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**An Overview of the U.S. LTC Insurance Market  
(Past and Present):  
The Economic Need for LTC Insurance, the History of  
LTC Regulation & Taxation and the Development of  
LTC Product Design Features**

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# **An Overview of the U.S. Long-Term Care Insurance Market (Past and Present): The Economic Need for LTC Insurance, the History of LTC Regulation and Taxation, and the Development of LTC Product Design Features**

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## **ABSTRACT**

We provide reasons for why U.S. individuals should save for and buy private long-term care (LTC) insurance in the context of demographic trends and increasing cost and coverage constraints on Medicare, Medicaid and the federal budget. Then, we review the history of national regulation (including the recently repealed CLASS Act), especially with respect to pricing and rate review processes. We also examine the U.S. tax code, as it has affected LTC insurance, with specific focus on distinguishing between qualified and non-qualified LTC policies and the lack of a cash surrender value, non-forfeiture clauses, and marketability due to long waiting periods. Next, we examine the LTC insurance market from the early years (1980s and 1990s) through today, with emphasis on the inadequacy of the level-premium structure, dissatisfaction with core LTC products from both consumers and insurance companies, and which carriers have either left the market or persisted into 2014. Finally, we contrast the primary features of LTC product design (so far) to what is needed to make LTC insurance viable going forward, with specific discussion on benefit triggers, coverage portability, non-forfeiture provisions, initial price levels and contract language, all as they help better align the interests of policyholders, regulators and insurers.

## **I. Introduction: Economic Need for U.S. Citizens to Save for Long-Term Care**

### **A. Aging Population and Other Demographic Shifts**

As the baby boom generation (i.e., defined by those born between 1946 and 1964) reaches age 65 between 2011 and 2029, there will be a heightened demand for services that provide care for the elderly. Such services have been largely provided by Medicare and Medicaid, but due to funding deficiencies at both the state and federal government levels, long-term health care may increasingly need to be funded by individuals through either out-of-pocket savings or private insurance plans. It is estimated that approximately two-thirds of U.S. individuals currently age 65 and over will need some long-term care (hereafter referred to as LTC) during their lives, either at home or by an outside institution [Chapman, 2012].

Since Medicare was created in 1965, there have been numerous improvements in both science and medicine that have contributed to increasing life expectancies. However, much of this increase is spent in disabled, rather than non-disabled, years. Stallard estimates that the future life expectancy for U.S. individuals aged 65 is currently 17.6 years, and 25.8 percent of these years are spent in a “disabled” state [Stallard, 2011]. Furthermore, for individuals aged 75, about 40 percent of remaining lifetime will incorporate disability, and for individuals aged 85, more than 60 percent of remaining years will include disability [Stallard, 2011]. Thus, there will be an increased need for professional health care services, especially late in one’s life.

In 2010, there were 48 million Americans enrolled in Medicare (of which 40 million were aged 65+ and the remaining 8 million were disabled and less than 65), and this figure is expected to increase to 80 million by 2030. During this 20-year period, the number of workers per Medicare enrollee is expected to decline from 3.7 to 2.4 [Potetz et al., 2011]. In 2010, the proportion of Americans aged 65+ was 13 percent, but this will grow to 19.8 percent by 2030 [Gibson, 2012]. Interestingly, both Germany (in 1994) and Japan (in 1997) converted to a government-provided universal LTC program when the proportion of their elderly populations passed the 15 to 16 percent mark. However, this seems unlikely in the United States due to economic and political constraints.

In addition, birth rates are falling, average family sizes are decreasing, the geographic distances among immediate family members are increasing, and the proportion of women in the labor force is increasing [Colombo & Mercier, 2011]. All of these trends suggest that there is less availability of informal, family-based support to provide in-home health care to elderly dependents. Thus, the need for formal LTC may be increasing. The U.S. Center for Medicare and Medicaid Services estimates that the number of Americans aged 65+ who will need LTC will increase from 9 million in 2006 to 12 million by 2020.

Finally, the rising incidence of dementia, which includes Alzheimer’s disease, especially among U.S. individuals in their 50s and 60s, will increase dementia-related societal costs by 80 percent from now until 2040 [Hurd et al., 2013]. This increase is mostly due to LTC services, both home-based and in institutions, rather than from medical services directly. In fact, the costs attributed to cognitive impairments are estimated to be even greater than those involving heart disease or cancer, even after excluding any informal care provided by family members.

## **B. Growing Cost of Medicare**

In 2011, Medicare spending was approximately 15 percent of the U.S. federal budget, and is expected to increase to 17 percent of the budget by 2020 [Potetz et al., 2011]. Medicare spending was \$560 billion in 2010, and is expected to top \$1 trillion per year by 2022 [Potetz et al., 2011]. Furthermore, Medicare expenditures were 3.6 percent of U.S. gross domestic product (GDP) in 2010, and are expected to increase to 5.6 percent of GDP in 2035, and 6.2 percent of GDP in 2080.<sup>1</sup> Interestingly, 27.4 percent of total Medicare spending is for elderly during the last year of life [Hogan et al., 2001].

A significant reason for why Medicare costs have increased is that many individuals buy Medigap policies to fill in coverage gaps in basic Medicare (Parts A and B), so as to reduce their out-of-pocket costs, but this may also encourage unnecessary use of health care services and thus increase Medicare expenditures overall. Second, Medicare employs a prospective payment structure whereby a hospital receives a fixed payment for a service that does not depend on actual utilization incurred (and thus, the hospital may get to pocket the remainder of payment for services not rendered).

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<sup>1</sup> See <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

### **C. Coverage Limitations of Medicare**

Many retirees erroneously believe that Medicare, either through its basic or supplemental programs, pays for nursing home care throughout one's lifetime. However, Medicare does not cover LTC provided by either custodial or non-skilled workers, but only provides medically necessary care in skilled nursing facilities or, if ordered by a doctor, rehabilitative care in one's home. More specifically, Medicare Part A will cover up to 90 days for hospital inpatient stays, along with a 60-day lifetime reserve (if the initial 90 days are exhausted). However, starting on day 61, the patient has a \$289 daily copay (in 2012), and each one of the lifetime reserve days requires a \$578 copay. Part A also covers care in a skilled nursing facility, but subject to the following restrictions: a prior hospital stay of at least three days is required, no custodial or traditional LTC services are covered, and there is a 100-day maximum per ailment (with the last 80 days requiring a daily copay of \$144.50). Also, Medicare Part B, which pertains specifically to outpatient services, has a \$140 deductible (in 2012) and requires the patient to pay 20 percent of all approved services in excess of this deductible.

Thus, Medicare does not provide a comprehensive care package, and even for services it covers, the patient may be subject to significant out-of-pocket costs in the absence of additional private insurance. Moreover, some providers do not serve Medicare patients at all, which can make access to care difficult for retirees who rely exclusively on Medicare. Providers complain that Medicare regulations, for example, may prevent them from operating profitably out of various nursing homes. Currently, Medicare covers only 48 percent of the cost of all medical services incurred by its enrollees. Thus, enrollees must cover the remainder of the costs (e.g., LTC, dental, vision, hearing) out-of-pocket.

As for dementia, with total cost estimates between \$157 billion and \$215 billion for 2010, Medicare only paid approximately \$11 billion (5 to 7 percent) of this amount [Hurd et al., 2013]. For the estimated \$28,500 annual cost attributed to an individual with dementia (in 2010), \$13,900 of this amount was for nursing home care, with \$6,200 for out-of-pocket spending, \$5,700 for home health care, and only \$2,700 covered by Medicare [Hurd et al., 2013]. Also, Medicare does not provide coverage for custodial-based LTC, regardless of whether it occurs at home or in an assisted living facility.

### **D. U.S. Federal Budget Deficit and Solvency Concerns**

In 2008, the Congressional Budget Office (CBO) wrote that "future growth in spending per beneficiary for Medicare and Medicaid ... will be the most important determinant of long-term trends in federal spending. Changing those programs in ways that reduce the growth of costs ... is ultimately the nation's central long-term challenge in setting federal fiscal policy." In the decade from 2010 to 2020, health care inflation is expected to be 5.8 percent per year, which is significantly larger than the general inflation rate due to increased utilization of medical services and new medical technologies that ratchet up the cost of health care.

