. Both of these disadvantages could adversely impact program participation.

Another alternative would be for the participating private insurers to collaborate in the development of a common set of marketing materials that would be used for general education of the public about LTC issues, with each individual insurer marketing and handling inquiries relating to its own products. This would ensure consistency in the general education message while at the same time allow insurers to distinguish themselves with their approach to marketing their specific

products. Collaborative marketing efforts could be coordinated by organizations such as the HIAA or the ACLI.

How should this marketing support be provided?

Another related issue is how marketing support for VFP LTC insurance would be provided. One option would be to market the coverage using group policy forms and to sell directly to individuals by using enrollment brochures (available upon request or mailed directly to those eligible), toll-free telephone lines, the Internet, videos, or enrollment meetings and seminars. This direct marketing approach could result in relatively low unit acquisition costs, would eliminate the need to build sales commissions into the premiums, would be least intrusive to the consumer, and has the greatest potential to reach most eligible Americans. Direct marketing does have some drawbacks, however. It would be difficult to tailor the marketing message to fit individual needs and circumstances (i.e., income, age, gender, and education level). Furthermore, the inherent complexity of LTC insurance would make direct marketing more difficult and, as in most direct marketing campaigns, a generally low response rate would be expected.

An alternative approach to marketing would be to sell individual policies through personal contact with an agent or broker. This would facilitate the customization of the marketing approach to better fit an individual's unique needs and circumstances and would be the preferred approach to explain a relatively new and complex product like LTC insurance. In comparison with direct marketing, a higher level of personalized customer service would also be provided.

Disadvantages of marketing through agents include: higher unit-acquisition costs and premiums, especially if significant sales compensation is paid to the agents; a more limited scope for the solicitation, since agents will most likely target only those with the socio-demographic characteristics that would make them more likely to buy LTC insurance; and generally higher lapse rates. There also are consumers who would prefer not to deal directly with insurance agents.

If individual insurance agents play a role in marketing VFP LTC insurance policies, the issue of sales compensation or commissions will need to be addressed. Certainly, providing significant financial incentives to sell this coverage would cause agents/brokers to be more aggressive in their marketing efforts. This may result in higher ultimate program participation rates. However, the higher costs related to commissioned sales may offset the advantages of this approach.

What role, if any, should there be for employers in marketing this coverage?

The potential role of employers in marketing VFP LTC insurance also needs to be considered. As is evident in the group LTC insurance market, active employer support and sponsorship of a VFP LTC insurance program can significantly increase participation and provide an effective means to communicate directly with the eligible population. A recent John Hancock/National Council on the Aging survey indicated that 70 percent of respondents whose employers did not offer LTC insurance would like their employer to offer it, and 77 percent said they would be interested in buying LTC insurance if it were offered by their employers. Premium payment via payroll deduction would also be an attractive plan feature that could increase participation levels. Mandating that employers offer VFP LTC insurance coverage to employees and retirees would also shift much of the marketing effort from the public to the private sector.

One approach to employer involvement would be to require all employers to offer a voluntary, government-approved, employer-sponsored plan from an LTC insurer chosen by the employer. Another would be to require employers to offer a menu of plans from all of the insurers selected by the government to participate in a VFP LTC insurance program. Both of these approaches may be perceived by employers as another federal mandate that will ultimately increase employer costs (despite the fact that the coverage would be employee-pay-all) or limit employer freedom to choose the offered plan and insurer. They would both also result in some administrative duplication and would not be as efficient as a nationally coordinated marketing campaign that does not involve employers directly.

Should private insurers still be able to market non-VFP LTC insurance plans?

If LTC insurance writers continue to market products that do not meet the VFP LTC insurance standards, public confusion over the difference between the provisions of a VFP LTC insurance plan and those offered outside of the VFP LTC insurance program may arise. This may impact VFP LTC insurance participation percentages negatively by siphoning off those who want to purchase a non-VFP LTC insurance plan. This may have adverse financial/selection consequences on the VFP LTC insurance program, depending on the program's underwriting requirements. Alternatives to VFP LTC insurance plans would, however, give consumers a broader choice of plans and insurers for their LTC insurance coverage and may make support of VFP LTC insurance more palatable from the private insurer perspective.

Requiring all LTC insurance plans to meet VFP LTC insurance standards could make benefit/price comparisons more straightforward for the consumer (especially if plan provisions are standardized), and could lead to increased VFP LTC insurance participation. The disadvantages of this may include the stifling of product and marketing innovation in the future, and the reduction of LTC insurance to a commodity where competition would be based mostly on price. One additional potential consequence of only allowing VFP LTC insurance compliant plans to be marketed is that some aspect of LTC insurance regulation could potentially be transferred from the states to the federal government.

Clearly, many marketing issues would need to be addressed in the development of a VFP LTC insurance program. Many of these marketing decisions can have a significant impact on the degree of program participation that would be expected, which, in turn, can affect the program's basic financial and

risk characteristics.

V. ADMINISTRATION

Overview

A broad range of options could be considered in the administration of a VFP LTC insurance program. In this section we consider possible roles for the federal government in this area. Responsibilities that are not taken on by the federal government could be taken on by the participating private insurers. A designated government agency could assist in the administration of the LTC program in several ways and at several levels of involvement. The agency could provide educational material to eligibles and/or participants. Dissemination of such material would be a critical success factor to any LTC program. The agency could function as a mechanism for participating carriers to reach eligibles. It could assist in developing LTC regulations and in determining eligible insurance carriers. The agency could help establish and maintain consumer confidence in the program by monitoring carrier experience and in addressing consumer complaints and concerns. Such a government agency would require funding. This could be provided through carrier contributions in order to remain budget-neutral.

