

Strengthening Risk Protection through Private Long-Term Care Insurance

Wesley Yin



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Abstract

Americans currently spend over \$300 billion a year on long-term services and supports (LTSS), paid for through government programs, private insurance, and importantly, individuals' own out-of-pocket spending. Indeed, elderly households' LTSS expenses present the largest source of out-of-pocket spending risk. However, the ability to insure against LTSS risks remains limited, with Medicaid (the main program providing coverage for these services) covering only limited LTSS. Moreover, with the number of elderly Americans expected to more than double in the next forty years, the number of people using LTSS and public expenditures on LTSS through Medicaid will both grow considerably in the coming decades, presenting important fiscal challenges. The financial risks facing middle-class Americans and the fiscal challenges facing Medicaid call for rethinking how households and the public sector finance LTSS needs.

This paper presents a proposal aimed at such a reform. First, I propose creating a new voluntary program, LTC Advantage, to help individuals purchase private long-term care (LTC) insurance. This progressive cost-sharing subsidy would be paid directly to the insurer to offset future LTSS claims, thereby lowering individuals' effective LTC insurance premiums. Second, I propose the creation of a shared-risk-corridor program to help insurers manage systematic and undiversifiable financial risks. Only losses and gains from business cycles and changing market-wide financial parameters—as opposed to losses from poor claims management and underpricing—would be eligible for protection. Finally, I put forth a menu of policy options to boost access and demand for the LTC Advantage Program. These options include plan standardization, modifications to the Employee Retirement Income Security Act (ERISA) to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, policies to encourage employers to offer private LTC insurance plans, and demonstration programs through the Centers for Medicare and Medicaid Services (CMS) to test financing models that more efficiently integrate LTSS, primary care, and acute care delivery through Medicare.

Undertaking these reforms does not necessarily require additional resources; rather, this proposal would require a financing system that redirects much of what is currently spent on out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance protection.

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Chapter 1. Introduction

The largest out-of-pocket spending risk for elderly households is the expense of care and assistance in the event of cognitive or physical impairment. A 65-year-old couple can expect to spend \$65,000 on long-term services and supports (LTSS), where LTSS is defined to include institutional long-term care (LTC) as well as home- and community-based assistance with daily living activities. This estimate of average spending masks the likelihood that some households will incur far larger costs; roughly 5 percent of elderly couples can expect to pay in excess of \$260,000 for LTSS (Webb and Zhivan 2010). To readers unfamiliar with LTSS risks, these staggering spending estimates may seem implausible, but they are directly tied to the disability risks that individuals face and the cost of LTSS. For instance, 3 percent of men and 10 percent of women will incur nursing home stays in excess of three years (Brown and Finkelstein 2008), at a cost of roughly \$80,000 per year (Metlife Mature Market Institute 2012).

The potential need for LTC and assistance exposes Americans to catastrophic financial risks from out-of-pocket spending on LTSS. While the wealthiest individuals can pay for these expenses through savings, most Americans do not earn and save enough to comfortably pay for LTSS, if needed. Medicaid offers LTC insurance as a critical safety net, but the coverage is means tested: to qualify for coverage, individuals might have to first spend down their assets so that they have sufficiently low levels of assets to meet eligibility requirements. Moreover, Medicaid's traditional bias towards financing institutionally based LTSS neglects the various needs and preferences of many Americans for home- or community-based care.

In theory, private LTC insurance could fill some of this gap in coverage for middle-class Americans, but few buy private LTC policies. Only 12 percent of elderly Americans (or 16 percent of the elderly population who do not qualify for Medicaid), many of whom are wealthy, have private policies (Johnson and Park 2011; Life Insurance Manufacturers' Research Association [LIMRA] 2010). In contrast, most middle-class households are exposed to the risk of having to spend down their assets to qualify for Medicaid coverage of LTSS and/or impose a financial burden on other family members to care for them. In short, many middle-class Americans are simply ill-prepared for the financial consequences of aging and the possibility of disability.

The financial risks facing middle-class Americans parallel the fiscal challenges facing our nation's public LTC entitlement programs. Medicaid spending on LTSS is expected to grow at 6 percent per year over the next ten years (Centers for Medicare and Medicaid Services [CMS] 2012), much faster than the growth rate of GDP. The pace of this spending is expected to increase after 2025, when baby boomers reach the ages at which LTSS needs are the highest. As a result, the projected fiscal pressures will put at risk the commitments to future Medicaid beneficiaries and other social investments, such as spending on education, infrastructure, and early childhood programs. The growing fiscal challenges demand reforms that foster greater efficiency while strengthening the critical safety net that Medicaid provides to the most vulnerable Americans.

This paper presents an LTC finance reform proposal aimed at two broad objectives: (1) improving the financial security of middle-class Americans, and (2) fostering greater efficiency in both public and private LTSS delivery to better meet the needs of beneficiaries. It proposes to expand LTC insurance coverage through the private insurance market, which provides an existing mechanism for administering LTC insurance and thus a pragmatic and potentially efficient platform.¹ In addition, this proposal acknowledges the current fiscal and political reality that neither a marked expansion in federal benefits nor a mandate on LTC insurance coverage are likely.² Accordingly, the proposed expansion of LTC coverage is structured as a voluntary program, with at most a modest budget impact. In addition, this paper acknowledges that the current landscape of Medicare, Medicaid, out-of-pocket spending, and private LTC insurance plans form a fragmented financing system that promotes little coordination across primary care, acute care, and LTSS delivery settings. Consistent with earlier proposals to reform LTC financing, this proposal recognizes that the totality of insurance coverage is too low or incomplete. Relief from the fiscal pressures of rising LTSS obligations must largely come from improved efficiency of LTSS delivery, not from cutting Medicaid benefits.

Operating within these constraints, the proposal involves three key pillars:

1. The federal government would offer an LTC Advantage subsidy and a Medicaid opt-out. This subsidy would

help individuals purchase private LTC insurance in lieu of claiming Medicaid LTC, though the Medicaid LTC provisions would remain intact for those who do not opt for the subsidy. The subsidy would vary in size based on income and health measures and would take the form of a cost-sharing subsidy for LTSS claims that would be paid directly to the insurer.

2. The federal government would establish a shared-risk-corridor program among insurers, beneficiaries, and the federal government. This program would foster premium stability and market confidence, while passing risks to where they are most appropriately held.
3. The federal government would consider a range of policies to achieve greater take-up of private LTC insurance, including plan standardization, modifications to the Employee Retirement Income Security Act (ERISA; 88 Stat.

829, PL 93-406, 1974) to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, policies to encourage employers to offer private LTC insurance plans, and demonstration programs through the CMS to test models for efficient financing of LTSS, primary care, and acute care delivery through Medicare.

This proposed path to expand private LTC insurance coverage does not necessarily require *more* financing. Rather, it requires redirecting much of what is currently spent in aggregate on out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance. Inaction risks the financial security of Americans, and the fiscal health of our public insurance programs. With an increasing share of our population retiring and entering ages of higher disability, the need for LTC finance reform is pressing.

Chapter 2. The Challenge: Underinsurance in the Long-Term Care Insurance Market

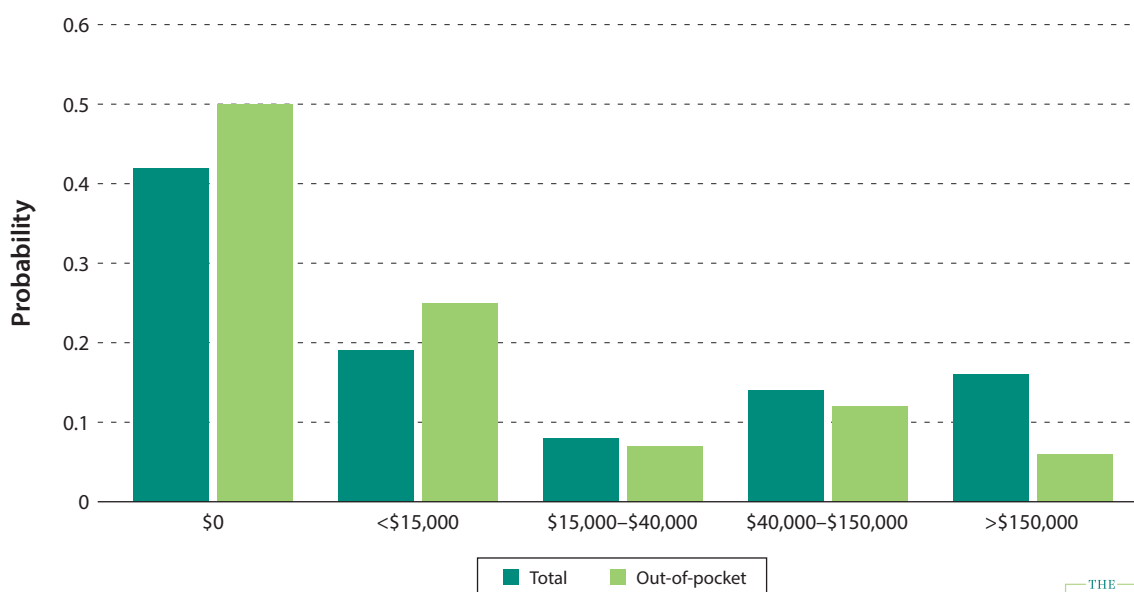
The number of elderly in the United States aged 80 and over is projected to double as a share of the population between 2010 and 2050 (Congressional Budget Office [CBO] 2013). The number of Americans that will need LTSS closely tracks the aging of the population, and is expected to more than double, from 12 million in 2010 to 27 million in 2050. And with LTSS spending expected to grow from 1.3 percent to 3 percent of GDP over this period, fiscal pressures on our public LTC programs will only intensify. In particular, Medicaid spending on LTSS is projected to grow at 6 percent per year over the next ten years (CMS 2012), far exceeding the growth rate of GDP. Medicaid spending on LTSS is expected to grow even faster beyond 2025, when baby boomers reach ages of peak LTSS needs.

Too few households have adequate insurance to protect their assets in the event of a serious long-term disability. Experiencing a long-term disability can mean incurring LTSS

spending that greatly impairs the financial well-being of disabled individuals and their families, often with catastrophic financial consequences. The chance that a senior will incur major out-of-pocket spending for LTSS is quite large (figure 1). A typical individual who is 65 years old in the United States has about a one in five chance of incurring \$40,000 or more in out-of-pocket spending on LTSS. As discussed below in section I, Medicare and Medicaid do not—and were not designed to—provide full protection against these financial risks. And where our public programs fall short, so too does the private insurance market.

The United States spent more than \$300 billion on LTSS in 2013 through public programs, private out-of-pocket spending, and private LTC insurance, according to estimates from Reeves and Musumeci (2015; figure 2). LTSS spending through Medicaid was approximately \$158 billion, or roughly one-third of all Medicaid expenditures. Out-of-pocket spending was \$59

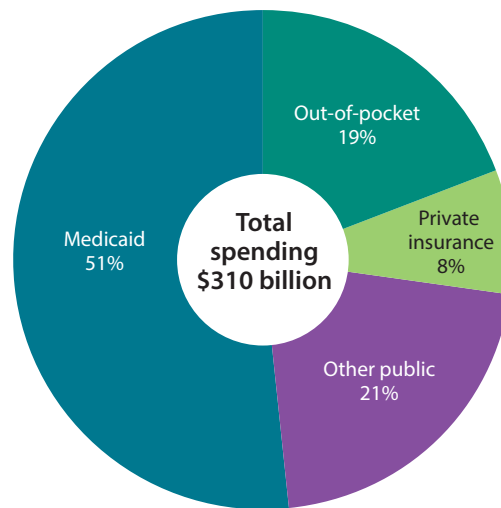
FIGURE 1. Probabilities of Total and Out-of-Pocket Lifetime Spending on Long-Term Services and Supports for an Individual Turning 65, by Level of Spending



Note: From Kemper, Komisar and Alecxih (2006), which reports the distribution of present discounted lifetime LTSS spending projected for a 65-year-old individual in 2005 dollars. The estimates include spending on nursing homes, assisted living and formal home care. Dollar thresholds reported in Kemper, Komisar and Alecxih (2006) were inflated at 4 percent—3 percent general inflation plus 1 percent increase in wages and fringe benefits—to 2015 dollars.

FIGURE 2.

Expenditures on Long-Term Services and Supports in 2013, by Source



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Source: Reaves and Musumeci (2015) based on CMS National Health Expenditure Accounts data for 2013.