As of April 2, 2013, the total debt in the United States had increased to \$16.8 trillion, with much of the increase realized since the onset of the 21st century. Both the Bush (due to tax cuts, military spending, and the funding of Medicare Part D for prescription drug coverage) and Obama (due to programs that addressed the financial crisis and other spending increases) administrations bear some responsibility. As for the "entitlement" programs of Medicare, Medicaid and Social Security, the Government Accountability Office (GAO) projects that these programs will have payouts that significantly exceed the tax revenues meant to fund them. More specifically, they estimate that the present value of the funding deficit is \$45.8 trillion over the next 75 years, with Medicare and Medicaid responsible for approximately five times more of the shortfall (\$38.2 trillion) than Social Security (\$7.6 trillion). Note that this \$45.8 trillion is not currently counted as part of the national debt level, but if it were, our deficit would increase from \$16.8 trillion to over \$62 trillion. In 2010, Alan Greenspan commented that "only

politically toxic cuts or rationing of medical care, a marked rise in the eligible age for health and retirement benefits, or significant inflation, can close the deficit.”

As relates to the GDP, U.S. health care costs are currently 17 percent of GDP, and the total debt-to-GDP ratio is approximately 100 percent [Dupourque, 2011]. If no changes are made, estimates are that this debt-to-GDP ratio will double by 2040, become 400 percent by 2060, and reach 600 percent by 2080. If nothing is done, forecasts are that the trust fund for Medicare Part A will become insolvent by 2024. Note that the gap between the expected Medicare benefits that will later be received over the taxes paid during working years to fund these benefits is positive across all major rating classes; that is, regardless of income level, marital status, retirement date, or gender, the system is projected to be underfunded. This is especially true for women, since they are likely to have more health care needs post-retirement due to their greater expected longevity. Because these projections bring into doubt the future viability of Medicare, individuals may increasingly become attracted to private LTC insurance.

#### **E. Need for Private LTC Insurance**

LTC insurance may cover custodial care, home health care, hospice care, assisted living care, adult day care and skilled nursing care (although not short-term hospital stays). Many of these services are not covered by Medicare, despite the assumption by many elderly that they are. These services may also be excluded from disability income policies that operate during one’s working years and from supplemental medical reimbursement policies after retirement. In short, many seniors either do not know or do not understand the limits of their coverage, especially as it affects their LTC needs. Although Medicaid does provide some of these services for individuals who meet the needs-based eligibility requirements, Medicaid benefits may be scaled back in years ahead (or eligibility tightened) due to the severity of fiscal constraints at both the state and federal government levels. In 2011, public funds accounted for 56 percent of total nursing home and retirement care expenses, with Medicaid leading the way at 31 percent and Medicare at 25 percent. Individuals paid 26 percent of this out-of-pocket, while private LTC insurance covered only 11 percent [Conning, 2013], although this proportion may grow as LTC policies already in force mature.

A greater presence from the LTC private insurance sector could help ease the funding strain on Medicaid, especially with respect to its coverage of home-based, community-based, and institutional-based LTC services. In-home care is the largest segment of the LTC industry, but neither basic Medicare nor Medicare supplemental insurance cover most home-based services. Furthermore, individuals who will need LTC in upcoming decades cannot just sit around and wait for the government to upgrade “entitlement” programs, especially since the American political system does not enable major change (in either direction) from the “status quo” to be adapted without great struggle (see Section II.H Re: The CLASS Act). Thus, regulators and LTC insurers have mutual incentives to work more closely together to create different types of innovative products.

The most appropriate subpopulation for marketing LTC insurance is the “middle mass,” which is the 55-64 age group, has an average annual income of \$75,000, and total average assets (excluding home value) just over \$100,000 [Meiners, 2012]. According to a 2010 retirement study by the Society of Actuaries (SOA), this “middle mass” represents 83 percent of the target market for LTC insurance because these individuals are most at risk for catastrophic LTC costs due to their low ability to fund this expense out-of-pocket, but their higher possibility of being able to afford insurance [Meiners, 2012]. However, the “middle mass” has not yet embraced LTC insurance, either because they don’t understand the risks that such coverage would mitigate against, or they perceive the coverage as being too expensive, perhaps because they underestimate the expected future costs associated with LTC. They may also still depend on informal care arrangements or put greater precedence on other retirement risks. Furthermore, many recently retired baby boomers may be ineligible for private insurance, due to restrictive

underwriting requirements, or may be forced to pay prohibitively high premiums, if they have already suffered a change in health status that would require chronic-based care.

Currently, the majority of LTC insurance sales are targeted toward the “middle affluent,” which is the 55-64 age group, has an average annual income of \$132,000, and total average assets (excluding home value) just under \$400,000 [Meiners, 2012]. This subpopulation has more discretionary income to spend on insurance, and the few agents who specialize in selling LTC prefer this group due to both a higher likelihood of closing a sale and the higher commission that will likely result from a greater amount being insured. The “middle affluent” represents the remaining 17 percent of the target market for LTC insurance [Meiners, 2012]. Note that very few sales are made to income classes below the “middle mass,” due to the cost of insurance and the likely reliance on, and eligibility for, Medicaid; also, it can be assumed that many of the “highly affluent” will self-insure.

The relatively high presence of cognitive dementia and Alzheimer’s disease, both of which require very lengthy periods of LTC, may serve as the greatest examples of the need for private LTC insurance. In 2010, the prevalence of dementia among the U.S. population aged 70 or over was 14.7 percent with the average cost per person estimated to be \$56,300 per year [Hurd et al., 2013]. The majority of this cost is custodial in nature, whereby disabled individuals receive human assistance with basic essential everyday functions (i.e., activities of daily living, or ADLs) like eating, bathing, dressing, toileting, inside mobility, and getting in and out of bed. More alarming, the total annual societal costs due to dementia are expected to double between 2010 and 2040 [Hurd et al., 2013]. As for Alzheimer’s disease, which is a substantial subset of dementia, a 1998 study estimated that 25 to 33 percent of all LTC claims (by frequency), and 40 to 50 percent of all LTC claims (by total cost) were related to Alzheimer’s [Macdonald & Pritchard, 2001].

Here are some additional interesting facts that illustrate the need for LTC insurance:

- At age 65, males will be chronically disabled for an average of 20 percent of their future life expectancy, at an average expected lifetime cost of \$29,000 (in 2000 dollars); for females, these figures increase to 30 percent and \$82,000, respectively [Linder, 2009]. Furthermore, 92 percent of these costs (for both genders) occur during “severe disability” episodes [Linder, 2009].
- Eighteen percent of all seniors will require more than one year in a nursing home facility.<sup>2</sup>
- Nursing home residents use approximately three times more services than those not in nursing homes (mostly due to their more severe disability status) [Kane, 2003].

## **II. History of LTC Regulation and Taxation**

### **A. LTC Insurance Regulation History**

LTC Insurance was first offered to U.S. consumers in 1974, rising from a market need to protect individuals in the future if they were no longer able to perform basic daily functions and activities. Initially, as LTC insurance had no targeted regulatory guidance or consumer protections in place, it had the potential to be highly susceptible to predatory practices that weakened its value within the market. For example, low-income individuals could be sold policies with premiums they ultimately could not afford; agents could convince people to cancel their current policy and replace it with a new one, which incurred an additional commission; insurers that previously did not review health status at policy issuance could later cancel policies on the grounds of pre-existing conditions. In

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<sup>2</sup> See <http://facts.kff.org/chart.aspx?cb=58&sctn=162&p=2> (Kaiser Family Foundation, 2010 Medicare Chartbook).

response, and recognizing the need for regulatory intervention, the National Association of Insurance Commissioners (NAIC) released the Long-Term Care Insurance Model Act (1987) and Long-Term Care Insurance Model Regulation (1988) to provide state regulators with a set of minimum standards and practices that insurance organizations should abide by. Over the course of the following years, the NAIC adopted additional standards to address the various concerns and unfair practices present within the LTC insurance market:

- The prohibition of post-claim underwriting practices to promote clarity to consumers during the policy issuance process, and to prevent insurers from unjustifiably cancelling policies upon identification of a claim<sup>3</sup>;
- Disclosure requirements to consumers and insurance companies during the policy replacement process to mitigate the frequency of agents replacing existing policies with new ones simply for the additional commission<sup>4</sup>;
- Suitability requirements to ensure customer understanding of product details to identify the most appropriate policy type to suit their needs<sup>5</sup>; and
- Standards for the use of benefit triggers within an LTC insurance policy.<sup>6</sup>

While state regulation ultimately governs the LTC insurance product, federal regulations have influenced the product structure and state adoption of NAIC standards. The release of the Health Insurance Portability and Accountability Act (HIPAA),<sup>7</sup> and its associated updates, have provided provisions that offer tax-qualified status to policies that comply with certain criteria, such as offering inflation protection and utilizing disability status as a benefit trigger. Similarly, the federal government's Deficit Reduction Act (2005) provides for additional consumer protections for Partnership policies by requiring certain standards that are consistent with NAIC guidance.