Options

The range of options that could be considered in the administration of a VFP LTC insurance program is as broad as the range of possible programs that could be instituted. One possibility would be for an agency of the federal government, such as HHS, HCFA, SSA, or a newly created agency, to do the administration. In this section, we consider possible roles and responsibilities of a government agency that might serve as the administrative core of a VFP LTC insurance program.

A VFP LTC insurance program would require that several key administrative functions be assumed by insurance carriers or by a designated government agency. A government agency could assist with these functions in several ways and at several levels of involvement. They are as follows:

- marketing and education;
- underwriting;
- claims administration;
- premium rate setting; and
- premium collection.

There are certain marketing functions for which the designated agency could provide assistance. The agency could provide educational material to eligibles and/or participants. Such educational material would be a critical success factor to any LTC program. There is currently a lack of knowledge within the general public of the LTC risk and which services are covered by Medicare and Medicare supplement insurance. The neutrality of a government agency would give the educational material important credibility. This material could include a description of which LTC services are and are not covered by Medicare, etc. The agency could provide worksheets that could be used to calculate target benefits and associated annual fund contributions. A shopper's guide and a description of LTC plan designs could also be provided. The agency could function as a mechanism for participating carriers to reach eligibles. The agency could send program information to the entire eligible market. Alternatively, the agency could provide lists of eligibles to participating carriers. The agency could provide a standard application to all applicants and submit them to the carriers.

Underwriting, claims administration, and premium rate setting are functions that insurers already handle routinely. They have developed expertise in these areas that would be difficult for a government agency to develop without a considerable investment of time and money. Also, if the insurers will be assuming the morbidity risk, it would be appropriate that they have control over risk selection, the amounts charged for assuming such risk and the payment and management of benefits within the limits (if any) established for the VFP LTC insurance program.

The designated agency could collect premiums directly from participants and reimburse the carriers periodically. Premium collections by a neutral government agency might encourage persistency and reduce transfers between carriers. This approach would require the development and implementation of a program-wide premium collection system. This in turn would require a considerable investment of time and money. Alternatively, the agency could have no involvement in premium collection. This portion of administration could be left with carriers who already have premium collection systems in place.

Besides administration of LTC insurance policies, the designated agency could also provide help in other areas of the VFP LTC insurance program. The agency could develop standard LTC regulations. It could also monitor the experience of participating carriers. Existing LTC experience exhibits could suffice for this. The agency could provide carrier and agent report cards with marketing materials to eligibles and annually to participants. These report cards would be based on consumer complaint and feedback from hotlines or questionnaires.

The designated agency could be responsible for determining eligible participating insurers. It could establish minimum requirements such as a minimum A. M. Best rating and risk-based capital (RBC) levels. The government agency could oversee transfer of policyholders from newly ineligible carriers.

Whatever functions are taken on by such a government agency would require funding. In order to maintain budget neutrality, this might be provided through carrier contributions in return for the rights to participate in the program.

VI. REGULATION

Overview

A VFP LTC insurance program could be regulated solely at the federal government level, solely at the state level, or by some combination of federal and state authorities. While insurance products are currently regulated at the state level, the passage of HIPAA and the creation of a set of federal standards for tax-qualified LTC insurance plans have already raised the issue of the relative roles of federal and state authorities in the regulation of the private LTC insurance market. Since regulation by either the federal or state government or some combination of both may impact VFP LTC insurance product design, administration, and consumer interest in purchasing the coverage, the question of how the program will be regulated should be considered early on in the development of VFP LTC insurance products.

Options

The VFP LTC insurance program could possibly be regulated solely by the states, as LTC insurance is currently regulated, or it could potentially be regulated solely at the federal government level, or by some combination of both federal and state agencies. The current state regulation of LTC insurance includes minimum standards with respect to benefit provisions, loss ratios, rate stabilization, sales practices, and consumer protection. While these standards are in most instances derived from the NAIC Model LTC Act and Regulations, a considerable amount of variation does exist from state to state. The recent passage of HIPAA introduced federal standards for tax-qualified LTC insurance plans, thereby raising the issue of the relative roles of the federal and state governments in the regulation of private LTC insurance.

The implementation of only federal regulation of a VFP LTC insurance program could result in uniformity of plan design and consumer protection standards over all 50 states. This may reduce consumer confusion over state variations, streamline insurer administration, and simplify the communications effort, thereby increasing potential participation. It may also streamline the process of requesting and receiving approval of an insurance plan if only one filing is required. On the other hand, it may impede creativity of new plan designs and improved delivery systems.

Federal regulation could have other disadvantages. This could set a precedent for federal insurance regulation that the states may find objectionable. The passage of HIPAA has already raised this issue. Inconsistency between the federal regulation of the federal plan and the state regulation of other LTC insurance plans marketed by private insurers may create consumer confusion and affect sales of both plans. It is possible that some states may prohibit the sale of VFP LTC insurance plans to their residents if they find their plan features objectionable or consumer protection standards violated. Alternatively, they may require that their residents be offered the choice to purchase either a VFP LTC insurance plan or a state approved plan. In addition to causing confusion on the part of the consumer, this could complicate, and thus increase the cost of, marketing the VFP LTC insurance plan(s), and increase administrative costs as insurers would have to develop, maintain, and train staff to service two different products. This occurred in California as a result of the passage of HIPAA.