Note: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home- and community-based care. Expenditures also include spending on ambulance providers and some post-acute care. This figure does not include Medicare spending on post-acute care (\$74.1 billion in 2013). All home- and community-based waiver services are attributed to Medicaid.

billion, or more than double the \$25 billion paid through private insurance and other private sources. In contrast, in the health-care sector as a whole, private insurance accounts for a much larger share of expenditures at approximately one-third while only about 12 percent of expenses are paid out of pocket (CMS 2010).

Moreover, the value of informal care provided annually for LTSS is considerably larger than households' exposure to out-of-pocket spending on LTSS. The costs incurred by informal caregivers represent a major source of uninsured financial risk. CBO (2013) estimates that the value of family and other informal caregiving services to be \$234 billion in 2011, on par with the total amount spent on formal LTSS that year. This estimate is based primarily on the imputed value of the time provided by caregivers, given prevailing wages for typical LTC workers.

I. SOURCES OF UNDERINSURANCE: PUBLIC PROGRAMS PROVIDE INCOMPLETE INSURANCE

In the United States, Medicare and Medicaid do not cover all services and eligibility is not universally based on need. For example, Medicare covers short-term skilled nursing and home health care following an acute care episode, but does not address high-skilled nursing care needs past 100 days, or institutional, assisted-living or community-based care needs for disabilities unrelated to an immediate acute care episode. This incompleteness is in contrast to most other large industrialized nations, where LTC insurance programs are universally available to individuals who need it, are

administered through social insurance programs with carve-out roles for private insurance, and where most LTSS needs are generally covered through public and private insurance (Gleckman 2010).

Medicaid covers nursing home care for individuals who meet state income and asset tests. Although state initiatives and waivers have, in more recent years, included coverage of home- and community-based services (HCBS), Medicaid still falls short in many respects. Together, Medicare and Medicaid coverage offers only a patchwork of LTC coverage since the type of delivery setting, the assets of individuals, and the health event precipitating the LTC need can differ across the two programs. Moreover, a particularly significant gap in coverage is apparent for individuals with assets above eligibility levels but who are not wealthy enough to pay for a major LTC episode. These households are exposed to major financial risks.

II. SOURCES OF UNDERINSURANCE: PRIVATE MARKET FAILURES

Although it is natural to assume that there is a role for private insurance to serve this market and fill this gap, impediments on both the supply side and the demand side of the private insurance market markedly limit its scope. On the supply side, two problems contribute to high premiums and a contracted market. First, insurers face financial risks that are common to the market and thus are not diversifiable. Profitability, even solvency, hinges on key financial parameters, such as long-term disability rates, disability duration, lapse rates, and

interest rates. And when setting level premiums, carriers must forecast these parameters decades into the future, a nearly impossible task that is fraught with uncertainty. Of course, carriers typically address financial uncertainties by pooling risks across beneficiaries. The problem here is that a carrier's experience with disability, lapse, and interest rates are largely common to the market. Interest rate yields are macroeconomic in nature; and lapse rates, disability rates, and duration are in the long run driven by long-run technological changes to health and medical productivity. Risks associated with these parameters are largely not diversifiable across beneficiaries (Cutler 1996). And for the same reason, they are not spreadable across carriers by a private reinsurer.

Second, the private LTC insurance market is voluntary and therefore subject to adverse selection. Carriers set premiums based on average claims for the risk pool. Consumers who predict they will have high LTSS needs will be most likely to purchase LTC insurance, raising average costs (and premiums) in the risk pool. The increase in premium discourages purchase among relatively healthier consumers—a dynamic that pushes up premiums and shrinks the market. To limit the market-destabilizing effects of adverse selection, LTC carriers underwrite policies, denying coverage to consumers who have elevated risks of high LTSS needs. Certain chronic diseases and physical impairments or a family history of certain diseases will disqualify an individual on the individual LTC market from coverage.

On the demand side, a variety of factors constrain the private insurance market. For one, the prospect of insurer insolvency and hikes on level premium policies has eroded consumer confidence in private LTC insurance products. Seniors concerned about these counterparty risks are less than half as likely to purchase private LTC insurance (Brown, Goda, and McGarry 2012). Turning to behavioral factors, a recent survey found that roughly half of seniors markedly underestimate the risks of needing LTSS (Metlife Mature Market Institute 2011), which likely reduces the demand for LTC insurance. Another survey found that about 13 percent of respondents who expected to live independently purchased private LTC insurance, which was about half the rate among those who believed they were not likely to live independently at some point because of their health (Brown, Goda, and McGarry 2012). And as with many cases when future events are both uncertain and viewed as unpleasant, factors like myopia and limited financial literacy as well as tendencies for inaction and status quo bias are also likely to influence the decision to buy LTC insurance (Friedemann et al. 2004; Lusardi and Mitchell 2007a and 2007b; Sorenson 2009).

One consequence of these supply-and-demand limitations is that carriers typically charge consumers high premiums that may not even cover claims in the event of a large, unexpected,

and unfavorable movements in carriers' nondiversifiable financial risks or swings in the demand for LTC insurance. Brown and Finkelstein (2008) estimate that private LTC premiums charge a load of 32 percent; that is, only 68 cents of every dollar paid in premiums go toward paying benefits, with the remaining 32 cents retained by the carrier to cover administrative costs, the costs of bearing idiosyncratic and nondiversifiable risks, and carriers' profits. In contrast, load fees for group health insurance and life insurance are much lower at 6 to 10 percent (Newhouse 2002) and 15 to 25 percent, respectively (Mitchell et al. 1999). Such high loads make private LTC insurance unappealing to all but the most risk-averse individuals and those who are the highest risks for LTSS needs. Indeed, research provides compelling evidence that selection into the LTC market is driven by these two types of consumers (Finkelstein and McGarry 2006).

When there are aggregate shocks, carriers are compelled to seek rate increases from state regulators, or to go insolvent, which contributes to the deterioration of consumer confidence in private LTC insurance products. In recent years the prolonged low interest rate environment has been the primary reason for recent and widely reported premium increases. Solvency is indeed sensitive to interest rates, and severe miscalculations of lapse rates can lead to insurer insolvency.

III. SOURCES OF UNDERINSURANCE: INTERACTIONS BETWEEN PRIVATE MARKET AND PUBLIC POLICY

Underinsurance also derives from Medicaid “crowding out,” or reducing, the demand for private LTC insurance (see Brown and Finkelstein 2008 and Pauly 1990 for formal discussions). In short, by its design, private LTC insurance helps policy owners protect their assets against LTSS spending risks. At the same time, private insurance makes it less likely for individuals to qualify for free Medicaid coverage since Medicaid LTC coverage is asset-tested. In other words, the incentives are such that, rather than purchase private LTC insurance, middle-class households with assets to protect may sensibly choose to spend down their assets to purchase LTSS before qualifying for Medicaid. This behavior is often referred to as Medicaid's “spend-down effect” on discouraging private insurance purchases.

Medicaid's “second-payer effect” also inhibits the purchase and take-up of private LTC insurance. By law, private policies must pay claims ahead of Medicaid, even when an individual is eligible for Medicaid coverage. Only after the private plan is exhausted does Medicaid coverage begin. Hence, payouts from any private plan simply delay the receipt of free Medicaid. As long as Medicaid is structured as a second payer, consumers face weak incentives to purchase private coverage *ahead* of Medicaid. Indeed, Brown and Finkelstein (2008) find that, in the presence of Medicaid, only men above the 60th percentile of the wealth distribution and women above the

70th percentile would find it advantageous to purchase even an actuarially fair priced private LTC policy. In part, this is because for a typical 65-year-old male with median wealth, 60 percent of benefits provided by private policy are redundant of benefits that would have been paid by Medicaid, absent private coverage. For a female beneficiary at the same age and wealth, the redundancy is nearly 75 percent.

To date, attempts to address the crowding out of LTC insurance have fallen short of remedying this source of underinsurance. Most policies in place appear to address the spend-down effect but not the second-payer effect. For example, some states allow LTC insurance policy holders to retain some portion of their assets and still qualify for Medicaid through LTC Partnership plans, but these plans do not address the second-payer effect. Indeed, research suggests Partnership plans appear to have only limited effects on coverage and that the benefits accrue to those who would have purchased private plans anyway (Sun and Webb 2013). This result is consistent with Brown and Finkelstein (2008), who show that even if all supply-side market failures were eliminated, *both* spend-down and second-payer effects of Medicaid need to be eliminated for there to be a substantial increase in the demand for private LTC insurance.

Another feature of Medicaid that contributes to underinsurance is its bias toward institutional care and the lack of coverage for informal caregiving. Many individuals who report having family members available to provide care, as well as those that

have a strong preference for family care, are dramatically less likely to purchase a private policy (Brown, Goda, and McGarry 2012). Informal care, with an imputed value of \$234 billion in 2011, represents a financial risk to caregivers. This estimated value of informal care captures the value of the time provided by family and other informal caregivers, and is roughly equivalent to the total annual spending on formal LTSS. With Medicaid's bias toward institutional care, coverage for HCBS continues to pose large risks.

On a final note, although affordability per se is not a market failure, it is perhaps one of the most important factors determining private LTC insurance purchase. Twenty-seven percent of individuals aged 60 and over in the top quintile of the wealth distribution have private LTC coverage, as compared to 19, 11, 7, and 4 percent in the next four quintiles, respectively (Brown and Finkelstein 2008). Naturally, the relationship between coverage rates and wealth combines two factors: affordability and having more assets to protect (hence a greater demand for insurance). Brown, Goda, and McGarry (2012) isolate the pure effect of costs, and find that stated concerns over affordability of premiums as well as about high load prices are among the strongest determinants of private LTC insurance purchase. Government intervention to support access among those for whom coverage is unaffordable would both enhance insurance coverage on social justice grounds and stabilize private LTC insurance markets by improving risk pools.

Chapter 3. The Proposal: Expanding Long-Term Services and Supports Risk Protection Through Private Long-Term Care Insurance

A successful LTC financing reform would be guided by the following three policy objectives: First, the reform must fundamentally address individuals’ risk exposure to potential long-term disability and catastrophic LTSS expenditure. LTC finance reform must therefore establish a progressive LTC financing system that increases LTC risk protection through insurance expansion. Second, the reform must establish a well-functioning private LTC insurance

market by addressing the market failures that give rise to high load pricing, premium instability, weak plan competition, and weak consumer demand for and trust in private LTC insurance. Third, the reform must achieve greater coordination and efficiency improvements across LTSS delivery systems. This means expanding support for HCBS in Medicaid and fostering greater coordination across acute care, primary care, and LTSS providers within both public and private payer settings.

TABLE 1.
Summary of Policy Proposals

Pillar	Basic design	Motivation	Comments
Long-Term Care Advantage Program	Offers a progressive cost-sharing subsidy to help individuals purchase private LTC insurance. This subsidy would be paid directly to the insurer to offset future LTSS claims, which would then lower an individual’s effective LTC insurance premium. The generosity of the cost-sharing subsidy would vary with an individual’s wealth and would be risk-rated.	The cost-sharing subsidy would increase LTC coverage rates, financing them progressively through greater private spending and Medicaid savings.	Structuring the public LTC benefit as a progressive cost-sharing subsidy, rather than as a second-payer benefit, eliminates the dampening effect that Medicaid’s current design has on private LTC insurance demand.
Shared-Risk-Corridor Program	Helps carriers manage systematic and unavoidable financial risks. Qualifying losses and gains—from business cycles and changing market-wide disability and lapse rates—would be shared among carriers, beneficiaries, and the government. Losses from poor claims management and underpricing—risks controlled by the insurers themselves—would not be eligible for protection.	This program would reduce premiums, foster premium stability and transparency, and promote consumer confidence in private LTC products.	Risk sharing would cover only losses associated with movements in market-wide financial parameters, and would therefore not incentivize carriers to undertake risky investments, underprice premiums, or engage in other irresponsible behavior with the expectation of a bail out.
Opportunities to Boost Access and Demand for LTC Advantage Program	Encourages standardization of insurance plans; allows penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans; encourages employers to offer private LTC insurance plans; and creates demonstration programs through CMS to test models for efficient financing of LTSS, primary care, and acute care delivery within Medicare.	These policies would boost access and demand for LTC Advantage coverage and improve the functioning of the private LTC insurance market. Specifically, they would improve consumer choice, plan competition, and oversight in addition to fostering improved coordination in health care and LTSS delivery.	Higher take-up of private LTC insurance is critical to achieving premium and load reductions, to enabling carriers to diversify idiosyncratic risks efficiently, and to aggressively confronting the fiscal challenges that arise as a result of individuals’ insufficient protection against LTSS risks.