## **B. LTC Insurance and the U.S. Tax Code**

The passing of HIPAA<sup>8</sup> was a well-intentioned yet flawed attempt to solve the problems that the LTC insurance industry still faces today. HIPAA gave rise to the enactment of Section 7702B of the Code,<sup>9</sup> which has further inhibited the ability of insurance companies to provide an LTC insurance product at a fair and marketable price for the consumer.

Congress passed HIPAA in order to improve and promote access to LTC services.<sup>10</sup> HIPAA provides favorable tax treatment to policyholders of qualified LTC insurance. Some of these benefits include tax-free treatment of amounts paid out under qualified policies and the ability for taxpayers to count premiums for qualified policies as deductible medical expenses on personal income tax returns.<sup>11</sup>

From a tax perspective, although HIPAA provided clarity with respect to the taxation of LTC insurance, it instituted burdensome clauses for the policyholders. Before HIPAA and Section 7702B, the Code lacked a specific regime for taxing policies, and thus, general tax principles and code sections were utilized to determine the taxability of benefits. As a result, there was uncertainty as to the proper tax treatment of benefits received under LTC insurance policies. However, HIPAA codified the tax treatment of LTC insurance and required that the benefit

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3 NAIC Long Term Care Insurance Model Regulation; see Section 11.

4 NAIC Long Term Care Insurance Model Regulation; Sections 14 and 25.

5 NAIC Long Term Care Insurance Model Regulation; Section 24.

6 NAIC Long Term Care Insurance Model Regulation; Section 29.

7 P.L. 104-191.

8 P.L. 104-191.

9 Unless otherwise indicated, all references to "section" are to the Internal Revenue Code of 1986, as amended (the "Code") and all "Service" or "IRS" references are to the Internal Revenue Service.

10 P.L. 104-191.

11 See Sections 213(d)(10) & 213(f).

trigger be based on whether the individual met specific, more burdensome qualifications under Section 7702B of the Code. These qualifications include whether a policyholder is unable to perform, without substantial assistance from another individual, at least two ADLs for a period of at least 90 days due to a loss of functional capacity.<sup>12</sup>

Additionally, HIPAA clarified that the favorable tax treatment is available to only qualified LTC insurance contracts. However, inasmuch as the tax incentives provide benefits for policyholders, there are still many individual taxpayers who cannot take full advantage of some tax benefits. One tax benefit that many individual taxpayers are not able to utilize is the deductibility of premiums paid for the policy. The Code states that generally a taxpayer can only deduct premiums once the taxpayer's medical expenses exceed 10 percent of adjusted gross income.<sup>13</sup> If LTC premiums were allowed as a deduction above the "adjusted gross income line" on an individual's federal tax return, similar to the treatment of contributions to retirement benefits or health insurance for the self-employed, more taxpayers would realize the benefit of such a permissible deduction.

Furthermore, the definition of a qualified LTC insurance policy under HIPAA and Section 7702B includes criteria that make the product undesirable. For instance, a qualified policy must exclude a cash surrender value (CSV), thus subjecting the insureds to staying with their current insurer or risk losing everything paid in on the policy with no ability to retain any benefits. The Code also requires a policyholder of a qualified plan to receive a letter from a licensed health care professional stating that the policyholder has lost the ability to perform two ADLs or be cognitively impaired as set forth in 7702B. It also requires the disabling conditions to be expected to last at least 90 days from the time this letter is written in order to receive benefits under the policy.

From both tax and economic perspectives, current individual policyholders of a qualified policy may be giving up a lot more in benefit coverage, transferability and premium negotiation power than the tax benefits they receive under HIPAA and Section 7702B. Significant changes are required in order for the Code to foster market-driven changes to products offered by the LTC insurance industry.

### **C. Lack of a CSV**

The Code's definition of a qualified LTC insurance contract inhibits the ability of insurance companies to provide LTC insurance that would qualify for beneficial tax treatment. Specifically, the definition prohibits a qualified policy from providing a CSV or other money value that can be paid, assigned, pledged or borrowed.<sup>14</sup> As a result, any policy that contains a CSV would not be considered a qualified insurance plan, and, thus, policyholders would lose any tax benefits they would otherwise be eligible to receive under the Code. Furthermore, the increase in a cash surrender benefit for a non-qualified policy would trigger taxable income for the policyholder of such a plan.

As a result, a policyholder of a qualified policy lacks the ability to gain any inside basis in the policy and thus hinders the transferability of the policy to another insurance policy provided by the same carrier or different carrier. This effectively takes away any leverage and negotiating power from the policyholder if and when the insurer decides to raise premiums. In other words, all qualified LTC insurance policies act as term insurance policies. The market does not provide a policyholder the ability to purchase a qualified policy similar to whole life insurance. Pure term life insurance policies do not provide the policyholder with any inside basis build-up (i.e., CSV), and any coverage is lost upon expiration of the term or default of premium payments. Similarly, without an inside basis, LTC insurance policyholders are limited to the benefits in their current policies and will lose any

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<sup>12</sup> See Section 7702(B)(c)(2).

<sup>13</sup> See Section 213(a). Individuals 65 and over, who will use the 7.5 percent floor until Jan. 1, 2017. Section 213(f).

<sup>14</sup> See Section 7702B(b)(1)(D).



amounts paid in should they default on the payment of premiums. As a result, policyholders are locked in to the policies with the current insurance companies or risk losing all coverage and premiums paid in.

This is a critical issue, given that insurance companies have historically erred in pricing LTC insurance policies amid the backdrop of significantly rising LTC costs. Thus, LTC insurance companies have had to raise premium rates, sometimes drastically, in order to compensate for inaccurate pricing due to errors in lapse, interest rates, mortality rates and increased benefit costs. The amount of the increase depended on the person's age when the insurance was purchased. The lack of inside basis means policyholders are forced to choose between losing the benefits completely by defaulting on the new premiums or negotiating a settlement wherein they are often left with significantly reduced benefits and/or coverage periods. A downgrade in a policy (i.e., a reduction in benefits) is deemed to be a partial lapse. As a result of the partial lapse, policyholders forfeit their level-premium equity. Generally, when younger and healthier persons purchase LTC insurance policies, they pay in premiums for a number of years before requiring benefits to be paid under the policies. As a result, significant reserves initially accumulate that are intended to cover benefits paid out when the insured is older. None of these options are attractive for policyholders who have paid in costly premiums, but lack the ability to pull their money out or transfer the value to a new policy. The result is a tax code constraining the ability of the markets to offer an LTC product to consumers at an affordable price that provides LTC benefits that consumers require.

#### **D. Lack of Actuarially Fair Non-Forfeiture Clauses**

The lack of portability for qualified LTC policies is an important component contributing to the lack of marketability for qualified policies. This problem is further exacerbated since LTC insurance companies generally do not offer an actuarially fair non-forfeiture value. These clauses would ideally provide the insured with equitable benefits even in the case of a default on premium payments.