State regulation of a VFP LTC insurance program would maintain continuity with the LTC insurance market since states currently regulate private LTC insurance. On the other hand, state regulation of the VFP LTC insurance program could result in plan design and consumer protection variations by state that may increase communications complexity, promote consumer confusion, and increase the insurers' administrative expenses, all of which may adversely impact VFP LTC insurance program participation. Also, if a state prohibits the sale of the VFP LTC insurance plan to its residents due to conflicting state laws, there would be a reduced access to and availability of the VFP LTC insurance program. Consumers may actually be hurt financially if there are federal income tax or other serious consequences to the purchase of a non-VFP LTC insurance plan that do not apply to the purchase of a VFP LTC insurance plan.

Conclusion

The above discussion should leave no doubt that designing a VFP LTC insurance program is a complex task. Much of the complexity derives from the voluntary nature of the program. Once the decision is made that participation in the program will be a voluntary choice, then all of the issues described above become relevant. What is perhaps surprising is that not all voluntary programs are the same, or even similar. The range of options identified above indicates that there are numerous ways to design a voluntary program that would be consistent with specific federal policy objectives. This suggests that a first step in the design of a VFP LTC insurance program could be to develop a clearly articulated statement of the programs goals. This statement could then be matched against each issue to narrow the options to a set consistent with those goals. These sets could then be matched across issues for coherency, eliminating contradictory or inconsistent choices, to array all alternative program designs consistent with the stated goals. Choices among these options would then depend on further analysis of their public policy and actuarial implications. The Academy Committee on LTC could assist with the latter assessment.

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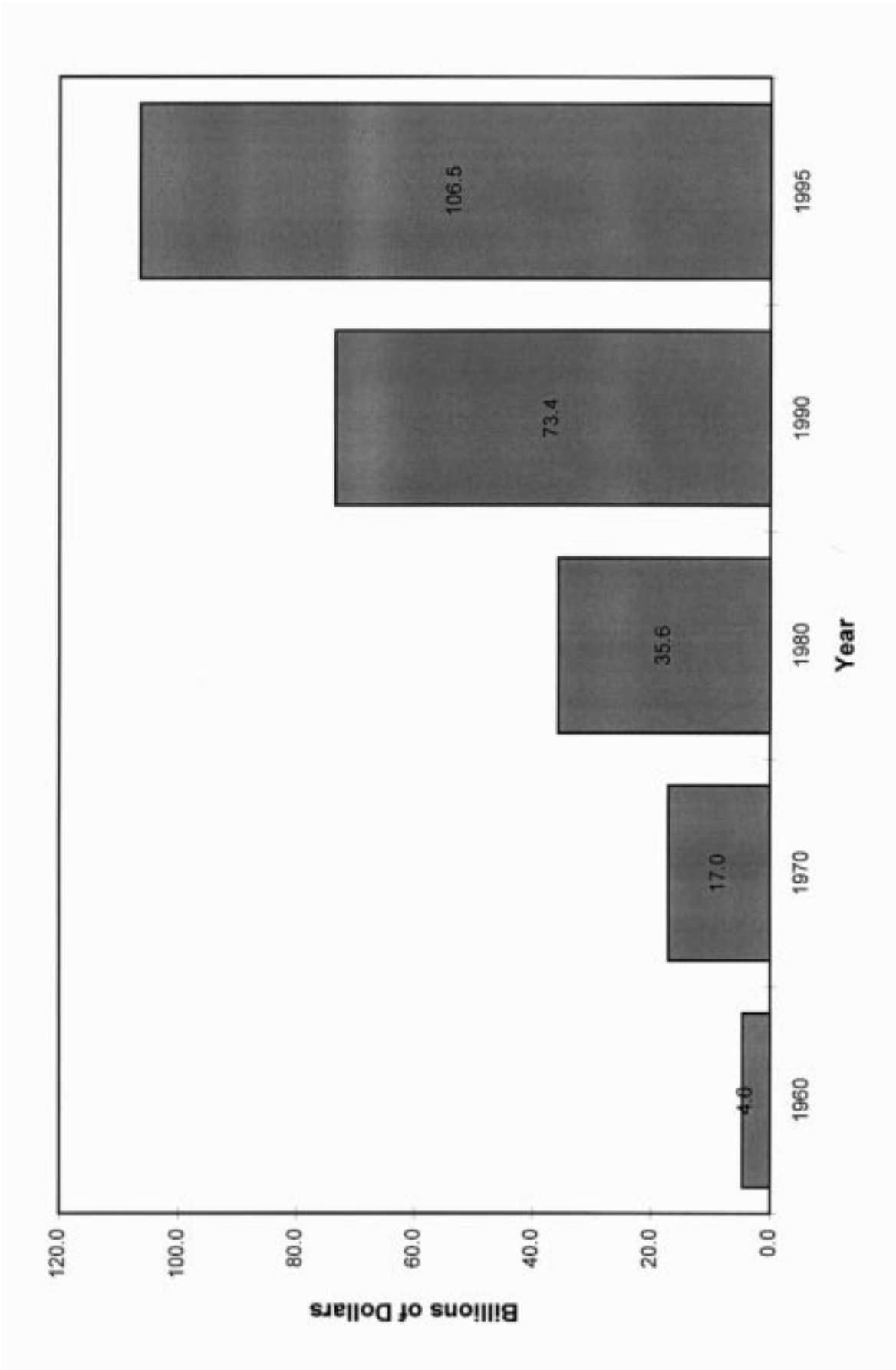
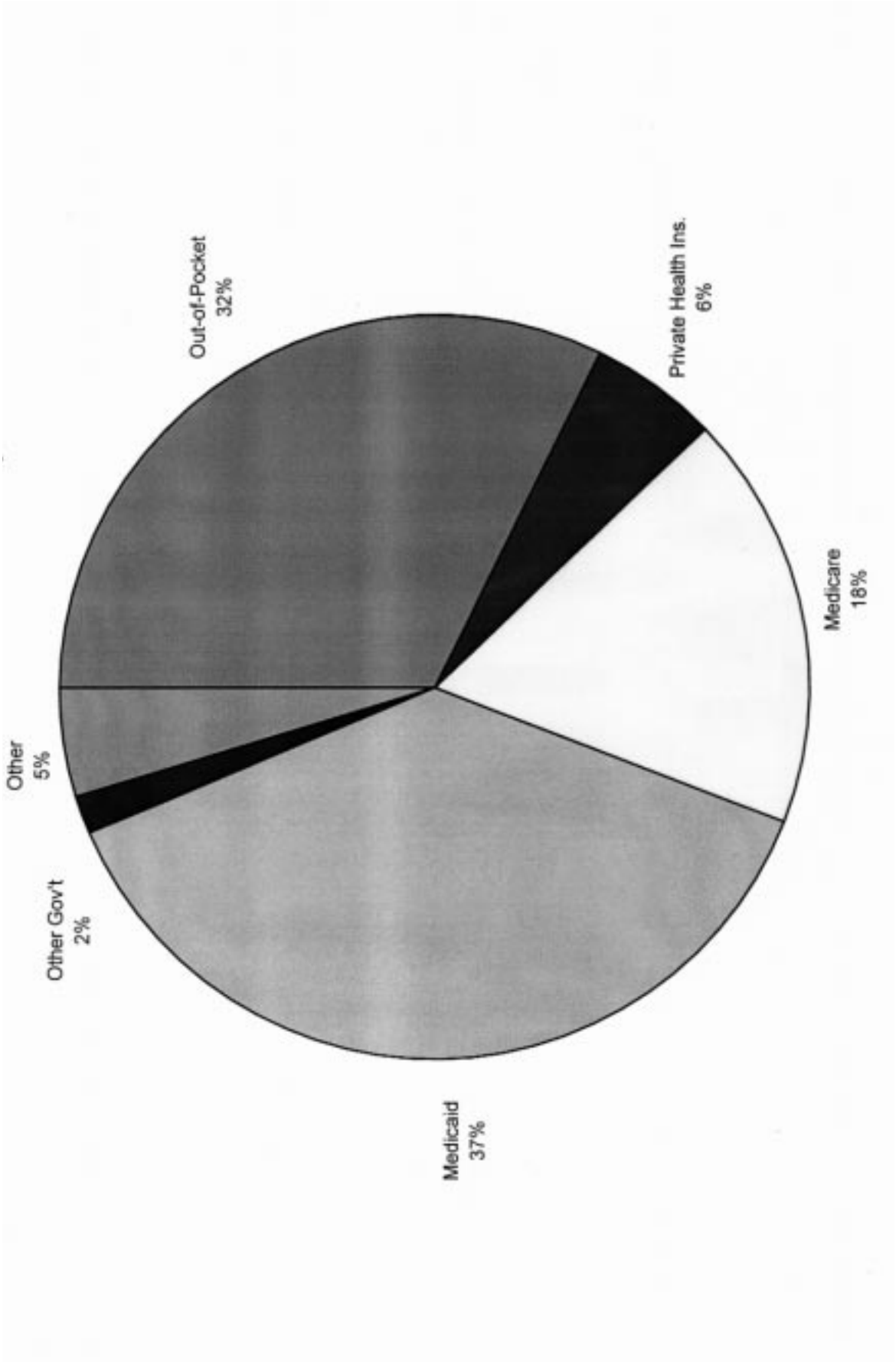
Figure 1