I. LONG-TERM CARE ADVANTAGE PROGRAM

A. Overview of the Long-Term Care Advantage Program

I propose establishing a voluntary LTC Advantage program in which individuals who purchase a private LTC insurance plan can receive a cost-sharing subsidy for LTSS claims, which would be paid directly to the insurer. The cost-share subsidy would lower future LTSS claims paid by the private plan, thereby lowering insurance plan premiums by a corresponding amount. In exchange for the subsidy, the individual would not be eligible for Medicaid LTC coverage. The size of the cost-sharing subsidy would be tied to lifetime Medicare earnings (and thus would be progressive) and risk rated so that poorer individuals and individuals with higher expected spending would receive larger subsidies. As a baseline proposal, the subsidy could be scaled so that the program has a minimal budget impact, net of Medicaid savings, with modest but meaningful impacts on risk protection for middle-class households. The total value of the most generous cost-sharing subsidy could also be capped at a daily or monthly maximum, pegged to reasonable rates for a defined package of LTSS, in order to foster cost containment and plan efficiency.

At its core, the subsidy simply converts an individual's expected future Medicaid benefit from a second-payer benefit to a cost-sharing benefit. Structured in this way, the subsidy eliminates Medicaid's tendency to crowd out private insurance by eliminating both the so-called spend-down effect (i.e., where private insurance delays receipt of Medicaid LTSS benefits) and second-payer effect (i.e., where benefits paid by a private plan duplicate Medicaid coverage).³ Buying private insurance with the subsidy does not *delay* Medicaid: the cost-sharing subsidy *is* the government benefit, which lowers private plan premiums. Individuals who wish to purchase greater risk protection need only pay for the net-of-subsidy premiums. In contrast, "topping-up" one's Medicaid LTSS benefits in this way is currently infeasible.

B. LTC Advantage Program Features

i. Eligibility

Underwriting and subsidy provisions encourage earlier participation in the LTC Advantage program. All individuals age 55 and younger, except for those with current or immediate LTSS needs, would be guaranteed coverage in the LTC Advantage program. Eligibility would be based on the abbreviated version of the application form used in the Federal Long-term Care Insurance Program. These individuals would be eligible to receive the standard subsidy that has been adjusted for selected individual-specific risk and wealth characteristics. Individuals between ages 55 and 65 would receive a slightly reduced subsidy. Individuals over age 55 would be subject to underwriting, which would be regulated by the U.S. Department of Health and Human Services (HHS) to ensure consistency and transparency.

ii. Exhaustion of Private Benefits

Any LTSS needs exceeding coverage by private LTC policies would continue to be covered by the LTC Advantage cost-sharing subsidy. This ensures that the small fraction of individuals—2 percent of men and 7 percent of women (Friedberg et al. 2014)—with LTSS needs exceeding five years have a safety net beyond the private market. To provide stronger catastrophic protection, the government cost-sharing percentage could be designed so that it increases after the fifth year of coverage, rather than remaining flat. Spending on these high-need cases is largely covered by Medicaid now, so this safety net feature would have little impact on the budget. Individuals who do not participate in the LTC Advantage program may still qualify for traditional Medicaid LTC coverage as they do now.

iii. Subsidy and Premium Determinations

The proposed model for determining the subsidy and premium level is a hybrid of the financing mechanisms and consumer choice architectures used in Medicare Advantage (MA) and the Patient Protection and Affordable Care Act (PL 111-148, 2010; commonly called the Affordable Care Act) health insurance exchanges. From the MA program, this proposal adopts its behind-the-scenes implementation of the subsidy, which transfers risk-adjusted payments from the public insurance program to private insurers without complicating the transfer of the subsidy by involving consumers. From the vantage point of the consumer, the plan-purchasing experience is greatly simplified. The same behind-the-scenes subsidy transfer would take place here.

Like the Affordable Care Act exchanges, the LTC Advantage program contains a progressive subsidy. The subsidy would take the form of government cost-sharing of LTSS claims. Because the government cost-share would lower future claims paid by the plan, premiums would fall in proportion to the size of the cost-sharing subsidy. An individual's cost-sharing subsidy, which could range from 0 percent to 100 percent of the maximum benefit, would be based on lifetime earnings and expected future LTSS spending. Individuals with lower wealth and higher LTSS spending risk would be given larger subsidies, and therefore face a lower net-of-subsidy plan premiums. Lifetime Medicare earnings provide a practical measure of wealth and are immune to strategic asset hiding. Some basic asset information could also be obtained to ensure that wealthier individuals with relatively low lifetime earnings would not receive unfairly large subsidies.

The cost-sharing subsidy level could be determined at the time of the LTC episode. Alternatively, the cost-sharing subsidy could be determined at age 65, which would allow insurers to know the cost-sharing subsidy much earlier in the life of the policy, giving them greater certainty when setting premiums. Plans would set premiums based on expected LTSS

spending, as they do now; in addition, they would factor in the government’s cost-sharing subsidy rate for future LTSS claims. Naturally, for plans purchased prior to age 65, premiums would depend on insurers’ forecast of the subsidy level based on lifetime earnings to date. Insurers would be allowed to update their premiums when the subsidy level is determined, say, at age 65.

The subsidy schedule could be set so that the cost-sharing subsidy equals an individual’s expected future Medicaid LTC spending, but the program subsidy need not achieve this precisely. The cost-sharing subsidy schedule could be dialed up or down depending on budget and coverage objectives. I also propose that the cost-sharing subsidy apply to HCBS. Doing so could conceivably increase or decrease government spending, depending on whether savings from the decreased spending of individuals choosing HCBS over more expensive institutional care (a substitution effect) exceeds the additional cost of HCBS among people who, absent the proposed subsidy, would not have sought Medicaid-financed LTSS (i.e., woodworking effects).⁴

Determination of the subsidy level could be performed by the office of Medicaid actuaries at CMS, who currently forecast Medicaid LTC spending. A number of characteristics could be used to forecast total and Medicaid LTSS spending, such as measures of wealth, age, sex, geographic area of residence, marital status, and health. This information would be obtained at age 65, when the subsidy level is set, and would be verified during the review process for final eligibility and subsidy determination. Section 5.1 includes a technical section on how LTC risks could be modeled, following leading industry standards.

On the insurer side, limited risk-rating of premiums would be permitted—that is, premiums would be allowed to vary based on the risk characteristics of the beneficiaries. These risk characteristics would be the *same* demographic and health factors used in the cost-sharing subsidy risk adjustments. Allowing for risk rating in this way would have two major advantages: First, limited risk rating (e.g., into several risk tiers) would reduce adverse selection by charging higher-risk beneficiaries a higher premium and would reduce the need for severe individual-level underwriting. Indeed, some

carriers currently offer risk-rated premiums by offering “good health” discounts to good risks, creating a two- or three-tiered premium schedule at any given age.

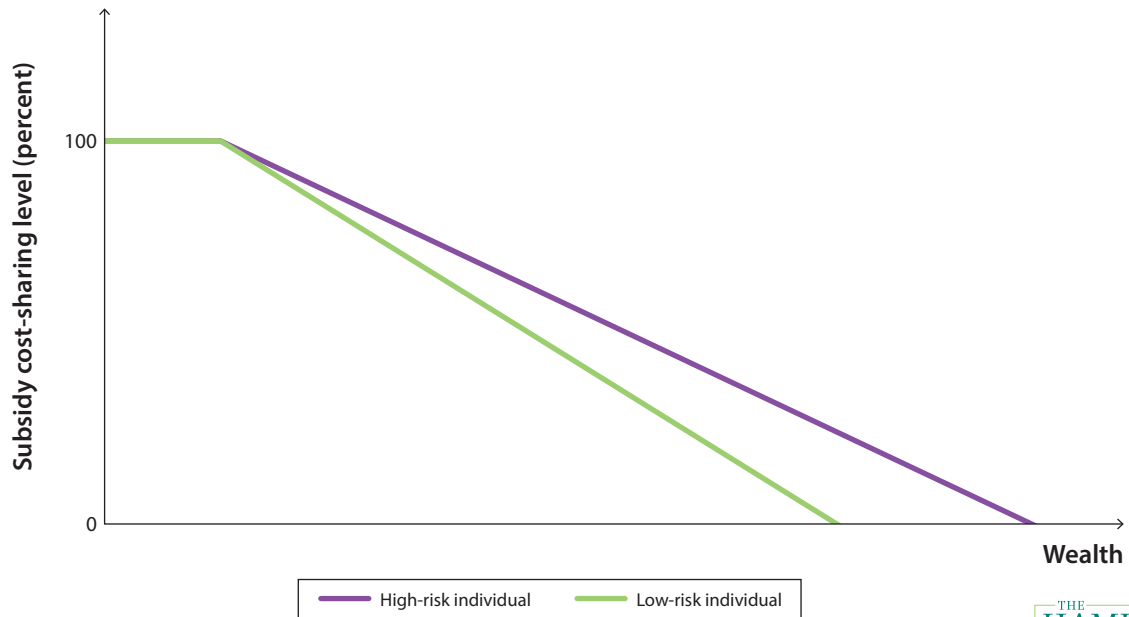
Second, by stipulating that premium risk rating and the cost-sharing subsidy’s built-in risk adjustments be based on the same information about the beneficiary’s risk characteristics, an individual’s cost-sharing subsidy (at least its risk-adjusted component) will tend to offset the higher premium she may face because of risk rating. As a result, individuals of the same age, region, and wealth would face the same net-of-subsidy premium, irrespective of LTSS spending risk. Note that all other characteristics that affect premiums would have already been embedded into the risk-rated premium and subsidy. As discussed below, tying the premium risk rating to the subsidy’s risk adjustment confers operational advantages for the consumer shopping experience, and for the administration of the subsidy.

The cost-sharing subsidy schedule could be dialed up or down depending on budget and coverage objectives.

The following figures illustrate how the government cost-sharing subsidy and the net-of-subsidy premium vary by wealth for individuals facing high and low expected LTSS spending risks, holding age and region of residence constant. In figure 3a we see that the amount of the subsidy is progressive: it declines as wealth increases. (Wealth here is measured by lifetime Medicare earnings at the point when individuals choose to enter the LTC Advantage program.) The subsidy schedule could be made more generous, or more progressive, to ensure that a larger portion of private premiums is covered among lower-wealth individuals. As shown, for individuals with low wealth the government cost share is 100 percent of the maximum benefit. Figure 3b shows the net-of-subsidy premiums for the same high- and low-risk individuals. At any

FIGURE 3A.

Subsidy Levels in the LTC Advantage Program

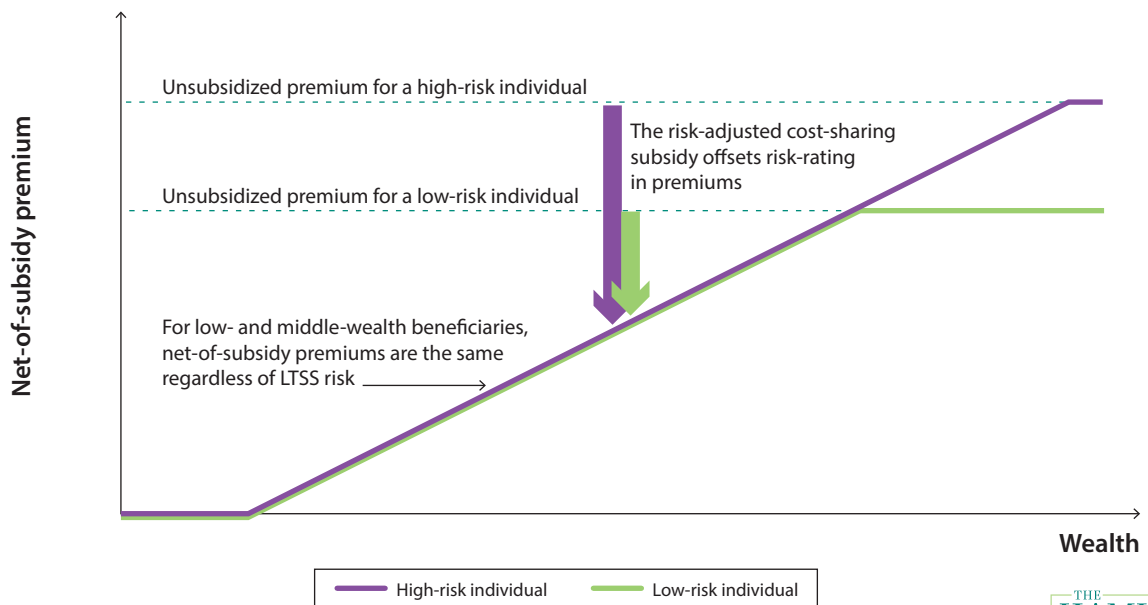


Note: This figure shows the government cost-sharing subsidy levels by wealth level for a high- and low-risk individual, holding age and region of residence constant. Wealth is measured by lifetime Medicare earnings at the point when individuals choose to enter the LTC Advantage program.