The Code contemplates non-forfeiture clauses being used in LTC policies. Section 7702B(g)(4) permits qualified LTC insurance policies to include non-forfeiture clauses in the case of a default in the payment of premiums. The permitted clauses may provide for reduced paid-up insurance, extended term insurance, a shortened benefit period, or other similar provisions approved by the appropriate state regulator.<sup>15</sup> It is obvious that a non-forfeiture clause would be attractive to consumers as they could potentially lock in a certain level of benefits. When insurance companies seek to increase rates, policyholders that are unable to pay, and whose policies do not contain a non-forfeiture clause, generally lose all the benefits or will end up negotiating for decreased benefits in exchange for less of an increase in premiums.

Moreover, the lack of use of the non-forfeiture clauses, combined with the Code prohibiting the inclusion of a CSV, results in policyholders being saddled with the prospect of being subjected to significant increases in rates with no options to roll over any value to a new policy or insurance product. While the Code contributes to the lack of portability for LTC policies under the 7702B provisions, it also seems to be anticipating that policies would be portable when viewed in connection with the 1035 provision. Section 1035 of the Code allows for a tax-free exchange of a qualified LTC insurance contract for another qualified LTC insurance contract.<sup>16</sup> This is at odds with the 7702B(b)(1)(D) prohibition of a CSV in LTC policies. Thus, the Code is not only contributing to the lack of affordable LTC insurance products but it also contradicts itself.

Note that the ability to purchase an LTC rider with either a life insurance policy or an annuity as a result of the 2006 Pension Protection Act<sup>17</sup> may be an attempt to dampen the effects of a lack of CSV. Unfortunately, there has been scant guidance from the Service as to the income tax consequences of these combination contracts.

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<sup>15</sup> See Section 7702B(g)(4)(B)(iii).

<sup>16</sup> Section 1035(a)(4).

<sup>17</sup> P.L. 109-280.

Where the Service has provided guidance, such as PLR 200919011, the result has been unfavorable to purchasers of LTC policies [Welsh & Parsazad, 2009]. In PLR 200919011, the Service concluded that amounts received from the CSV of the annuity contract with respect to benefits received under the LTC rider are excluded from income, and, therefore, reduce the investment in the contract. This has the effect of converting the tax-free benefits received into a tax-deferred benefit, as the insured will recognize the reduction in the investment in the contract as income when it is surrendered, an unfavorable result for the insured.

#### **E. Lack of Marketability Due to 90-Day “Chronically Ill” Period**

Under Section 7702B(c)(a)(A), qualified LTC insurance services are provided to individuals who are “chronically ill.” The Code defines a chronically ill individual as one who has been certified by a licensed health care practitioner as unable to perform, without substantial assistance from another individual, at least two ADLs for a period of at least 90 days due to a loss of functional capacity.<sup>18</sup> There is a high likelihood that individuals who survive to older ages will need assistance with ADLs. This assistance is costly, and there are few alternative sources available to help cover these expenses. The framework established by the Code does not allow for policyholders to receive benefits unless the period of disablement is expected to last for 90 days. In order to meet those requirements, insurers have designed tax-qualified policies that require the policyholder to wait for the first 90 days during which they require LTC. They must wait 90 days and be certified as “chronically ill” by a licensed health care practitioner before they can receive benefits. During this period, the policyholder who has been paying monthly premiums in a timely manner for a policy that has no CSV and no inside basis must now potentially pay substantial amounts out-of-pocket for LTC to the extent it is not covered by Medicare or other insurance coverage.

The 90-day waiting period may discourage individuals from purchasing qualified LTC policies. However, a reduction in the waiting period, as seen in non-qualified LTC insurance policies, generally results in higher premiums to the insured. Currently, the Code inhibits the ability of market forces to shape the terms as the market desires. While the benefit of a reduction in the 90-day waiting period may not exceed the potential increase in premiums, market forces free of code interference should be permitted to dictate the terms of LTC insurance.

#### **F. Qualified versus Non-Qualified LTC Insurance Policies**

To attract customers, insurance carriers might consider offering policies that include a CSV or policies that reduce the 90-day waiting period, among other possible options. However, to do so would transform an otherwise qualified LTC insurance policy into a non-qualified LTC insurance policy under the Code. This would have significant tax implications for policyholders and further discourage consumers from purchasing LTC insurance.

In order to qualify as an LTC insurance policy under the Code, the policy “must only provide coverage for qualified LTC services, cannot provide coverage for amounts reimbursable under Title XVIII of the Social Security Act, must be guaranteed renewable, must not provide a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed, must provide that all policyholder dividends and premium refunds be applied against future premiums or to increase benefits, and provide certain consumer protection provisions.”<sup>19</sup> All qualified LTC insurance contracts receive the beneficial tax treatment provided to accident and health insurance contracts and employer-provided accident and health plans under the Code.<sup>20</sup> The beneficial tax treatment accorded to qualified contracts includes the exclusion from gross income of amounts

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<sup>18</sup> Section 7702B(c)(2)(A)(i).

<sup>19</sup> Section 7702B(b) & (g).

<sup>20</sup> Section 7702B(a).

received as benefits under the contract,<sup>21</sup> the exclusion from gross income of premiums paid by an employer on behalf of an employee for LTC insurance,<sup>22</sup> and the deduction of eligible LTC insurance premiums paid on the tax returns of the self-employed,<sup>23</sup> among other benefits.

As a result of the significant tax benefits provided to qualified contracts, particularly to those that purchase the policies through employers, qualified insurance policies should be attractive to potential insureds. As it stands now, policyholders seeking coverage through non-qualified policies would lose tax deductions and be hit with income inclusions at exactly the time they cannot afford it. Despite the fact that many believe that a CSV in a non-qualified policy would not be income, this has not been codified and policyholders risk a significant inclusion in taxable income. In sum, congressional insistence on dictating the marketplace for LTC insurance through the Code has prevented consumers from finding LTC policies with benefits that would also incur favorable tax treatment. Coincidentally, those terms, such as offering a CSV, non-forfeiture clauses, and potential changes to the 90-day waiting period, may be just what is needed to attract more people to purchase LTC insurance.

### **G. Pricing and Rate Review Processes**

Regulatory standards for LTC insurance pricing have evolved significantly since the product's introduction, largely due to the adverse impact of initial standards on company pricing models. Prior to 2000, the vast majority of state LTC insurance regulation based pricing justification on expected loss ratio. NAIC's model utilized a 60 percent loss ratio standard to help mitigate risks of excessive or inadequate rating programs. However, by using such a standard, the NAIC's regulatory approach did not necessarily promote rate adequacy. Given the long-tailed nature of the product and the lack of product-specific actuarial data, pricing could not rely on past performance to develop an adequate pricing structure. As a result, LTC insurance policies were often rated far too low to cover incurred losses, and often companies found themselves with a significant rate need. To combat rate inadequacy, large rate increases were approved in many states, leading to a significant loss of coverage for consumers who were unable to pay for their new policy premiums.

Recognizing the need for regulatory intervention, the NAIC in 2000 amended the existing regulation and included a more comprehensive structure for rate setting and justification. Rather than simply using loss ratio, the updated regulation focuses on the evaluation of the anticipated costs over the lifetime of a policy, thus promoting the consideration of a longer-term policy perspective in augmenting product rating. Standards also require actuaries to review rate adequacy and provide a margin of error within their pricing model, allowing for greater stability for product rates. Loss ratio requirements are still utilized, but these new standards (58 percent for new products; 85 percent for rate changes)<sup>24</sup> provide greater specificity on loss expectations for product introduction and continuation. However, while these standards have been beneficial for many customers, others have not been impacted due to either a lack of state adoption or the lack of retroactive effectiveness (e.g., for policies issued pre-2000).<sup>25</sup>

The controversy over rates often becomes a very public debate. Consumers most adversely impacted by large rate increases are typically those who are already "seniors" and have invested for years in the product. Now, as they get closer to a period where they might actually need the protection afforded in the product, they are confronted with "rate shock" on a product that was sold as having level premium. The political pressure associated

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21 Section 7702B(a)(1) ("a qualified long-term care insurance contract shall be treated as an accident and health insurance contract..."); Section 104(a)(3) ("...gross income does not include – amounts received through accident or health insurance...for personal injuries or sickness..."). Note that the exclusion from gross income is subject to the limitations detailed in Section 7702B(d) related to per diem benefits.