Source: Data from Levit et al. (1996), p. 201), inflated to constant 1995 dollars using the ratio of the year-end consumer price index (CPIU); BLS, U.S. Department of Labor) for 1995 to the year-end consumer price index for the reference year.

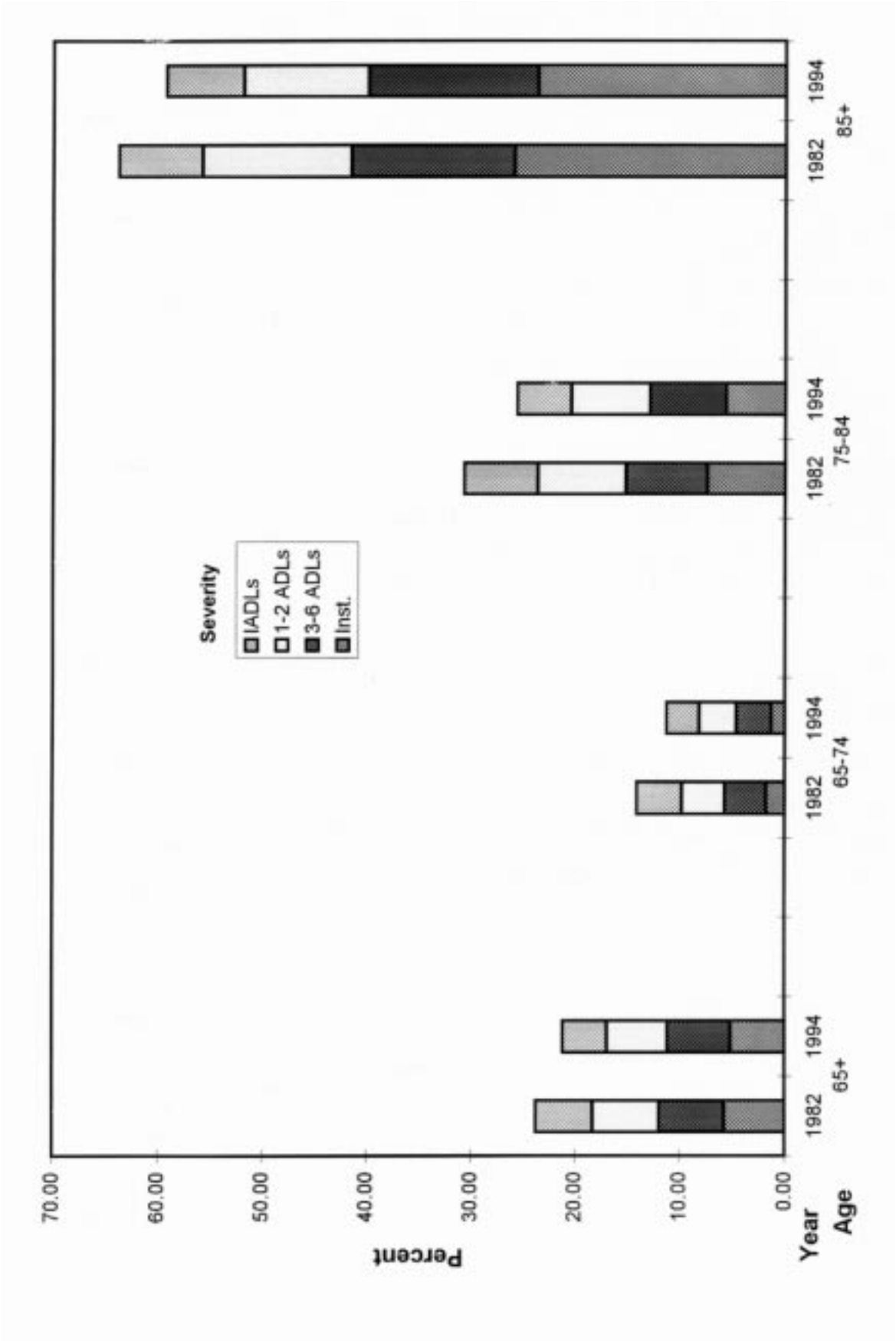
Figure 2



Source: Data from Levit et al. (1996, p. 188).

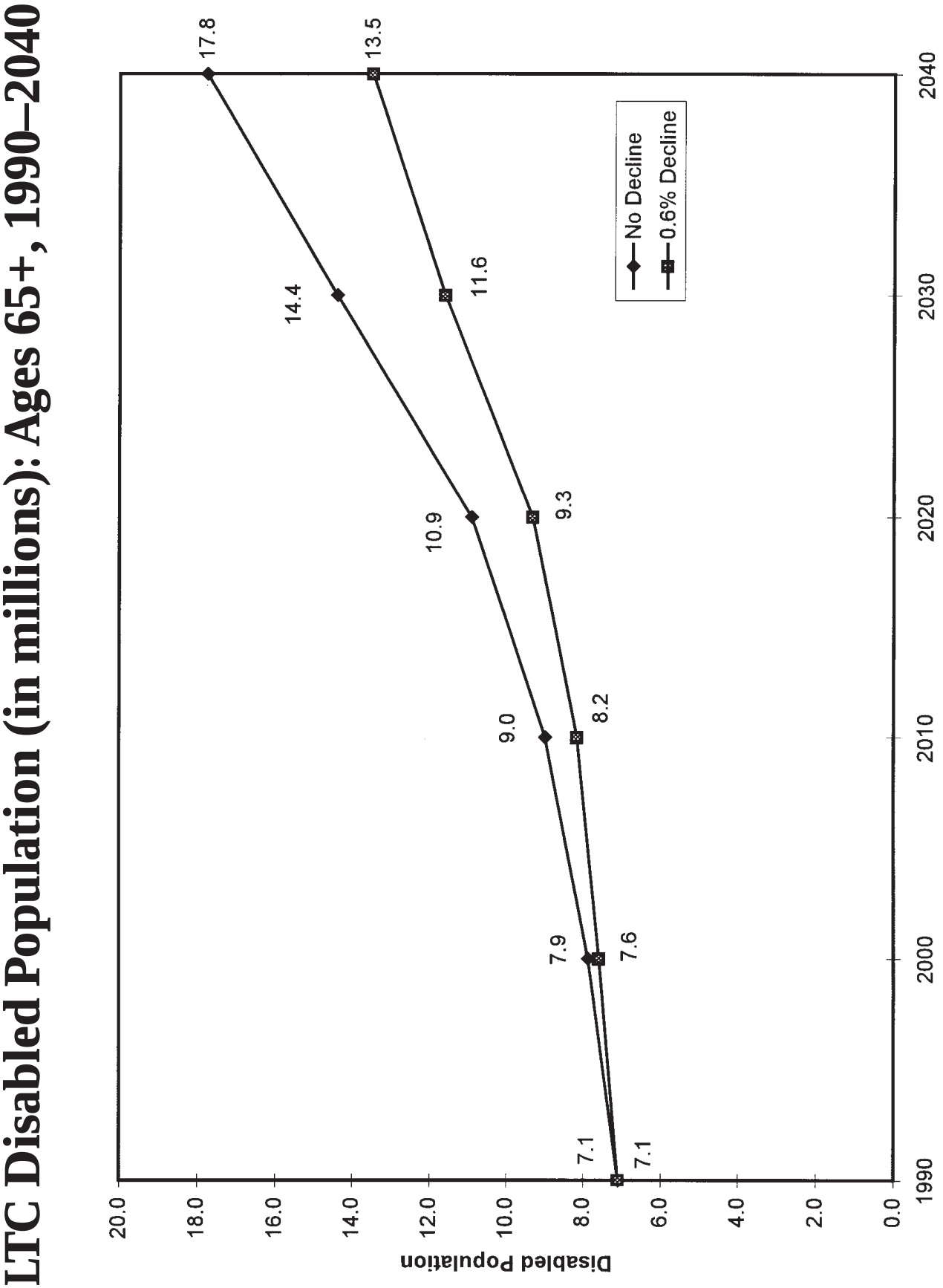
Figure 3

LTC Status by Year, Age, and Severity



Source: Data from the 1982 and 1994 National Long-term Care Surveys, tabulated by the Center for Demographic Studies, Duke University.