FIGURE 3B.

Net-of-Subsidy Premiums in the LTC Advantage Program



Note: This figure shows the net-of-subsidy premiums by wealth level for a high- and low-risk individual, holding age and region constant. Wealth is measured by lifetime Medicare earnings at the point when individuals choose to enter the LTC Advantage program. For a given wealth level, the risk-adjusted cost-sharing subsidy lowers future claims obligations of the plan, thereby lowering premiums. The premium reduction offsets premium risk rating so that all beneficiaries with the same wealth face the same net-of-subsidy premiums. At higher wealth levels, the subsidy for low-risk types phase out, and only the highest-risk types receive a small subsidy to offset risk rating.



given wealth level, the net-of-subsidy premium is the same for the high- and low-risk types because risk rating in premiums is offset by the risk adjustment in the subsidy level. As such, net-of-subsidy premiums differ only by lifetime Medicare earnings and age, elements that are easily provided when shopping for plans.

Importantly, consumers would, with the assistance of an agent or while logged on to an exchange Web site, provide basic information on age, sex, and marital status, geography, and health questions. Additionally, the consumer would report her lifetime earnings based on her most recent Medicare earnings statement. Again, the risk adjustments mean that premiums for any given plan will depend only on lifetime Medicare earnings and location, making plan comparison easier. Plans would be standardized, to foster consumer choice and plan competition, as discussed in section 3.III.A. Final premiums and coverage determination would be determined only after the individual undergoes the insurer's formal application process. In this way, the shopping experience is similar to buying car insurance online, where customers input parameters for a projected quote but are told their final quote only after they have been formally screened.

iv. Renewals and Disenrollment

Once approved, the beneficiaries would begin to pay monthly premiums. As long as beneficiaries pay their net-of-subsidy premiums, the LTC insurance policies would be guaranteed to be renewable. Beneficiaries could voluntarily disenroll, but could not reenroll in the program. Beneficiaries who disenroll or cease to pay their net-of-subsidy premiums would face a shortened benefit period or receive a cash payout in proportion to the amount of premiums paid.

If the private insurer leaves the market, or if premium increases rise above a predetermined level (which should be more uncommon, given the premium-stabilizing policies described in Section 3.II), its beneficiaries would have the option to disenroll or to join another insurance plan with guarantee issue, and at the same premiums paid by similar enrollees in the new plan (according to the age, year of purchase, and risk rating at the time of the original enrollment).

v. Expanded Product Types offered in the Long-Term Care Advantage Program

Plans that offer only HCBS would be eligible for the LTC Advantage subsidy. The HCBS-only plans would not offer full nursing home-care coverage, thus providing beneficiaries with the flexibility to choose lower-cost LTC coverage in home- and community-based settings that many seniors prefer. If institutional care is needed, the HCBS plan would contribute the daily maximum for HCBS coverage, and would then bill the patient for the remainder of the amount. The premium subsidy for HCBS-only plans would be

proportionally less than the subsidy given for a traditional LTC plan that included LTSS in institutional settings. In this way, individuals who choose the HCBS plans would be doing so on the basis of preferences for HCBS care, thereby limiting the cost of potential woodworking effects of the subsidy on overall program spending, and potentially generating savings.

Additionally, hybrid insurance products, such as a deferred annuity with an LTC rider, would be eligible for the program subsidy. Products that combine LTC insurance with longevity annuities provide retirement security at a reasonable cost. (Longevity annuities are deferred annuities that individuals purchase before age 65 and in which payments begin only after an advanced age such as 80 or 85.) Longevity annuities offer seniors financial protection from living past their savings, while the LTC insurance offers insurance for the cost of care if seniors suffer a major disability. Hence, hybrid products would provide insurance against two of the primary risks faced in retirement. Crucially, beneficiaries needing LTC are typically less likely to receive longevity payments, and the offsetting nature of these risks allows insurers to offer the combination product more cheaply than they could if selling the products separately (Abraham and Harris 2014). For a complete description of these products, see Warshawsky (1997), Murtaugh et al. (2001), and Warshawsky (2007).

C. Examples of Hypothetical Experiences within the Long-Term Care Advantage Program

I give examples for several types of individuals to show how the proposed LTC Advantage program would lower premiums and strengthen financial incentives to purchase insurance for a range of beneficiaries. The examples focus on hypothetical individuals at different wealth levels and LTSS spending risks, which in turn determine subsidy levels, the degree of underwriting, and the incentives they face in choosing whether to purchase asset protection. For each of our hypothetical individuals, who are all assumed to be 50 years old today, table 2a summarizes sociodemographic characteristics, monthly payments for a standardized LTC plan under the current and proposed systems, and possible outcomes after a given LTC event. For each of the individuals, I assume the same benchmark policy that costs \$150 per month.

Amanda is in good health. She has \$25,000 in assets, which places her at the 20th percentile of the wealth distribution. While she has some assets to protect in the event that she experiences a long-term disability or illness, she is close to qualifying for Medicaid. Under the LTC Advantage program, her risk-rated and progressive subsidy would come to \$45 per month, or about a 30 percent premium reduction. Because Amanda is in good health, she would pass underwriting. However, because the net-of-subsidy premium at \$105/month is still quite high relative to her ability to pay, and the fact that she is close to Medicaid asset thresholds already, she does not

TABLE 2A.

Examples of Individuals Enrolling in the LTC Advantage Program at Age 50

	Amanda Low wealth and no underwriting risk		Brad Median wealth and no underwriting risk		Chad Median wealth and underwriting risk		Dan High wealth and no underwriting risk	
Age	50		50		50		50	
Wealth	\$25,000		\$125,000		\$125,000		\$250,000	
Health status	Healthy		Healthy		Physical impairments and pre-diabetic		Healthy	
	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program
Monthly premium	\$150	\$105	\$150	\$125	\$165	\$125	\$150	\$140
Underwriting	Pass	Pass	Pass	Pass	Fail	Pass	Pass	Pass
LTC Insurance	Uninsured	Declines LTC Advantage Program	Uninsured	Opts into LTC Advantage Program	Uninsured	Opts into LTC Advantage Program	Opts into LTC Advantage Program	Opts into LTC Advantage Program
In the case of an LTC event	Goes on Medicaid	Goes on Medicaid	Spends down; goes on Medicaid	Relies on LTC insurance	Spends down; goes on Medicaid	Relies on LTC insurance; may go on Medicaid	Relies on LTC insurance	Relies on LTC insurance

TABLE 2B.

Examples of Individuals Enrolling in the LTC Advantage Program at Age 60

	Amanda Low wealth and no underwriting risk		Brad Median wealth and no underwriting risk		Chad Median wealth and underwriting risk		Dan High wealth and no underwriting risk	
Age	60		60		60		60	
Wealth	\$30,000		\$175,000		\$175,000		\$325,000	
Health status	Healthy		Healthy		Physical impairments and pre-diabetic		Healthy	
	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program	Current Market	LTC Advantage Program
Monthly premium	\$200	\$165	\$200	\$176	\$220	\$176	\$200	\$190
Underwriting	Pass	Pass	Pass	Pass	Fail	Fail	Pass	Pass
LTC Insurance	Uninsured	Declines LTC Advantage Program	Uninsured	Opts into LTC Advantage Program	Uninsured	Uninsured	Opts into LTC Advantage Program	Opts into LTC Advantage Program
In the case of an LTC event	Goes on Medicaid	Goes on Medicaid	Spends down; goes on Medicaid	Relies on LTC insurance	Spends down; goes on Medicaid	Spends down; goes on Medicaid	Relies on LTC insurance	Relies on LTC insurance

opt into the LTC Advantage program. In the event of long-term disability requiring LTSS, most likely she would incur some out-of-pocket spending but would quickly qualify for Medicaid LTC coverage. In Amanda's case, the larger subsidy and minimal underwriting provisions for early enrollment do not affect her decision.

Brad is also in good health. His assets are about \$125,000, which is approximately the median asset level for Americans at his age. If he did chose to forgo private LTC insurance (as 92 percent of individuals in his wealth bracket do), he would face a better-than-odds chance of LTSS expenses depleting his assets before he becomes eligible for Medicaid. Under the LTC Advantage program, he would receive a 15 percent subsidy

by enrolling early, which would bring his monthly premium down \$25 to \$125/month. In the event of an LTC disability requiring LTSS, Brad would be insured for over \$160,000, plus inflation protection. Brad could even choose a two-year plan and pay less per month. The expenditures on the premiums would count as spend-down, making him immediately eligible for catastrophic Medicaid LTC coverage if the policy is exhausted, all while protecting his \$125,000 in assets.

If Brad were to wait ten years to purchase LTC insurance at age 60, his premiums would rise to \$200/month. Table 2b shows the options available to these hypothetical individuals at age 60: Brad's LTC Advantage subsidy would fall from 15 to 12 percent. The \$24/month subsidy is only slightly smaller than the \$25/month subsidy he would have received if he enrolled early, but by delaying, Brad would receive this subsidy for *ten fewer years*. Moreover, by waiting past age 55 to enroll, Brad must undergo conventional underwriting, and may be more likely to be denied coverage.

Chad is identical to Brad, except that Chad has chronic health conditions that might disqualify him given the underwriting in today's market. Moreover, while Brad (and, for that matter, Amanda and Dan) is offered a good health "discount," Chad may be charged a risk-rated premium that is higher than Brad's. Typically, Chad could be charged 10 percent higher premiums. In this example, Chad would be denied coverage due to his walking impairment and prediabetic conditions.

In the LTC Advantage program, the risk-adjusted subsidy offsets the risk rating for premiums, which in turn relaxes underwriting without causing premiums for beneficiaries to rise and stanches potential adverse selection. Chad therefore sees two related benefits of the program: first, he is offered coverage; and second, his net-of-subsidy premium is the same as Brad's. Note, however, that if Chad waits until he is 60 to enroll in the LTC Advantage program, he will be subject to underwriting and likely denied coverage; and if offered coverage, he would receive a smaller subsidy than at 50.

Dan is at the top of the wealth distribution. He is ineligible for subsidies but he may purchase an LTC Advantage eligible plan and take advantage of the plan standardization, improved plan choice, and competition. Tables 2a and 2b both show Dan as facing slightly lower premiums in the LTC Advantage program. This is due to improved competition, as well as potential pricing efficiencies from premium stabilization and carrier risk-reduction policies. (These policies are discussed in detail in section 3.II). These same pricing efficiencies would be experienced by all consumers, but for the purposes of salience I show them only for Dan.

D. Evidence Supporting a Demand Response to Subsidies

Allowing individuals to top up should foster much greater demand for private policies. An excellent simulation comes

from Brown and Finkelstein (2008), who model insurance demand in the presence of Medicaid. As discussed in section 2.III, the authors find that in the presence of Medicaid, only men above the 60th percentile of the wealth distribution and women above the 70th percentile would find it advantageous to purchase even an actuarially fair-priced private LTC policy.

Importantly, Brown and Finkelstein (2008) also model a scenario where individuals are given their expected present discounted value of their Medicaid LTC benefit in lieu of receiving Medicaid. Under very reasonable assumptions about risk aversion, they find that nearly all individuals with assets above current Medicaid eligibility would be better off by contributing private spending to top up this subsidy to purchase more-comprehensive insurance. At the low ends of the distribution, these subsidies would have to be enormous—large enough to make private insurance nearly free—to make them better off with the combined subsidy and private plan. Naturally, when subsidies are small, only higher-wealth individuals stand to benefit from the subsidy program.

The French system Allocation Personnalisée d'Autonomie (APA) system is an example of a public LTC insurance benefit structured as a cost-share. The APA provides a cash allowance according to the assessed level of dependence, and is capped at a monthly maximum. The relevant feature of the APA for the current proposal is its progressive cost-sharing design. Depending on their income, beneficiaries forgo a certain percentage of the allowance, with the highest income earners receiving only 10 percent of the maximum APA allowance (Organisation for Economic Co-operation and Development 2011). Structuring the public LTC benefit as a cost share eliminates crowd-out effects on private insurance demand. Indeed, the private LTC market in France is relatively well-functioning. The coverage rate in France among individuals over age 60 is more than 25 percent, or roughly double the coverage rate in the United States (Gleckman 2010).