22 Section 7702B(a)(3); Section 106(a).

23 Section 162(l)(2)(C).

24 NAIC Long Term Care Insurance Model Regulation; see Section 20.

25 GAO-08-712. Oversight of Long-Term Care Insurance, p. 17,

with this dynamic is what puts regulators in the uncomfortable position of assessing actuarial supported rates, which arguably ensures solvency, but which may also cause public outcry from the individual consumer. Proposed rate increases are often the subject of public hearings, which further heighten sensitivities, and can potentially become a bit of a spectacle. There is little sympathy from the consumer perspective—“Why should I have to subsidize a big insurance company when they get it wrong?” The arguments on both sides are strong and put the regulator in the unenviable position of trying to strike the right balance. Our view is that the product design is flawed, and that it is not the regulator’s job to correct this flaw (i.e., regulate an insurer’s failure).

#### **H. The CLASS Act (as a Government-Funded Plan Alternative)**

In March 2010, the controversial “CLASS Act” was signed into law by President Obama, after having been passed by both branches of Congress in late 2009. CLASS created a publicly funded federal insurance program for LTC, and was a reaction to the increased expenses incurred under state Medicaid plans from rising health care costs and demographic changes. A primary goal of CLASS was to make LTC services available to individuals who could not pass the underwriting standards of private insurance companies, and to provide benefits to those currently disabled and needing assistance to remain in the community and work. The basic terms of this voluntary, guaranteed issue program stipulated that enrollees would pay monthly premiums (approximately \$65) through payroll deduction, become benefit-eligible after five years if at least three of these five years were spent working, and thereafter be eligible to receive a lifetime daily cash benefit (varying between \$50 and \$75 per day, depending on disability level).

However, this legislation was extremely unpopular in the insurance industry, and quickly shown to be flawed by actuaries. The SOA and American Academy of Actuaries (AAA) claimed that CLASS was unlikely to entice more than a small proportion of the intended population, primarily due to the \$50 to \$75 daily benefit being insufficient [Schoonveld, 2009]. CLASS beneficiaries would still have significant out-of-pocket costs and remain a burden to state Medicaid programs. More importantly, due to the voluntary nature of the program and both the guaranteed issue and opt-out provisions, the SOA deemed CLASS to be too risky under the proposed level-premium structure [Schoonveld, 2009]. Adverse selection would likely result since individuals who expect to incur high utilization costs would be more likely to enroll. Projections estimated that “actuarially sound” premium levels, that incorporate the effects of adverse selection, would be closer to \$160 per month, considerably higher than the CLASS proposed \$65 level [Schoonveld, 2009]. Furthermore, if premiums were increased to \$160, relatively healthy individuals would almost surely not participate for fear of subsidizing the less healthy; ultimately, the total premiums collected would be insufficient to cover total enrollee costs.

Proponents of CLASS indicated that its implementation would save Medicare \$2 billion over the next 10 years. However, critics of CLASS countered by labeling it a “financial gimmick” or even a “Ponzi scheme,” that would not only fail to help the federal government’s fiscal problems, but exacerbate them. Most troubling, though, was an actuarial projection by the SOA that estimated that CLASS would be insolvent within 11 years [Hagelman, 2010]. Thus, in October 2011, just 17 months after CLASS was signed into law, President Obama announced the program would soon be dropped. In January 2013, this became a reality when CLASS was officially repealed.

### **III. The U.S. Long-Term Care Insurance Market (to Date)**

Note that the discussion below focuses mostly on the development of the individual, stand-alone LTC insurance market, although we later introduce some of the more popular recent LTC product innovations (see Section III.F).

## **A. Level Premium Structure**

The costs of LTC insurance benefits increase with age, and such increases are especially sharp at advanced ages. Thus, level-premium products that provide lifetime benefits have significantly lower premiums for younger entry ages. Ideally, these level premiums will pre-fund future benefits in early years when costs are low, and as assets are accumulated and invested, they will become sufficient to cover the heavier expected costs in later years. A standard LTC insurance policy contains the following language: "... guaranteed renewable with level premiums anticipated for the life of the policy" [Pfannerstill, 2009]. Thus, policyholders are led to believe that premiums will not increase, and may complain to regulators if this quasi-promise is broken. This is especially true of premiums that have already been paid over an extended period (with little to no benefit payout). Recently, there has been increased scrutiny by both the national media and government when LTC insurers have requested subsequent rate increases. However, regulators must juggle the ability of policyholders to absorb rate increases and the ability of LTC insurers to remain viable enough to pay benefits long into the future.

In 2000, the NAIC created additional Long-Term Care Insurance Model Regulation, commonly known as the "rate stability law," in order to protect consumers from unexpected rate increases for their LTC policies. The law states that no approval for an initial premium schedule shall be granted unless the actuary "certifies that the ... schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable ... with no future premium increases anticipated."<sup>26</sup> In addition, the regulation mandates that if companies do increase rates, the minimum loss ratio (based on the higher premiums) is 85 percent.<sup>27</sup> Another primary motivation for this legislation is to prevent unscrupulous insurers from intentionally underpricing initial rates in order to build market share, and subsequently raising rates when policyholders will no longer be insurable if they want to switch carriers. Thus, LTC insurers should only be granted rate increases if their past experience was especially adverse; if past experience was only mildly to moderately adverse, they are expected to address this problem by increasing their "provision for adverse deviation" reserve, or through either capital or reinsurance.

Typically, many state regulators only approve a proportion of rate increase requests, and may in fact have a specific cap on what this proportion can be; even when an increase is approved, it is often not for the full percentage amount requested. States may reject some requests for political reasons, or when there is heightened scrutiny on regulators due to intensified consumer complaints. Some states may require concessions from the LTC insurers in order to approve increases, such as limiting the benefit period, or requiring a paid-up benefit (not typically present in standard LTC policies) if a policyholder lapses. However, if too many rate increase requests are denied, more LTC carriers will exit the market or go bankrupt, which puts increasing burdens on struggling Medicaid programs, which in turn may increase taxes for all. In 2013, State Farm, MetLife, and New York Life (among others) all requested rate increases. Many other carriers (e.g., John Hancock) were approved to market gender-based LTC insurance, which allows women to be charged higher rates than men (since female LTC costs are 2.5 to three times more than for men).

## **B. Why Initial LTC Insurance Premiums Were Undervalued**

LTC policies from the early years (1980s to 1990s) suffered from being underpriced, due to claim assumptions that were too aggressive, underwriting practices that were too loose, and inaccurate mortality, lapse, and interest rate assumptions. Furthermore, these problems were pervasive across the industry, as everyone needed to use similar, overly optimistic assumptions in order to compete on price. Ultimately, these older blocks

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<sup>26</sup> NAIC Long Term Care Insurance Model Regulation; see Section 10.

<sup>27</sup> NAIC Long Term Care Insurance Model Regulation; see Section 20.

were discovered to be underpriced, which caused companies to increase the reserves supporting these products, take sizable losses, and in several cases, exit the LTC market altogether. With respect to the pricing assumptions for LTC insurance, there have been four major areas where current reality turned out to be quite different from prior expectations:

- Lower-than-expected investment income
- Lower-than-expected lapse rates
- Higher-than-expected morbidity experience
- Higher-than-expected margins needed for adverse deviation.

First, investment income levels have not been sufficient to fund liabilities due to interest rates remaining low for so long. Just like they are for life insurance, interest rates are a very material assumption affecting LTC insurance profits—a decrease of just 50 basis points will require a 15 percent premium increase just for the insurer to maintain the same profit margin [Conning, 2013]. Investment income on early-year premiums that are meant to pre-fund later-year LTC claims incorporates 40 to 60 percent of the revenue used to pay claims [Conning, 2013]. In 2012, LTC insurers had to increase reserves by 22 percent due to investment returns being lower than projected [Conning, 2013].

Much like with interest rates, if lapse rates turn out to be different than expected, this can affect LTC pricing models quite adversely, especially due to the inherently long time horizon of the product. LTC can be a termination-supported product. When a policyholder lapses or dies, that accumulated reserve is distributed to those who remain in the pool. Lower-than-expected active life terminations result in less-than-expected funds distributed to survivors, and therefore inadequate assets to fund benefits. Some LTC projections are done 60 years ahead, since new applicants may potentially survive that long. Initially, actuaries believed that lapse rates for LTC products would be very similar to those assumed for Medicare Supplement products, typically in the 4 to 5 percent range [Conning, 2013]. However, over time, and especially in recent years, actual lapse rates turned out to be much lower, as policyholders were afraid to lose the lifetime benefits of their LTC policies that they had been funding over several years (or decades), in comparison to life products where policyholders are entitled to a return of a significant portion of their equity should they lapse.