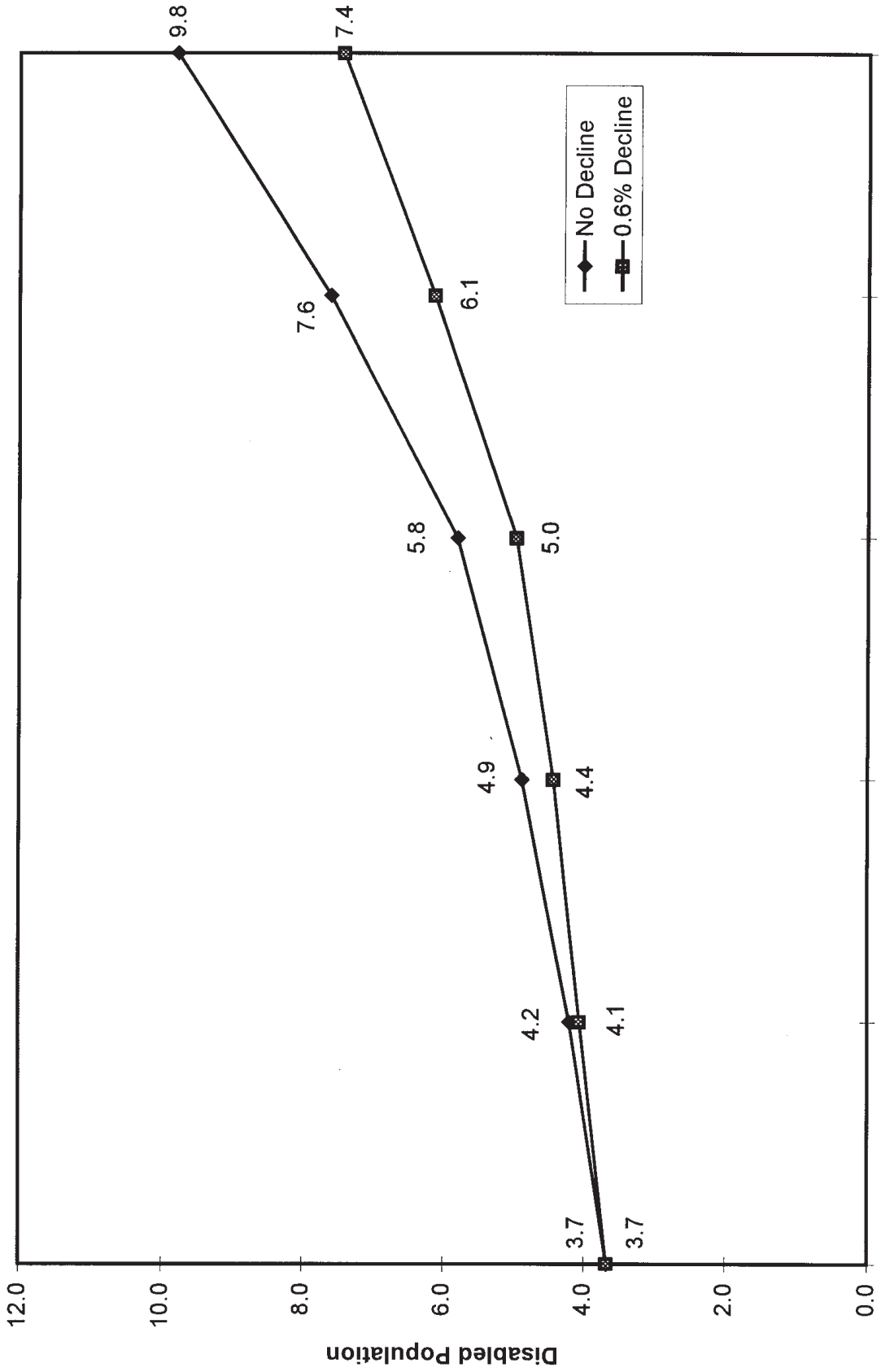
Figure 4



Source: Social Security Area population projections from Bell and Kumar (1996); severe LTC disability rates from the 1982 and 1994 National Long-term Care Surveys, tabulated by the Center for Demographic Studies, Duke University.