II. SHARED-RISK-CORRIDOR PROGRAM TO MANAGE RISK AND STABILIZE PREMIUMS

A. Overview

As discussed in section 2.II, carriers have difficulty predicting interest rates, disability rates, and lapse rates decades into the future. Movements in these parameters are outside the control of carriers and common to the market, making them difficult to spread or to hedge. This uncertainty forces insurers to set premiums very high. And even then, if a poor interest rate environment persists too long, or if disability rates or duration are fundamentally altered due to medical technology, carriers would require premium increases, or become insolvent. Private insurers are simply ill-equipped to handle such macroeconomic risks.

I propose a two-sided risk-corridor program that spreads risks across carriers, beneficiaries, and the government in transparent ways. Much like the successful Part D risk-corridor program, the goal is to foster premium stability and market confidence, while passing risks to where they are most appropriately held. In brief, the risk-corridor program would have the following features:

- It would cover only those carrier losses attributed to unfavorable movements in market-wide parameters, such as interest rates, disability rates, and lapse rates (henceforth referred to as qualifying losses). The program would therefore not lead to irresponsible underpricing of premiums, risky investing behavior, or poor claims management (henceforth referred to as idiosyncratic losses), with the expectation of a bailout.
- Initial qualifying losses would be held by the carrier.
- Moderate qualifying losses would be shared by the carrier and beneficiaries. That is, regulations would permit carriers to increase premiums or decrease benefits in transparent and limited ways if losses reach this second loss region.
- Qualifying losses beyond this second region would be shared by the carrier and the federal government, which is best equipped to bear macroeconomic risk.
- In exchange for these risk protections, profits due to favorable movements in these market-wide financial parameters would be shared with consumers and with the federal government in corridors that mirror the loss-protection corridors.
- Idiosyncratic losses and profits would be ineligible for risk-corridor assessment.

It is important to note that the carriers currently hold or pass the future uncertainty to consumers and the government, albeit in unsystematic and nontransparent ways. Risks from unfavorable movements in these parameters currently are already borne by consumers, through higher premiums, unexpected premium increases, and benefit reductions. And the small size of the private insurance market means that Medicaid currently bears the risk of large expenditures due to increases in disability duration and disability rates. The purpose of the shared-risk corridor is to assign this risk in an appropriate and transparent way so as to improve certainty throughout the market, and, in the course, foster premium stability and achieve lower premiums.

B. Design Options for a Shared-Risk-Corridor Program

Creating a risk-corridor program for only market-wide risks raises a few operational challenges. Unlike health insurance, where contracts are annual, LTC premiums and claims are paid out over several decades, complicating how and when

risk-corridor assessments are administered. Additionally, the risk-corridor program would need to disentangle idiosyncratic losses from losses due to common shocks.

Among the many options, one possible design would be to assess carrier performance for pre-specified cohorts of policies that are written. Carriers that participate in the LTC Advantage program would agree to the industry standard actuarial models and the determination of benchmark financial parameters and benchmark premiums. (Section 5.1 provides a description of the actuarial modeling, and the determination of benchmarks).

To administer the risk-corridor program, one option would be to enable a new agency within HHS to determine assumptions about financial parameters, including interest rates, lapse rates, disability rates, and duration. The assumptions would imply what a reasonable benchmark premium would be for a portfolio of policies, based on industry standard LTC actuarial modeling. At predetermined time intervals (e.g., every five years), the agency administering the program would assess the performance of carriers' portfolios over a look-back period to determine how much (if any) of the losses are attributable to unfavorable departures from forecasted interest rates, market-wide disability rates, and lapse rates. The risk-corridor assessment could then be repeated at the same interval (e.g., every five years) for a given portfolio to allow for adequate information about industry averages to accumulate while ensuring that carriers are not exposed to lengthy periods of losses in unfavorable market environments.

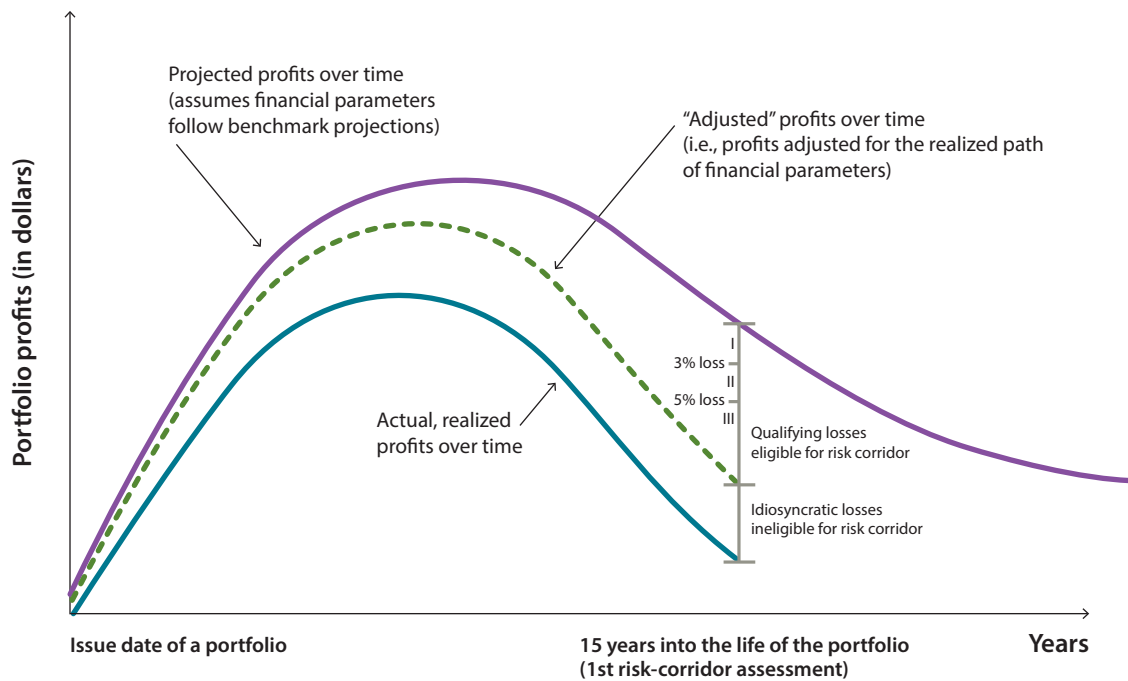
C. Risk Corridors When There Are Losses

Figure 4 depicts losses eligible for the risk corridor in a hypothetical loss scenario. The purple line depicts projected profits over time of a portfolio of LTC insurance policies, assuming that financial parameters (e.g., interest rates, disability rates, lapse rates) follow benchmark projections at the issue date. The dotted green line shows "adjusted" portfolio profits over time (i.e., projected profits, but adjusted for the realized path of market-average financial parameters). The blue line shows the actual realized portfolio profits over time. Only losses attributed to unfavorable movements in market-wide risks (regions, I, II and III in figure 4) are eligible for the risk corridor.

Immediate qualifying losses (e.g., adjusted profits are within 3 percent of the benchmark profits forecasted for the assessment year; region I) would be borne by the carrier. Moderate qualifying losses between 3 and 5 percent (region II) would be absorbed by carriers who would then pass on some portion of the losses to beneficiaries through higher premiums or reduced coverage. Regulations would permit carriers to increase premiums in transparent and limited ways if losses reach this second corridor. Such transparency would reduce consumer uncertainty about rate increases,

FIGURE 4.

Risk-Corridor Program in a Hypothetical Loss Scenario



Note: The distance between the purple and the dotted green lines depicts the losses that qualify for the risk-corridor program. Qualifying losses below 3 percent (region I) are borne by carriers. Qualifying losses between 3 and 5 percent (region II) are shared by carriers and beneficiaries. Qualifying losses beyond 5 percent (region III) are shared by carriers and the government. Idiosyncratic losses (e.g., due to underpricing, bad claims management) would not be eligible for the risk corridor.



and give consumers confidence that premium changes are regulated and not arbitrary. The same regulations that guide how premiums can rise would also stipulate how premiums would fall in favorable interest rate environments.

Similarly, plans could offer beneficiaries the option of adjusting plan benefits in response to the interest rate environment while keeping premiums level. Regulations could specify how, for example, inflation protection or daily coverage maximums could decline in response to moderate losses due to unfavorable interest rates, or unexpected increases in market-wide disability or lapse rates. Again, the beneficiary would have flexibility to choose premium increases or reduced benefits, and with the assurance that any changes adhered to federal regulations. As mentioned earlier, consumers are already bearing this risk. As a way to lower premiums, individuals are increasingly shifting to plans that offer lower inflation protection and lower daily coverage maximums. In 2013 only 22 percent of new policy holders purchased 5 percent inflation protections, down from nearly 50 percent in 2007 (Gleckman 2015). At the same time, purchase of plans with 3 percent protection has increased sharply recently. Yet existing policy holders are forced to make similar adjustments, albeit through unexpected premium increases.

Finally, the government would bear much of the risk of qualifying losses exceeding 5 percent of the benchmark forecasted profits (region III). Carriers would still retain losses in this region (e.g., 20 percent) so as to maintain incentives to efficiently manage claims. Note that tail risk borne by the government in this risk region is currently largely borne by the government through Medicaid. The proposed program would simply make this government backing explicit, allowing the private market to function better.

D. Benefits of Transparent Risk Sharing

Guidelines on premium increases in response to unanticipated changes in interest rates and investment yields would further add transparency and consumer confidence to LTC products. Moreover, carriers would need to earn less profits (i.e., a lower risk premium) to bear markedly lower risk, now that these aggregate risks are being offloaded in this transparent way. Lower risk also means carriers can hold less on reserve. Together, these responses have the potential to lower premiums and raise consumer demand for coverage.

Additionally, partitioning risks into those that are common to the market and those that are specific to a carrier allows for the carrier-specific risks (due to claims management, investments, and pricing strategies) to be easily (and appropriately) spread

by a private reinsurer. The risk-corridor program would allow private reinsurers to risk rate the performance of carriers along outcomes that carriers are more in control of. And by structuring the risk in the market in this way, the risk-corridor program would further foster lower and more-efficient premium pricing.

There is quite a bit of evidence of the benefits of shared risk, specifically the market-stabilizing benefits of the government bearing risks that are common to the market. In these cases, government backing substantially increases liquidity and stability. For example, the Federal Deposit Insurance Corporation (FDIC) has long been credited with restoring consumer confidence in deposits following bank runs of the Great Depression (FDIC 1998). More recently, the FDIC's Temporary Liquidity Guarantee Program (TLGP), created at the height of the recent financial crises, insured unsecured interbank loans as well as certain transaction accounts with balances above FDIC levels. TLGP-backed debt traded at marked discounts relative to non-backed debt, revealing greater investor confidence and liquidity at a time when lending was frozen (Ambrose, Cheng, and King 2013).

Important lessons about how the government can effectively serve as a backstop to private risk can also be drawn from the housing finance sector. When private mortgage credit dries up, the government-sponsored enterprises (GSEs) Fannie Mae, Freddie Mac, and the Federal Housing Authority (FHA) frequently scale up their support of the primary mortgage market. During the most recent financial crisis, the ability of the GSEs and FHA to increase their support of the mortgage market helped provide and maintain critical liquidity in the housing market. Indeed, the current housing finance reform movement broadly acknowledges the liquidity and countercyclical benefits of government guarantees, and an explicit government role in insuring tail risk is central to many housing finance reform proposals (CBO 2014).

Just as government backing in the housing finance and TLGP-debt settings led to lower interest rates, government tail risk protection proposed here should also lead to reduced load pricing and lower premiums. Also, while the risk-corridor program would not eliminate all insolvency risk, or the need for LTC insurance premium increases, it would greatly reduce them. Surveys indicate that demand for private LTC insurance is greatly influenced by perceived counterparty risk to consumers (Brown, Goda, and McGarry 2012). Just as FDIC insurance improved consumer confidence in deposit banks, improved premium stability and reduced insolvency risk would potentially bolster confidence in the LTC insurance market, likely resulting in greater demand and broader enrollment. Reductions in tail risk would also lower the break-even level of capital needed to support losses, potentially offering another channel by which premiums could decline.