Morbidity is perhaps the most complex of all assumptions that support LTC products, as it involves incidence rates, claim continuance patterns, and the proportion of LTC costs that are utilized when a claim occurs. Because LTC products are relatively new, there is not a large degree of credibility with experience when these products were priced. In addition, there is not yet a standard LTC morbidity table that companies can use to increase data credibility, which is especially a problem for insurers just entering the market that can then not even rely on baseline projections. Furthermore, sound morbidity estimates should also incorporate disability patterns, including the progression among varying states of disability severity (and death), and recovery rates from disability, neither of which have been adequately analyzed by the LTC insurance community. A morbidity estimate, based on current conditions, may be insufficient due to socio-economic and medical trends that have altered what is considered care and what is reimbursable. Thus, even if LTC insurers have not yet underestimated morbidity risk on their block of business, morbidity is sufficiently complex to cause potential problems in the future.

In addition to the financial losses incurred to date, insurers have reviewed the risk/return trade-off of the product, due to adverse selection concerns, and as a result, left or reduced their presence in the LTC market. For example, the average issue age has trended younger recently, and with persistency rates continuing to fall, the duration of claims liabilities is lengthening so as to create significant long-tail risk. As the time horizon for blocks of LTC business increases, the confidence in model projections, especially those incorporating any type of lifetime guarantees, becomes shaky. Insurers must also monitor their business mix to ensure they don't have too much proportionate exposure in relatively high-risk groups. For example, the percentage of females covered should be

capped, or separate rate structures should be applied to men and women, since women are several times more expensive than men; also, the regional distribution mix should be tracked to prevent overexposure in areas with a high cost of living. In addition, LTC insurers who offer a “restoration of benefits” provision should be wary of claimant “recoveries” just before benefits are about to expire, as such claimants may simply be attempting to reset their benefit levels for intended future utilization. Finally, there have also been recent societal changes that affected the LTC private insurance market, including the growth of paid informal caregivers and assisted living facilities. Although some of these facilities do accept private payment for LTC insurance, others accept Supplemental Security Income as the primary method of payment.

### **C. Consumer Dissatisfaction with LTC Insurance Product Terms**

Consumers have been, and continue to be, generally resistant to buying stand-alone LTC insurance. The negative publicity from rate increase requests has further eroded the public trust in insurance companies that sell LTC. The NAIC’s “rate stabilization law” of 2000 was meant to make rate increases rare, but the frequency of requests has been increasing due to the consistently adverse experience that has developed, even for policies that were issued after this law. For example, in 2010, John Hancock requested a 40 percent rate increase for the majority of its LTC policyholders, while AIG, MetLife and Lincoln National (LNC) all requested increases between 10 and 40 percent [Tergesen & Scism, 2010].

Policyholders that are facing large rate increases cannot simply “walk away” and change carriers because their higher age (and possible lower health status) may make their new entry-level premium even higher than what their old carrier would charge after the rate increase (if they are even insurable at all). Furthermore, for policyholders that choose to lapse their initial policy, they get nothing back from all the premiums they paid in. Interestingly, very few insureds will choose to lapse after rate increases are approved; rather, lapse rates are highest early on in an LTC policy’s term. This is often due to buyer’s remorse, a lack of prior knowledge about the limitations of what is covered, or dissatisfaction over the service provided by the insurance company once a claims request is initiated. Even policyholders that ultimately receive their benefits have complained about the sometimes laborious process required (e.g., multiple phone calls and mountains of paperwork).

Many Americans simply resist purchasing LTC insurance because it is perceived as being too expensive. For example, a policy that provides a \$200 daily lifetime benefit with a 5 percent inflation protection provision could cost one who is aged 60 at policy inception over \$500 per month, and if a couple were to buy this product, the price could approach \$1,000 per month [Mohoric, 2013]. The NAIC suggests that individuals should not spend more than 7 percent of their annual income on LTC insurance, so that if consumers abide by this suggestion, many at the lower or moderate end of the “middle mass” will not be able to afford this type of indefinite, inflation-protected coverage. Thus, buyers of LTC insurance need to have both a sufficient amount of discretionary income, and be willing to part with it.

Another consumer complaint is that LTC insurance does not fully cover the entire elderly disabled population. According to Stallard, about half of this disabled population does not meet the eligibility requirements for tax-qualified LTC insurance policies due to not satisfying either HIPAA’s ADL trigger definitions or its cognitive impairment trigger [Stallard, 2011]. To be eligible for LTC benefits under such a policy, the individual must be “unable to perform without substantial assistance from another individual at least two ... ADLs ... for at least 90 days due to a loss of functional capacity,” or the individual requires “substantial supervision to protect him- or herself from threats to health and safety due to severe cognitive impairment.” For those that fail these eligibility tests, they must still pay for LTC costs “out-of-pocket,” which may be in addition to all the LTC premiums they have already paid their insurer. A related consumer complaint that may become increasingly prevalent is the use of genetic testing when initial underwriting is conducted. For example, studies have shown a strong link between

genetic composition and one's likelihood to develop Alzheimer's disease, and genetic testing can identify the presence of these gene markers, which if allowed as a rating factor would increase rates on those affected. However, consumers feel that it is unfair to discriminate based on genetic factors, since (unlike lifestyle factors) one has no control over their genetic composition or family history.

#### **D. Insurance Company Dissatisfaction with LTC Insurance Product Structure**

Because interest rates have been low for so long, LTC insurers have been subject to reinvestment risk, whereby they are investing cash flows (that are meant to support claims reserves) from expiring assets at rates lower than what was previously assumed. The majority of assets that back LTC products are investment-grade corporate bonds, both of which have low yields. Furthermore, the longer-term versions of these bonds have a maximum duration of between 10 and 15 years, which is less than the duration of LTC liabilities that can be 20 years or more. Note that the volume of 30-year corporate bonds is limited, and even if employed, the duration may still be too low. Thus, there is an asset-and-liability mismatch problem, which is exacerbated by decreasing lapse rates, which in turn lengthens liabilities. Convertible bonds and equities could be used to increase the duration of the asset portfolio, but there exists both regulatory and liquidity constraints that limit their use. Equities may be considered too volatile amid recent stock market swings. Thus, LTC insurers are now seeking alternative asset classes that may lengthen duration and provide additional yield.

Another worry of LTC insurers is the recent proposal by Health and Human Services (HHS), a federal agency, to extend 2008's Genetics Information Nondiscrimination Act (GINA), originally meant for medical insurance, to LTC insurance. GINA prevents the use of genetic information in underwriting practices, and if adapted for LTC, would impose a significantly greater risk of adverse selection. Both life and LTC insurers argue that their products provide long-term coverage using a level-premium structure, so the initial medical underwriting process is of utmost importance. Both family history and the results of genetic tests must be incorporated because LTC policy premiums cannot be increased due to deterioration in an insured's health after inception (although they can be increased for a whole class of policyholders, subject to regulatory approval). For example, if the presence of the APOE gene associated with Alzheimer's disease was a known fact for potential insureds, but unknown to their LTC insurer, the resulting effects from adverse selection could increase premiums for all by at least 30 percent [Plumb & Stallard, 2011]. Stallard estimates that about half of the variability in individual frailty is genetic, while the other half is due to non-genetic factors like smoking, poor nutrition, lack of exercise, and alcohol and drug use [Stallard, 2007].

As previously mentioned, LTC policies have typically employed unisex rates, which could be viewed as inequitable since males who have much lower claim costs would be subsidizing females. For example, the costs of females in skilled nursing facilities are about 40 percent higher than the costs of males (due mostly to higher incidence rates), and the costs of females using home health care are more than 50 percent higher than the costs for males [Macdonald & Pritchard, 2001]. Also, females are more likely to be institutionalized, and to live longer while institutionalized, than males. Not surprisingly, more females buy LTC insurance than males [Loomis, 2009], and in addition, among LTC insurance buyers, females have lower lapse rates than males [Stallard, 2011]. Note that recently, both of the top two LTC insurance carriers (Genworth Financial and John Hancock), among others, have decided to introduce sex-distinct rates to address these issues, largely because of the substantial differences in mortality rates between the two genders.