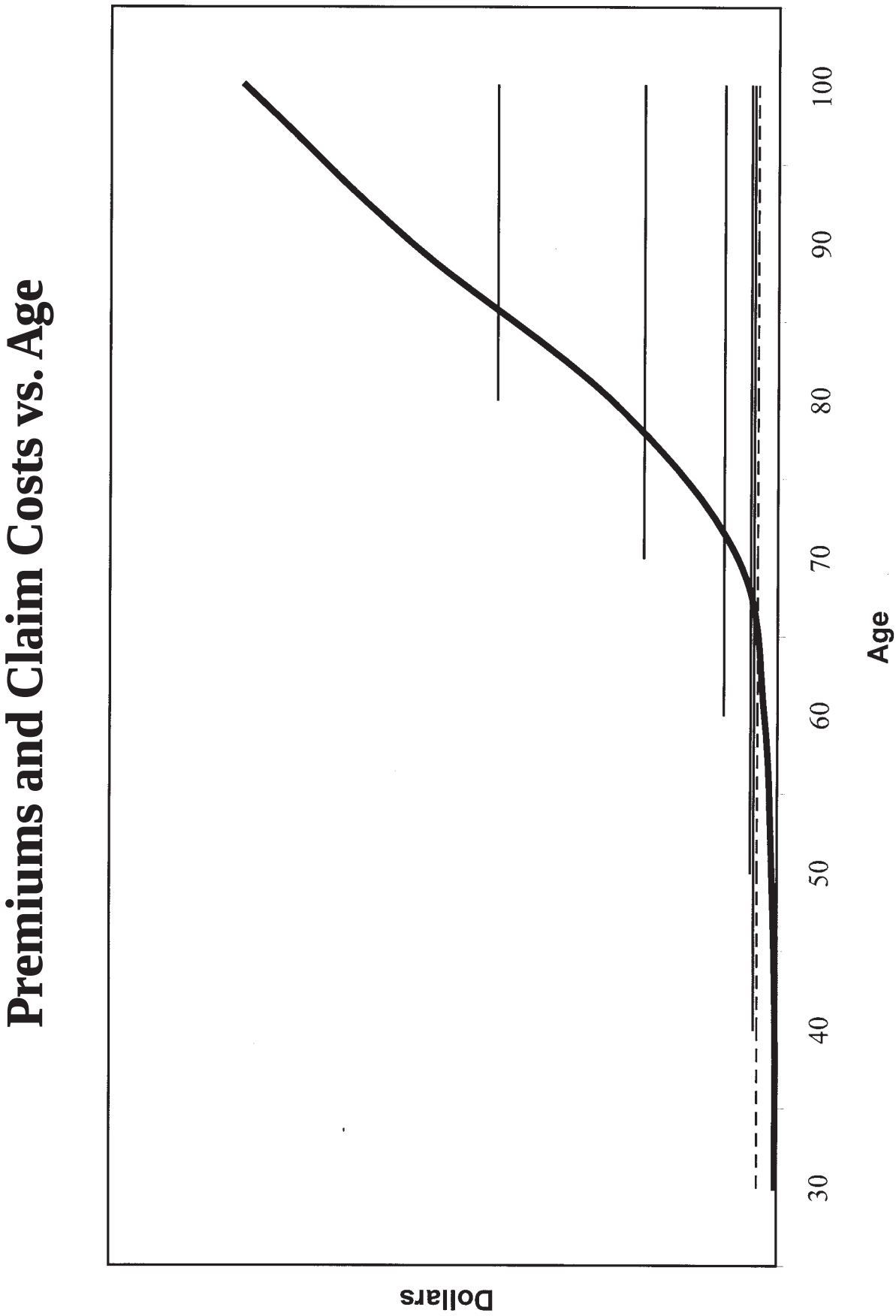
Figure 5

Severely LTC Disabled Population (in millions): Ages 65+, 1990–2040



Source: Social Security Area population projections from Bell and Kumar(1996); LTC disability rates from 1982 and 1994 National Long-term Care Surveys, tabulated by the Center for Demographic Studies, Duke University.