E. Limiting Moral Hazard

Typically, the benefits of government backing must be weighed against the cost of potential moral hazard, such as the carrier making riskier investments, poorly managing claims, and underpricing premiums to gain market share, with the expectation that the losses would be covered by the risk-corridor program. Indeed, in the FDIC and housing finance settings, moral hazard has led to market disruptions. Complicating matters, political pressure and human limits on forecasting accuracy often lead to underpricing government reinsurance premiums, such as the GSEs' guarantee fee, and underfunding the program, as experienced by the Pension Benefit Guaranty Corporation (PBGC) program, the federal agency that insures defined benefits pension obligations.

Critically, the shared-risk-corridor program would be designed to avoid moral hazard on the part of carriers. The risk-corridor program would not cover carrier-specific losses due to underpricing, underperforming investments, claims management, or behaviors that caused unfavorable lapse, disability, and claims rates *in excess* of market averages. Nor would it demand payments to the program as a result of profitable outcomes from those same behaviors. In other words, carriers would bear the full consequences and reap the full benefits of their own actions; only loss and profits related to movements in market-wide disability and lapse rates would be subject to the risk corridor. Moreover, when structured as a two-sided program, the government would not have to charge a fee to provide the risk corridor.

III. ADDITIONAL OPPORTUNITIES TO BOOST ACCESS AND DEMAND FOR LONG-TERM CARE ADVANTAGE

A number of policies could be considered to encourage greater take-up of LTC Advantage than the cost-share subsidy and shared-risk-corridor program can accomplish on their own. Higher take-up is critical to achieving premium and load reductions, to enabling carriers to diversify idiosyncratic risks efficiently, and to aggressively confront the fiscal challenges due to individuals' shortfalls in protection against LTSS risks. Some of these policies are straightforward, while others are relatively ambitious and would require coordination among legislators, government agencies, employers, and regulatory bodies. In line with the far-reaching aims of these policies, section 3.III provides an overview of, rather than a detailed prescription for, the range of opportunities to support broader coverage of private LTC insurance across more households.

A. Long-Term Care Advantage Exchange and Product Standardization

HHS would work with the National Association of Insurance Commissioners (NAIC) to set the standards for private LTC insurance policies licensed by state that are eligible for the LTC Advantage program. Carriers that sell policies

that conform to these standards, whether as individual or group private insurance, could then participate in the LTC Advantage program, and avail themselves of the subsidy and risk-reduction programs (discussed in sections 3.I and 3.II), as well as of the general marketing advantages that program participation involves. With standardization, LTC Advantage plans would vary only along a few key dimensions, such as these:

- **Elimination period:** The time between the onset of the qualifying disability and receipt of benefits. Typically, policies with longer elimination periods have lower premiums.
- **Benefit period:** The length of time the plan pays benefits. Typically, policies with longer benefits periods have higher premiums.
- **Daily benefit:** The maximum daily claims payout. For instance, a policy might have a maximum daily benefit of \$150/day and a benefit period of three years, or equivalently a total benefit amount of \$164,250.
- **Inflation protection rate:** The annual percentage increase in the daily maximum. Inflation protection typically increases premiums, but ensures that the daily maximum benefits are not eroded by the rising cost of care.

Within each dimension, the number of options could be limited. This follows the Federal LTC Insurance Program, which recently limited plans to four standardized plans that vary in daily benefit amount, benefits period, and inflation adjustment. Enrollment in the federal program jumped 20 percent after the regulation went into effect (O'Brien 2012). A similar degree of standardization could be established for LTC Advantage eligible plans. For example, eligible plans could have 6- or 12-month elimination periods; two-, three-, or five-year benefit periods; \$125 or \$175 daily maximums; and 4 or 5 percent inflation adjustments. States, in conjunction with NAIC, could have the flexibility to specify whether only specific combinations could be offered within the state. For example, public employees in Minnesota are offered a choice of only four types of LTC insurance products, which only differ along three dimensions.

The immediate benefit of standardization is making plans easier for consumers to compare. And because of that, a downstream benefit of standardization is promoting competition. For example, standardization in the Medicare supplemental insurance (called Medigap) market is thought to have reduced consumer confusion (Fox, Snyder, and Rice 2003; Thomas and Rice 1992), lowered selling costs, and led to a larger fraction of premiums being paid to claims (Thomas and Rice 1992). The Massachusetts health insurance exchange has had a similar experience. A recent regulatory change reduced the number of

plans available on the exchange to only seven deductible and copay combinations, a large reduction from when insurers had wide latitude to design plans. Standardization led to large shifts in the market share of insurers, and to consumers choosing plans that are more generous (Ericson and Starc 2013).

Some thought and experimentation would need to go into the design of the exchange interface and choice architecture. Well-designed exchanges have the potential to empower consumers to make even better choice, and further foster competition. Indeed, the way plan options are presented, described, and compared can measurably impact plan choices and market shares on insurance exchanges (Cox et al. 2015; Ericson and Starc 2013; Ubel, Comerford, and Johnson 2015).

B. The Employee Retirement Income Security Act (ERISA): Tapping Existing Pools of Retirement Savings

LTC insurance provides retirement security by protecting against catastrophic LTC spending risks. Savings, by contrast, offer a means of self-insurance. Standard economic theory would suggest that a typical risk-averse individual would be better off purchasing some insurance to catastrophic LTC spending. While it would seem natural that individuals would use a portion of their retirement savings to purchase insurance that improves their retirement security, regulatory barriers make this difficult.

Americans have a growing pool of assets with which to purchase LTC insurance. Between 2000 and 2014, the amount of savings in defined-contribution plans and IRAs more than doubled from \$5.5 trillion to \$12.6 trillion (Investment Company Institute 2014)—a 38 percent real increase. This wealth represents a pool of savings that can be used to self-insure against LTSS risks in retirement (and should be protected against LTSS risks).

However, tax rules currently do not permit penalty-free distributions from tax-preferred retirement for LTC insurance purchase. Eliminating this restriction would allow for penalty-free distributions from 401(k), IRA and 403(b) accounts to pay for LTC Advantage eligible plan premiums. Individuals would still have to pay taxes on the amount withdrawn, but would not be subject to the 10 percent penalty for early withdrawals. Early distributions from Roth 401(k) and Roth IRA accounts for LTC premium payments would not be taxed, and would also be penalty free.

This proposal would require that Congress modify ERISA, which currently does not permit penalty-free distributions for LTC premiums before age 59½. This is particularly beneficial given the importance of encouraging earlier financial planning and enrollment into LTC coverage. At these ages, underwriting of LTC Advantage policies is less severe and premiums less expensive. The penalty-free distributions would

extend to all LTC Advantage program products, including any HCBS-only or combination deferred annuity-LTC products. Modifying ERISA in this way would likely have minimal budget consequences as the policy would simply allow taxable withdrawals at an earlier date.

C. Possibilities for Expanding Access through Employers

For a number of reasons, the scope for expanding access to LTC insurance through employers, particularly larger employers, is promising. Employers provide information about insurance products and benefits, and they provide this information to a captive employee audience during annual open enrollments. Large employers also bring scale economies to marketing, leading to lower premiums. Additionally, the employer setting pools individuals of varying and uncorrelated risks. All of these factors help expand enrollment and reduce adverse selection, which has allowed employers to offer group LTC insurance coverage with limited underwriting as compared to the individual market. For these same reasons, employers have been a relatively efficient channel for marketing health and group life insurance.

Despite these potential efficiencies, LTC insurance offer rates are still very low. Approximately 34,000 companies offer LTC insurance to their employees. These companies comprise 20 percent of companies with at least ten employees, and just 0.5 percent of all U.S. employers (Pincus et al. 2013). And, take-up rates among employees who are offered LTC insurance is less than 5 percent. Pincus and coauthors estimate that 112 million non-self-employed workers do not have access to LTC insurance in the workplace. These individuals represent an untapped pool for whom access to LTC products is more limited and more expensive, and also restricted to the individual market.

A number of policies could be considered that could encourage greater employer offer rates and thus employee take-up. For example, through a modification to ERISA like that mentioned in section 3.III.B, employers offering tax-advantaged retirement accounts could be encouraged or required to notify employees about penalty-free distributions from these retirement accounts for the LTC premium contributions, as well as the available subsidies from the LTC Advantage program. Also, companies could be encouraged to auto-enroll qualified employees in an LTC Advantage plan. Offering and auto-enrolling LTC Advantage eligible plans could be seen as a benefit in which employers help their employees avail themselves of the LTC Advantage subsidy. Employees could choose to disenroll, given that participation would remain voluntary, but they would need to make an active decision to do so. Auto-enrollment policy could be particularly beneficial among the 19,000 medium to large firms that currently offer LTC policies, but where take-up is low. Ample evidence points to the importance of default participation in retirement savings and the effectiveness of passive enrollment (Beshears et al. 2008; Carroll et al. 2009). And

while many studies have focused on programs that pair default retirement savings account participation with employer match contributions, the success of automatic enrollment at increasing participation in employer-sponsored retirement savings accounts appears to be driven mainly by auto-enrollment, and only modestly by employer matching (Beshears et al. 2010).

An alternative, but more proactive, policy reform for consideration would be to mandate through legislation that certain employers—for example, large firms with suitable wage earning and job tenure profiles, or those offering 401(k), 403(b) or other retirement accounts—offer LTC insurance plans. Take-up would still be voluntary at these firms, but employers would be required to offer group or multi-life LTC insurance to employees as part of their retirement planning options. As one possibility, an offer mandate could target the roughly 4 million companies that offer health and dental insurance or at least one voluntary benefit and automatic enrollment for their retirement savings plans, but do not offer LTC options. And among these companies, the 1,500 largest companies have 5,000 or more employees, and represent more than 15 million employees. Their size and current benefit offerings make these large companies reasonable platforms for employer LTC insurance offers. Such a mandate would require legislation, and while employers would not be required to contribute to premiums, the benefits of an offer mandate would have to be considered with the burden of compliance to employers.

D. Medicare Care Coordination Demonstration Program

CMS has a long history of granting states flexibility to experiment with alternative models of using federal and state funds to finance health care services. State waivers, as these vehicles are known, have been used to create a number of innovative mechanisms to foster more-meaningful coordination of LTSS, acute care, and primary care delivery within the Medicaid and dual-eligible populations. Nineteen states currently participate in capitated managed long-term services and supports programs under § 1115 and § 1915(b)/(c) demonstrations (Kaiser 2014). Many states are using these waivers to increase beneficiary access to HCBS, and provide the necessary financing provisions to increase delivery integrations. Expanding and testing these initiatives—while updating guidelines to protect beneficiaries, improve quality measures, and build in explicit mechanisms to coordinate delivery—would represent a meaningful step toward improving the efficiency and financing of Medicaid LTSS delivery.

No initiatives exist for the non-dual-eligible Medicare population—that is, for the 40 million Medicare beneficiaries (80 percent of the total Medicare population) who are not eligible for Medicaid. Yet the returns to seniors from improved coordination between acute and LTSS delivery care—in the form of better care and livelihood, to improved Medicare finances—are potentially great. The most glaring

challenge is overcoming the fragmented financing system. Among Medicare beneficiaries, LTSS is paid for out of pocket; provided for informally; or, for a minority of Americans, paid for in part by private insurers. With the exception of Medicare's 100-day skilled nursing benefit, sources of LTSS financing are not well-integrated with Medicare's financing of acute and primary care.

I propose establishing limited demonstration programs to test coordinated care models within Medicare. The demonstration would integrate the financing for primary care, acute care, and LTSS under a single private Medicare Advantage (MA) insurer or Accountable Care Organization (ACO) mechanism, as a necessary step to foster meaningful care coordination of care delivery. In both MA and ACO settings, it will be important to garner sufficient enrollment to make population health care and LTSS management feasible. Therefore the demonstration program would ideally be implemented in select counties of participating states.

The voluntary LTC Advantage program provides a natural platform to implement a demonstration. In areas participating in the demonstration, individuals would simply have an additional Medicare-sponsored option to choose from. The LTC Advantage program's subsidy, underwriting provisions and regulations, and incentives for early enrollment would apply identically to the Medicare-sponsored option. CMS would follow the same underwriting standards regulating private LTC Advantage plan carriers. Net-of-subsidy premiums would be paid directly to Medicare. Medicare would hold these contributions in trust until an individual reaches age 65, when she enrolls in Medicare fee-for-service or MA. At this point, the individual would choose whether to apply her premium contributions toward an integrated MA plan with LTC benefits (an MA-LTC option) or seek care within an ACO with LTC benefits (the ACO-LTC option). Both options unify financing of acute, outpatient, and LTSS delivery under a single payer, a necessary condition to stimulate care coordination.