There are many negative consequences for LTC insurers when they must apply for rate increases. For instance, in the past, such announcements have led to very expensive class action lawsuits. Even without any potential legal action, rate increases can create bad publicity that may reduce customer satisfaction with the product, along with additional expenses associated with the time-consuming regulatory filing process. Also, even if



the rate increase is approved, the insurer can expect additional adverse selection since individuals who expect high future utilization will be less likely to lapse than those that expect to be healthy. The impact of adverse selection will be inversely proportional to the percentage of the population covered by private LTC insurance, inversely proportional to an individual's age at policy inception, and directly proportional to the percentage of insureds that had genetic testing.

Another problem for LTC carriers is that there are fewer agents and advisers discussing LTC insurance with their clientele, and for those that do, they readily admit the product has been a tough sell. This consolidated distribution system not only reduces overall access to consumers, but will ultimately lower sales and the quality of service provided, especially since many agents who do sell stand-alone LTC products do not necessarily specialize in just LTC. Furthermore, many agents have complained about the administrative inconvenience when applying for LTC insurance, since the industry does not yet have a set of standardized forms. Other concerns with the LTC industry, from the perspective of insurance companies, include:

- There has not been an increase in actuarial expertise for LTC products, despite the maturing of the market since its early days in the 1980s [Conning, 2013].
- Beneficiaries (and their providers) may have a financial incentive to create or maintain disability, which creates moral hazard. This is especially true for policies with lifetime benefits, where the policyholders have no incentive to conserve their unlimited benefits. Note that lifetime benefit policies typically have incidence rates that are 30 to 40 percent higher than those for limited benefit policies [Kane, 2003].
- It is hard to objectively specify claim criteria due to the complexity of disability.
- There are data security issues (e.g., identity theft, confidentiality) as systems have moved online.

#### **E. Carriers That Have Exited the Market (and Persisted)**

Despite increasing demand for LTC services, overall sales for private, stand-alone LTC insurance have been decreasing, and the number of insurers offering either individual or group-based LTC insurance has also been falling [Chapman, 2012]. The market is very highly concentrated. In 2012, out of the 86 companies reporting either group or individual LTC premiums:

- The top 25 (based on direct premium for group and individual combined) had 96 percent of the market share; the top 10 had 78 percent of the market share, and the top five had 61 percent [Conning, 2013].
- The top 10 (based on earned premium for group insurance only) had 98 percent of the market share; the top five had 91.5 percent of the market share [Conning, 2013].
- The top 10 (based on earned premium for individual insurance only) had 83 percent of the market share; the top five had 67.5 percent of the market share [Conning, 2013].

For LTC carriers that are not among the industry leaders, it can be especially challenging to compete in such a concentrated market, and many have decided to reduce or stop future participation in the market or apply for rate increases [Anonymous, *Insurance Journal (online)*, 2012]. As companies exit the market, and several key players have done exactly that during the past decade (see below), the market becomes further consolidated. Also, a concentrated market serves as a significant barrier to entry if there are any new companies considering offering LTC insurance.

The following table shows the top 10 carriers for LTC insurance in 2012, based on direct premium, when group and individual insurance is aggregated:

Company Name	Direct Premium (in \$Millions) (Group & Individual), 2012	LTC Insurance Market Share, 2012
Genworth Financial	2,316	22.8%
John Hancock	1,628	16.0%
Metropolitan	1,018	10.0%
CONSECO	620	6.1%
UNUM	577	5.7%
AEGON	507	5.0%
Prudential of America	450	4.4%
Northwestern Mutual	385	3.8%
Ameriprise	247	2.4%
New York Life	222	2.2%
TOTAL (for top 10)	7,970	78.4%

Here is the corresponding table for 2007, five years earlier:

Company Name	Direct Premium (in \$Millions) (Group & Individual), 2007	LTC Insurance Market Share, 2007
Genworth Financial	1,753	20.3%
John Hancock	1,281	14.8%
Metropolitan	982	11.3%
CONSECO	869	10.0%
UNUM	536	6.2%
AEGON	516	6.0%
Penn Treaty American Group	280	3.2%
Ameriprise	230	2.7%
Allianz	217	2.5%
Assurant	188	2.2%
TOTAL (for top 10)	6,852	79.2%

When comparing these two tables, note that the ranking of the top six remained the same from 2007 to 2012, but the total market share of the two most dominant players (Genworth and John Hancock) was higher in 2012

(38.8 percent) than in 2007 (35.1 percent). More importantly, 6 of the 10 companies in the 2007 table announced they were discontinuing LTC sales sometime between 2002 and 2011 (Ameriprise in 2002, AEGON in 2005, Penn Treaty in 2008, Allianz in 2009, Assurant in 2010, and Metropolitan in 2011). In addition, UNUM announced a sales freeze in 2012. Thus, only Genworth, John Hancock and Banker's Life/CONSECO are continuing with new sales presently, although AEGON is also continuing new sales under the TransAmerica name. Note that many of these exiting companies still appear in the 2012 table, since they continue to receive premiums on their in-force business.

#### **F. State of the LTC Insurance Market Today**

In 2010, approximately 250,000 individual, stand-alone LTC policies were issued, with about 8 million such policies in force overall [Benz, 2011M]. The average age of new buyers, which had been 68 in 1990, and declined to 61 in 2005, fell even further to 57 in 2010, with the average annual premium at \$2,150 [Tergesen & Scism, 2010]. Individual sales still dominate group sales in the LTC market, with an estimated 80 to 90 percent of policies in force classified as individual [Conning, 2013]. Despite the sales slump observed in the late 2000s, individual sales increased by 13 percent in 2010, and group sales were up 24 percent [Stoltzfus & Feng, 2011]. The rates of increase were similar in early 2011. In 2012, direct premiums were up but earned premiums were down. In the first two months of 2013, LTC applications for coverage from leading insurers were 30 to 55 percent higher than during the same period in 2012 [Conning, 2013].

As for recent innovations, the "partnership program" has some traction, whereby an insured who becomes chronically disabled first draws on their private LTC insurance, albeit with a more limited benefit period than with traditional LTC plans. Then, when their benefits expire, they are eligible to receive publicly funded Medicaid. There have been other innovations suggested to control increases in LTC premiums, most of which also involve additional benefit limitations. For example, more copays, longer elimination periods, lower inflation rates applied to benefit runoff, and more strict triggers to become initially benefit-eligible, might be required for future insureds. A more radical idea would be to change the level-premium structure (currently based on issue age) to an increasing premium structure (based on attained age), similar to the structure of term insurance. This could lead to an average annual premium increase of about 10 percent [Mohoric, 2013]. Alternatively, an LTC insurer could create an LTC account, which would pre-fund LTC coverage when individuals are working, similar to what is done for individual retirement accounts (IRAs)/401(k) plans. Regardless of whether or not these innovations are ultimately adapted, the LTC insurance market will be more effective if and when the participation rate increases from its current level of 10 percent, since the market is highly voluntary and vulnerable to adverse selection. Increasing participation could be accomplished through product changes that improve the affordability for potential new customers, and with a more aggressive marketing campaign.

Another major innovation in the LTC industry is the recent proliferation of combo, or "linked" products, where an LTC rider is sold jointly with either a life insurance policy (whole life or universal), or an annuity (immediate or deferred). Although combo products have been around for several decades, they really took off in 2009-2010 [Benz, 2011S], as a result of recent changes in taxation policy (see below). Combo products still enjoy double-digit growth rates for individual-based new LTC sales, especially for individuals in their 40s and 50s [Conning, 2013]. In fact, about one-third of new sales in the LTC insurance market now involve combo/linked products. For the traditional life insurance option, with a "living benefit" LTC rider, the policyholder can pay a large, single premium at time of issue and essentially lock in the price for future benefits; there are also other types of payment arrangements available (e.g., 10-pays or lifetime premiums). The policyholders can then draw on their death benefits tax-free if they become chronically disabled, due to the tax-favored status of combo plans as outlined in the 2006 Pension Protection Act. Another benefit, from the insurer's perspective, is that the mortality risk from the life insurance is balanced by the morbidity risk from the LTC insurance. An LTC insurer might also

decide to use a “universal life structure,” whereby any investment and/or interest rate risks are transferred to the insured.