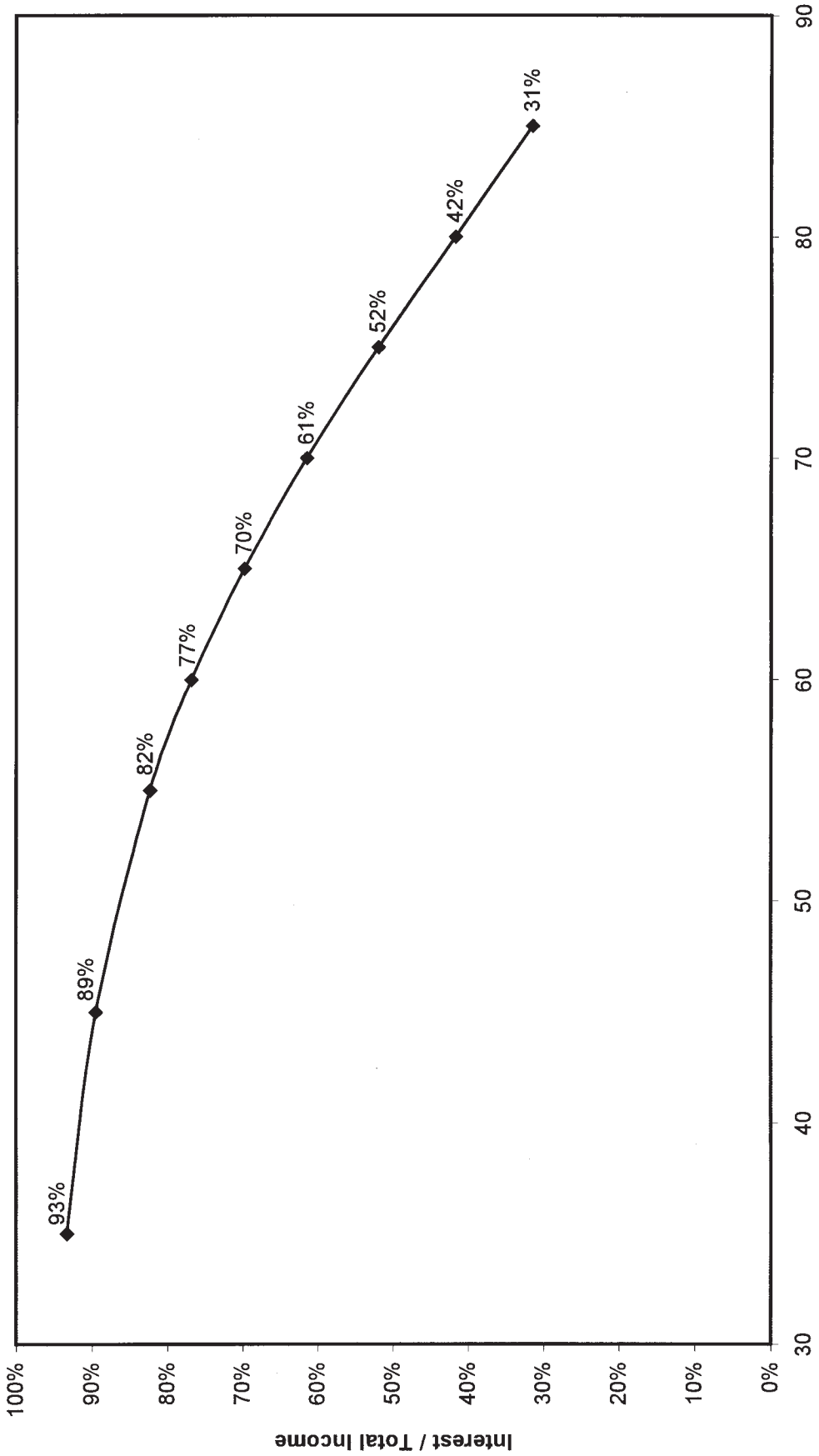
Figure 6



Source: Actuarial Forecasting and Research, Inc.'s illustrative calculations of LTC premiums and claim costs.

Figure 7

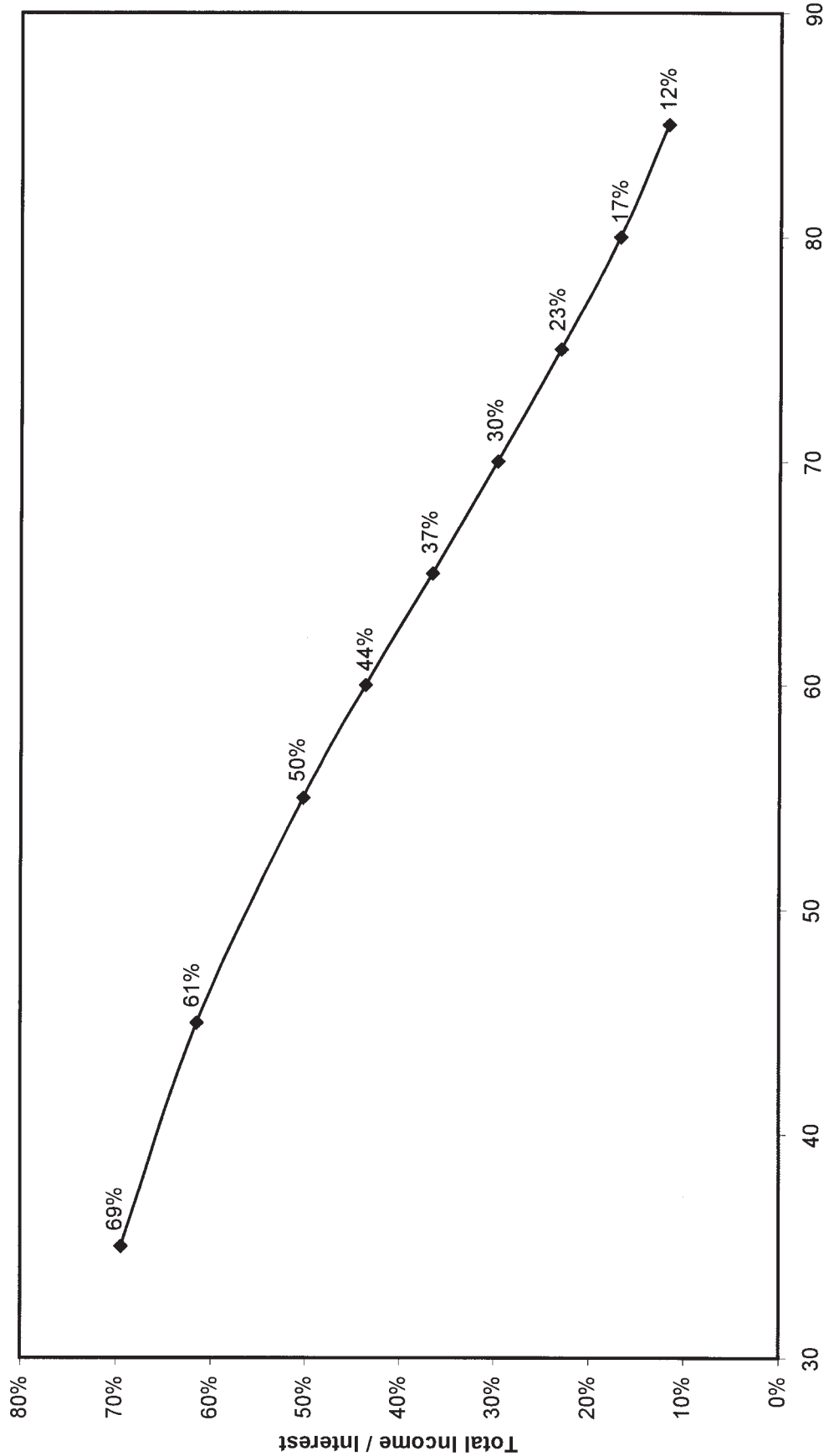
Percentage of Benefits Paid From Investment Income by Comprehensive LTC Policy With Inflation Protection and Low Administrative Expense



Source: Actuarial Research Corporation's illustrative calculations of percentage of LTC benefits that could be funded from investment income.

Figure 8

Percentage of Benefits Paid From Investment Income by Comprehensive LTC Policy With Inflation Protection Sold Through Agents



Source: Actuarial Research Corporation's illustrative calculations of percentage of LTC benefits that could be funded from investment income.

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