If an individual chooses to receive care within an ACO, Medicare would simply retain the accumulated and ongoing premiums. The ACO-LTC mechanism could also transfer a

portion of the accumulated premiums to the ACO to finance investments that promote care integration. The beneficiary would continue to pay Medicare the net-of-subsidy premiums. CMS would then risk adjust the ACO's shared saving spending targets to account for projected spending on LTSS.

Under the MA-LTC option, the MA plans would guarantee coverage to beneficiaries, given that those enrollees would have already passed underwriting when they initially opted into the LTC Advantage program (potentially many years earlier). If the beneficiary delayed opt-in until age 65, when enrolling in Medicare, the MA plan, rather than CMS, would conduct the underwriting. In either case, Medicare would transfer whatever accumulated premiums (plus interest, as determined by regulation) to the MA plan as a lump sum. The lump sum payment would lower the monthly net premiums for the MA-LTC policy. Once the individual enrolls in the MA-LTC plan, the beneficiary would cease to pay Medicare the premium, and would pay the MA insurer a premium for both traditional MA and LTC benefits. And just as with conventional LTC Advantage premiums, the LTC component of the MA-LTC policy premium would be reduced for low-wealth beneficiaries, reflecting the progressive government cost-sharing subsidy on future LTSS claims. And the risk-adjusted component of the LTC Advantage subsidy would effectively function as risk-adjusted capitation payment on the LTC component of the MA-LTC plan.

One challenge is to establish ways for beneficiaries to switch MA-LTC insurers so that they are not tied to the health plan for lack of LTC insurance portability. Just as with any standalone LTC Advantage plan, beneficiaries can switch MA-LTC plans if premiums rise excessively. This risk should be minimized with the rate regulations and risk corridor protections described in section 3.II. Also, absent a large rate increases, beneficiaries would still be able to voluntarily disenroll and receive a cash payment. The level of the cash surrender value (CSV) would be regulated, recognizing that a higher CSV would raise premiums whereas a lower CSV would lead to reduced portability. The demonstrations would need to consider and evaluate this trade-off.

Chapter 4. Coverage, Budget, and Distributional Impacts of the Long-Term Care Advantage Program

I. COVERAGE RATES

I simulate the effects of the LTC Advantage subsidy on LTC insurance coverage rates and government spending. The effects depend on a few key policy levers and assumptions. First, both coverage rates and spending depend on the generosity of the subsidy. Larger subsidies increase coverage rates but at a higher cost. Much of subsidy spending would be paid for by savings from Medicaid; however, subsidies will also go to some of the 11 percent of Americans who already purchase private LTC insurance—the classic problem of subsidizing an existing base in order to incentivize consumer behavior. Also note that wealthier individuals are more responsive to subsidies but generate less Medicaid savings. Therefore the degree of progressivity of the subsidy will affect the trade-off between net spending (subsidy spending net of Medicaid savings) and coverage increases, with implications for the types of Americans who benefit from the program.

Second, the spending and coverage impacts will also depend on the effects on premiums of proposed policies that operate through supply-side channels. Broader enrollment, premium stabilization, and carrier risk reduction policies, discussed in chapter 3, are designed to lower carrier costs and load pricing. In theory, newly covered individuals in the market can have lower or higher spending risks than those currently in the market. But with underwriting and incentives for earlier enrollment in place, the LTC Advantage program is likely to pull in younger and healthier individuals.

Potentially most important are the premium stabilization policies. Reducing the nondiversifiable risks that carriers currently bear will likely reduce load prices. Loads are estimated to be around 0.4 (i.e., premiums represent 1.4 times the amount expected to be paid in claims). Unlike the effects of the subsidies, for which several studies provide reliable estimates, few studies provide relevant guidance on how market-stabilizing provisions could affect premiums. Hence the simulation of coverage and spending effects assumes a plausible range of price reductions from market efficiencies.

As one benchmark proposal, I model an average subsidy of 12 percent of private LTC insurance premiums. Column 1 of table 3 shows the benchmark subsidy levels. The dollar amount of the subsidy is pegged to a gender-neutrally priced \$2,400/year policy for a 60-year-old individual with three years of \$150/day benefits, a 90-day elimination period, and 4 percent inflation protection. The subsidy is progressive, with the subsidy rate set to 25 percent for individuals in the lowest decile, 12 percent for the median individual, and subsidies that decline rapidly in the upper two deciles.

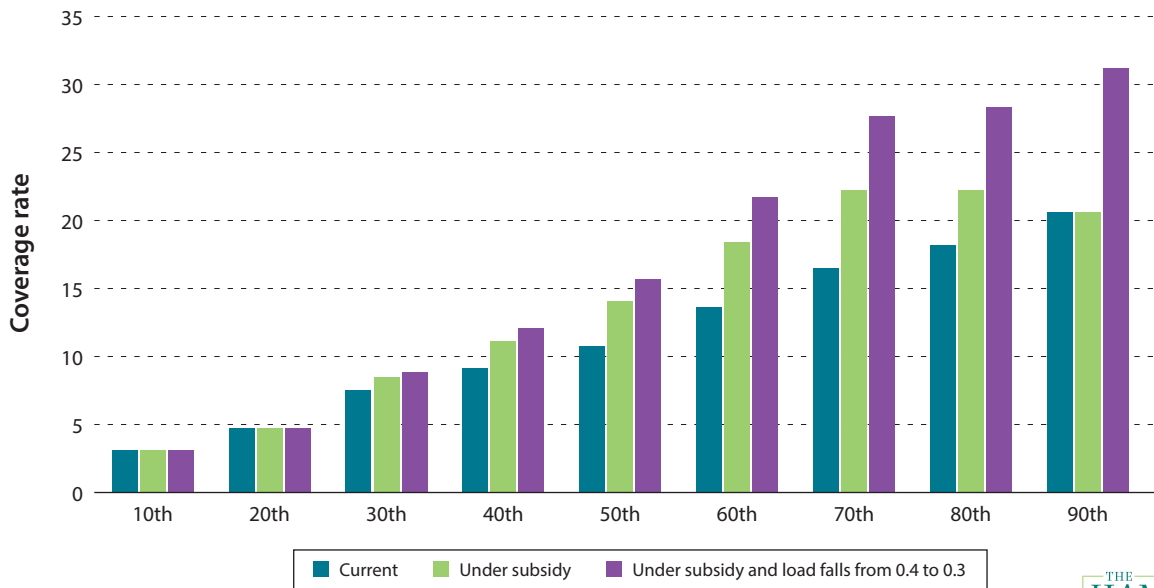
Table 3 reports simulated coverage impacts in response to the benchmark subsidy. Simulations are based on elasticity estimates, which measure how strongly consumers respond to the subsidy, reported by Courtemanche and He (2009) and Goda (2011). The two studies report similar price elasticities of around 3.5 (i.e., a 1 percent decrease in premiums leads

TABLE 3.
Coverage Rates Under Subsidy, by Percentiles in Wealth Distribution

	Benchmark subsidy (percent of private LTC insurance premiums)	Coverage rates				
		Current	Under subsidy only	Under subsidy and load falls 0.05	Under subsidy and load falls 0.10	Under subsidy and load falls 0.15
Overall	12.0	11.6	14.0	15.4	17.0	18.7
Bottom 30 percentiles	20.0	5.1	5.4	5.5	5.6	5.6
30–79th percentiles	12.0	12.5	17.6	19.2	21.1	23.3
Top 20 percentiles	1.0	19.4	21.5	25.2	29.8	34.3

FIGURE 5.

Simulated Private Long-Term Care Insurance Coverage Rates, by Wealth Decile



Note: This figure shows current and simulated LTC coverage rates by wealth decile under two proposed scenarios: one assuming premiums fall due to the subsidy alone, and a second in which premiums fall due to the subsidy and to declines in load pricing as a result of the proposed supply-side policies.



to a 3.5 percent increase in coverage rates). Goda further estimates price elasticities at different points in the wealth distribution, and finds much larger responsiveness among wealthier individuals, and little to no response among the poorest individuals.

I use these elasticity estimates to simulate changes in coverage rates across the wealth distribution in response to the benchmark subsidy (column 3).⁵ Overall the benchmark subsidy generates a modest increase in coverage, from 11.6 percent to 14 percent. This represents an increase of 2 million 50- to 64-year-old individuals with LTC insurance coverage. Note that much of the increase—1.5 million individuals—comprise middle-class individuals, among whom coverage rates increase by 5.1 percentage points, from 12.5 to 17.6 percent.

Two factors explain why the impacts are found mainly among the middle class. First, low-wealth individuals do not respond to the subsidy, which follows from the negligible response to tax incentives estimated in the literature. Low responsiveness is consistent with utility-based model simulations. Absent a subsidy that makes private coverage nearly free, individuals at low wealth levels will not purchase private coverage. Second, at high wealth levels the benchmark subsidy phases out sharply. So while high-wealth individuals are responsive to prices, they receive small to no subsidies in the benchmark subsidy schedule.

The rightmost three columns of table 3 show the simulated coverage rate changes under the benchmark subsidy as well as under assumptions about the decreases in load pricing in response to broader enrollment and proposed risk-reduction policies. The columns show declines in load pricing from .40 to 0.35, 0.30, and 0.25, respectively. (These changes correspond to 12.5, 25, and 37.5 percent drops in expected gross profits required by carriers since they would be bearing markedly lower undiversifiable macroeconomic risk.)

In this simulation, middle-class Americans respond to the lower load fees and premiums by taking up greater coverage. Under the moderate scenario, where consumers are offered the benchmark subsidy schedule and load fees fall from 0.4 to 0.3 (column 5), the coverage rate rises 8.6 percentage points (from 12.5 to 21.1 percent) among the middle class—nearly a 70 percent increase, or nearly 2.6 million more middle-class individuals.

As in the benchmark scenario, low-wealth individuals do not respond to the cost-sharing subsidy and lower premium—their coverage rate hardly increases. The cost of private LTC insurance is simply too high, the subsidy too small, and assets above Medicaid levels too low, for these individuals to top-up the subsidy and purchase private insurance. Low wealth individuals would access Medicaid with little spend-down. Finally, while wealthier individuals receive little cost-sharing subsidies, they reap the benefits of improved pricing efficiency.

Lower premiums in the LTC market markedly increase coverage rates among these individuals. Figure 5 shows the simulated coverage rates by decile, for the current (status quo), and for both the benchmark and load reduction (from 0.4 to 0.3) scenarios. The benchmark subsidy targets middle-class Americans, while any additional effects on pricing efficiency results in middle- and upper-wealth individuals significantly increasing LTC coverage.

II. BUDGET IMPACT

The proposed LTC Advantage program affects net federal government spending through two channels: (1) the cost of the subsidy (increase in spending), and (2) projected Medicaid savings from expanded private insurance coverage (decrease in spending). Simulated Medicaid savings are based on Brown and Finkelstein (2008), who estimate lifetime Medicaid spending for individuals with and without private LTC insurance coverage. Their estimates by wealth decile, in particular, allow me to translate simulated coverage increases into higher federal budget outlays, offsetting reductions in Medicaid expenditures, and net spending across the wealth distribution.