#### **IV. Conclusion: Product Design for LTC 2.0 (Improvements Relative to LTC 1.0)**

##### **A. Review of LTC 1.0 (Legacy) Product Design**

The original LTC products, which we will refer to as LTC 1.0, were designed to be another form of disability income (guaranteed renewable, no actuarially sound non-forfeiture, level funded) with the regulation, tax rules and health care rules encouraging this design. In the end, the LTC product design today satisfies all the regulatory bodies, the insurance company (to the extent rate increase requests are not determined via a political process) and the tax authorities. The one stakeholder the product does not satisfy in its current state is the end consumer. If private insurance and self-funding are to have roles in reducing the federal deficit brought on by the aging of the population, then all parties need to focus on a design that satisfies the needs of the insurance-buying public. We refer to these designs as LTC 2.0.

Insurance companies have decades of experience and understanding of mortality risk. For LTC 2.0 to be successful, a re-think of the design is necessary to reflect the traditional methods insurers have used in the past to pool long-duration risk. In this case, we believe that LTC insurance should have a similar design to the other long-duration products. For example, more pricing should relate to non-guaranteed elements, and more risk should be shared within the pool of LTC policyholders.

The typical LTC legacy product (essentially designed on a disability platform) is flawed for several reasons, and has produced an imbalance of risk and flexibility for both the carrier and the consumer:

- It was designed to satisfy multiple constituents (e.g., health code, tax code, insurance code, etc.) at the (unintended) expense of the consumer.
- It builds up level premium equity and requires the policyholders to lose it if they exit the policy. As a result, regulators protect consumers from “unjustified” rate increases. However, the regulatory decision process is risky and might be influenced by political events. This creates a level of risk for the carrier that can have material implications.
- Legacy LTC products are supported by investor capital, whereas the typical whole life contract does not solely rely on investor capital.
- The legacy LTC carrier bears tremendous risks by attempting to project and match assets to liabilities for time horizons of up to 40 years.
- Legacy LTC carriers have also made 40-year assumptions with respect to morbidity.

As a result, the legacy products skew consumer behavior by misleading expectations about level premiums and, in some cases, unlimited benefits, and a “use it or lose it” perception due to non-forfeiture options.

In order to maintain ratings, preserve capital, and avoid unpredictable reliance on regulators, carriers must introduce economic levers into new products that are adjustable without regulatory approval. Examples include dividends, non-guaranteed interest credits, and adjustable charges up to a contractual limit. In exchange, regulation should insist on the inclusion of an actuarially fair non-forfeiture value, which allows policyholders to exit the deal while preserving their level-premium equity. Such a mechanism should remove the regulator from the process of approving rate increases, but more similar to life insurance, requires the regulator to review both the policy form and the non-forfeiture schedule.

## **B. Benefit Triggers**

Product design with respect to benefit triggers materially impacts experience. For example, policies are generally classified as either tax qualified or non-tax qualified, depending on their adherence to tax law regarding benefits and how they are accessed. One reason that Congress passed HIPAA in 1996 was to ensure that LTC insurance policies that meet certain standards receive favorable tax benefits. As a result, tax-qualified plans provide benefits contingent on the claimant's abilities to perform ADLs or cognitive capability, combined with an expectation that the condition will last longer than 90 days. As a result of the combined specifications for ADLs (or cognitive issues) and 90 days' duration, tax-qualified eligibility requirements are more stringent than typical non-tax qualified requirements which, for most policies, provide benefits based solely on certification of medical necessity (from a physician's statement) without regard to duration, or level of capacity. Thus, premiums on non-tax qualified policies are far more expensive than on otherwise equivalent tax qualified policies.

## **C. Portability of Coverage**

The likely solution to address the industry's flawed legacy reimbursement products is to provide portability with coverage for basic care needs. Legacy LTC products are "long-term level-funded" with no policyholder options should the market or the company change. Products that have built in inherent value typically give the policyholder options on what to do with that value if circumstances change. Alternative designs are emerging, featuring cash value benefits based on non-forfeiture agreements. Carriers are primarily labeling these designs as "life insurance" rather than LTC because of the legal challenges in offering non-forfeiture benefit for LTC.

## **D. Non-Forfeiture Helps Create Fair Insurance Practice**

Regulators do not need to approve rates or rate increases for individual life because the policyholder has the option of taking the accumulated value of the policy to another carrier. In this scenario, the policyholder and company interests are aligned, so that there is no need for a regulator to intervene. Instead, the regulator's focus is on disclosure and solvency, and on ensuring that the non-forfeiture value when the product is initially sold is fair. Offering a similar option to an LTC policyholder can result in the market policing company mispricing rather than the regulator. Note that non-forfeiture does not need to be a cash surrender benefit; it can also be any benefit that increases portability (e.g., lifetime annuitization of the reserve that can be used to pay premiums to a different carrier or a reduced paid-up).

## **E. Addressing the Problem of Selling LTC Insurance at Overly Aggressive Prices**

Whenever there is a long-dated cash flow, and someone gets paid to do a transaction, that cash flow will be priced aggressively. This occurred not only in LTC but also in life settlements, state and municipal pension plans, subprime mortgages and project finance. It only takes one overly aggressive, irresponsible player to de-stabilize an entire market. For example, the original individuals that priced the legacy products got paid for the sales, but suffered no consequences for the resulting failure. We are not implying they did this knowingly; rather, incentives will always either consciously or unconsciously skew decision-making. This is simply part of human nature.

If the regulator approves both the form and the actuarially fair non-forfeiture benefit, then the regulator no longer needs to approve rate increases. By giving the policyholders a way to exit the deal while preserving their level-premium equity, the regulatory protections on the rating side are no longer needed. The regulators can focus on LTC the same way they focus on life insurance (i.e., market conduct, initial form approval and solvency).

## **F. Contract Language and Poorly Defined Product Definitions**

Many legacy policies provide weak or inadequate language protecting the carrier's right to independently ascertain evidence of the claimant's condition. Also, many policies have language that allows a physician's statement as final evidence for care requirements, which can further increase carrier's risk. The independence of the assessor is paramount in establishing the claimant's disability based on functional performance of activities of daily living. However, physicians are not generally trained as care management specialists, and tend to advocate on behalf of their patients.

## **G. How LTC 2.0 Addresses the Fatal Flaw of Existing Products**

With existing products, it is often in the best interest of the company for an in-force policyholder to lapse, while this is contrary to the interests of the insured. An LTC 2.0 product that offers an actuarially fair exit for the policyholder should succeed in aligning the interests of the company, policyholders and regulators, which would result in greater market stability. Moreover, since the life insurance industry requires the pooling of losses to help manage long-term risks, and LTC products may be even riskier from this perspective, it seems counterintuitive to suggest that LTC insurers assume these risks without also utilizing some pooling mechanism.

## **H. Summary of Improvements Incorporated into LTC 2.0**

Most innovations in LTC product design should move toward those already incorporated in long-duration products (e.g., whole life or universal life insurance). More specifically, this includes non-guaranteed elements and increased risk-sharing among the pool of LTC policyholders, both of which would enhance market cohesion. Carriers would rely on the flexibility of dividends, interest credits, and adjustable charges (up to contractual limits) to avoid overdependence on regulatory approval. An actuarially fair non-forfeiture value, which might be a CSV, a credit toward future premiums, or reduced paid-up insurance, would allow policyholders to leave an LTC contract while preserving their investment in past premiums, while enabling them to move their coverage elsewhere if so desired. Then, the regulator's role would be reduced to simply approving both the non-forfeiture benefit and the original policy form, while the private LTC insurance market would now govern the mispricing of products in place of regulators. Finally, LTC insurers should be more careful about contract language, benefit triggers and product definitions, while ensuring that the physician assessing disability is both objective and qualified.

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