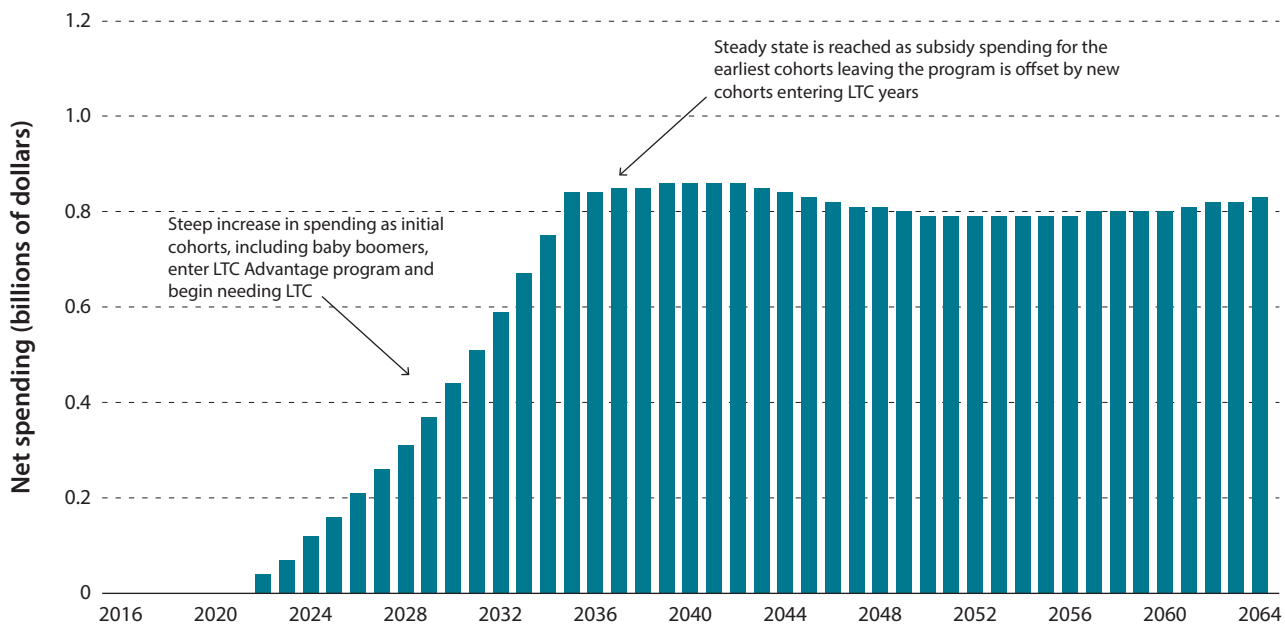
Figure 6 shows the annual net spending, defined as subsidy spending minus any Medicaid savings accrued that year.⁶

Government spending on the cost-share subsidy would rise sharply over its first two decade, as the oldest among the initial program participants age into their 70s and 80s, and as new cohorts enter the program. At about 20 years after the start of the program, net spending reaches a steady state, where the number of people entering the program and experiencing LTSS claims is offset by the number of people leaving the program. Net spending in the steady state is estimated to be about \$0.8 billion per year.

The bars in figure 6 depict net spending for the LTC Advantage program, under the moderate assumption that risk-reduction and premium-stabilization policies result in pricing efficiencies that drop loads from 0.4 to 0.3.

The program leads to very modest increases in public spending among low-wealth individuals because only a few currently have private LTC coverage and would benefit from a subsidy. Among middle-class individuals, the cost-sharing subsidy leads to lower premiums and increased coverage. Much of the subsidy spending, but not all, is offset by future Medicaid savings. Individuals at the highest wealth deciles receive little to no subsidies. But because of their higher coverage rates, subsidy spending for this group is large and is somewhat offset by their Medicaid savings.

FIGURE 6.
Net Spending on LTC Advantage Program, 2016–2064



Note: Net spending refers to spending on the LTC Advantage subsidy program minus Medicaid savings accrued that year under the assumption that risk-reduction and premium-stabilization policies result in pricing efficiencies that drop loads from 0.4 to 0.3. Spending on the LTC Advantage subsidy program each year is the sum of subsidy payments to all individuals who have coverage. The model assumes that individuals entering the program are 50 to 64 years old; that individuals have a 2-percent death rate each year after the age of 65; and that LTC needs begin at age 70, with expected claims risk rising 10 percent per year until age 84. Estimates of total expected LTC spending and Medicaid savings due to LTC insurance coverage by wealth decile come from Brown and Finkelstein (2008).

III. FURTHER DISCUSSION

A. Impact on Coverage Rates and Budget

Three points are worth bearing in mind when evaluating the merits of this proposal. First, as noted at the outset of this paper, relying on subsidies to increase coverage and encourage earlier enrollment, as opposed to a program mandate, requires spending. Because consumers are not highly responsive to subsidies, a small subsidy program, as designed here, will generate modest increases in coverage. Steady state spending of roughly \$0.8 billion per year is associated with a nearly 70 percent increase in coverage among the middle class.

The coverage response simulated here does not capture the benefits of the many proposed policies that potentially boost consumer demand and would thus understate the likely increase in enrollment from the policy. Premium stabilization, product standardization, and general improvements in awareness through program implementation all enhance consumer responsiveness to subsidies but may not be fully captured here. In addition, the price elasticity estimates used in the simulation of take-up were based on studies of tax incentives, *in the presence of Medicaid crowd-out*, which dampens demand for private LTC insurance. The LTC Advantage cost-share subsidy design eliminates this dampening effect on demand, suggesting that the consumers would be more responsive to the subsidy than modeled here. Hence, for this reason, too, the simulated effects of the proposed subsidy reported in section 4.II are likely to be underestimates.

Second, policies that achieve pricing efficiencies offer a cost-effective way to increase coverage. Even a conservative improvement in pricing efficiency would result in higher coverage rates, and lower steady state net spending, than with the subsidy alone. Insulating carriers from market-wide risks that the private market is ill-suited to bear is necessary and offers a cost-effective way of lowering premiums and increasing coverage rates. The effects of the proposed risk-reduction programs on pricing efficiency may well be understated in the moderate scenario. The simulations suggest that supply-side efforts that result in meaningful pricing efficiencies, when combined with subsidies, can be an effective way to achieve a meaningful expansion in risk protections among middle-class Americans, without a marked increase in spending.

Finally, the steady state net spending level is smaller than the current tax expenditures on federal LTC premiums. The federal deduction costs approximately \$2 billion per year and primarily benefits higher-wealth individuals (Goda 2011). Capping that deduction among the wealthiest taxpayers—those most able to pay for their own LTSS needs—would pay for the LTC Advantage subsidy program in steady state.

B. Addressing Adverse Selection

A major concern with a voluntary program is the potential for higher-risk individuals to select into the private insurance market, causing premiums to rise. If this selection is strong enough, healthier individuals could be priced out, which would lead to even higher premiums and an even smaller private market. Five broad strategies would address the destabilizing effects of potentially severe adverse selection. First, limited underwriting would be permitted for individuals younger than age 55. This is akin to the limited underwriting in the group LTC market, which has had success limiting adverse

Insulating carriers from market-wide risks that the private market is ill-suited to bear is necessary and offers a cost-effective way of lowering premiums and increasing coverage rates.

selection. Conventional underwriting would be allowed for individuals older than 55, as is standard practice now in the individual market. These measures alone keep adverse selection in check. They are firm measures, and could be relaxed slightly depending on how effective the subsidies as well as consumer protections and outreach are at broadening enrollment among healthier individuals.

Second, the LTC Advantage program would permit some risk rating of premiums. To the beneficiaries, the tiered premiums are offset by risk-adjusted premiums. To carriers, higher premiums for higher-rated beneficiaries help to dampen the need to raise premiums for everyone else. In other words, risk rating helps reduce adverse selection; meanwhile (the risk-adjusted component of) the subsidy helps improve access by

those hurt through risk rating. The risk-adjusted component of the subsidy is a clear example of the trade-off between access and spending, given a measure that limits adverse selection.

Third, several supply-side policies aim to decrease the aggregate and nondiversifiable risks that carriers currently bear. The risk-reduction and premium-stabilization policies discussed in section 3.II have great potential to lower the risk premia that carriers need to earn in the market, resulting in more-efficient pricing. This alone would encourage larger and broader enrollment. Meanwhile, these same interventions foster stable premiums and lower carrier insolvency risks, thereby building consumer trust and demand for LTC insurance.

Fourth, the subsidy would boost demand for LTC insurance. The subsidy is an explicit financial inducement to encourage enrollment. More than that, the subsidy could be designed to target earlier enrollment, as outlined in section 3.I, thereby improving the pool of risk in the private market and lowering premiums. Currently, less than 10 percent of people younger than 45, but nearly 50 percent of people over 80, are

disqualified (Assistant Secretary for Planning and Evaluations [ASPE] 2012). In this proposal, those opting into the program before age 55 would receive the full benchmark benefit. The subsidy benefit could then decline with age (e.g., 90 percent if participation occurs between ages 55 and 59, 80 percent between ages 60 and 64, and zero at age 65 and thereafter). Likewise, the LTC Advantage program would allow for only minimal underwriting at younger ages, with these limits peeled back with age at enrollment.

Finally, the proposal and the design features—the premium-stabilizing policies, product standardization, and modifications to ERISA—would also boost demand for LTC private, while deepening enrollment among healthier and younger individuals. Encouraging greater employer-based LTC insurance offer rates would improve consumer awareness and access, while plan standardization would make plan shopping easier and would foster plan and price competition. Together they contribute to lower premiums and greater consumer demand, particularly among healthier working-age individuals who currently choose to stay out of the market.

Chapter 5. Questions and Concerns

1. How would subsidies be modeled?

The CMS would calculate the level of the federal cost-sharing subsidy, using lifetime Medicare earnings. The subsidy is larger for individuals with higher expected future LTSS spending and for individuals with lower lifetime Medicare earnings. CMS actuaries would use industry standard health state and utilization models to predict future LTSS spending (see Brown and Finkelstein 2007 and Robinson 2002 for a discussion of the models used in the industry). Predicted spending would correspond to a subsidy level, and would then be adjusted for lifetime earnings by a formula set by CMS actuaries and updated over time to adapt to market conditions.

LTSS spending prediction models use LTC survey data to estimate transition probabilities across different health statuses, and duration in these states, as a function of age and sex. Specifically, they rely on Markov probabilities, which can then be combined with survey-based estimates of expected utilization and spending on at-home care, assisted living facilities, or institutional settings, as a function of age, sex, health state, and geographic area of residence. When combined, these models can be used to predict future LTSS spending by age, sex, geographic area of residence, and current health status. These models are widely used by private insurers and state agencies that administer public LTC benefits and regulate LTC products. Actuaries at CMS could employ similar models to predict future spending based on age, sex, geography, marital status, and current health status, for example.

2. Will covering LTSS needs after private coverage through the LTC Advantage program is exhausted lead to greater public spending?

No. Spending on high-need cases—that is, where an individual needs LTSS for longer than five years—is largely covered by Medicaid now, so this safety net feature of LTC Advantage would have little impact on the budget. Also note that private policies are ill-equipped to handle the risks associated with long benefit periods, and such products would likely not exist in the market so there is an appropriate public sector role to remedy this missing market.

3. Will LTC care be affordable for low-wealth and low-income individuals?

Private plans potentially would not be able to negotiate reimbursement rates achieved by Medicaid. As a result, there may be concerns that costs to individuals would increase such that lower wealth and income individuals would not be able to afford the premiums. Several options could be considered. First, the subsidy could be made more progressive, for example by boosting the maximum cost-share subsidy at lower wealth levels and phasing out the subsidy more steeply at higher wealth levels.

A more ambitious option would be to allow flexibility for states to actively set rates with providers on behalf of all insurers, particularly where negotiated rates may be significantly higher than Medicaid rates. Such states could stipulate that all LTC plans and contracted providers doing business in the state must accept rates set by the state. This option would be no different from how prices are currently determined within Medicaid LTC coverage.

On a final note, if individuals elect to spend more on LTC insurance than on out-of-pocket LTSS spending through Medicaid, the additional spending could also pay for higher service quality, which would mitigate the higher expenditures. Whether these additional expenditures make individuals worse off than they were without the LTC insurance would depend on how much they value the higher service quality relative to how much they forgo in other competing expenditures. Because, under the proposal, private plans would have an incentive to compete on efficiency and the higher provider prices negotiated by the private plans could be offset to some degree by these efficiency gains, low-wealth and low-income individuals would benefit on these grounds.

4. Won't the risk-corridor program just lead to moral hazard?

No. The most obvious sources of moral hazard would be insurers engaging in riskier investments, poor claims management, and underpricing of premiums to gain market share. The risk corridor does not insure carriers from losses due to these behaviors. Only losses associated with unanticipated movements in market-wide disability rates, duration, and lapse and interest rates would be

covered. And even then, only a portion of those losses above some trigger rate would be covered. Losses from both of these behaviors would not be covered by the risk-corridor program. Also, losses beyond the attachment point are held by the carrier, ensuring that carriers retain incentives to manage claims efficiently, even in the risk corridor.

5. What will the risk-corridor program cost? And won't there be pressure to underprice government fees?

Structuring the risk-corridor program as a two-sided risk-sharing program negates the need for charging a government fee. The program would require actuaries appropriately determining the financial parameters in the actuarial modeling so that premium setting is such that risks of reaching either side of the corridors are reasonably balanced.

These would be determined in regulation, with input from industry and NAIC.

It is important also to note that the spending risks associated with macroeconomic shocks to disability rates and duration are largely borne by Medicaid now. The new risk-corridor program simply makes this explicit. The tail risk protection offered by the risk corridor also allows carriers to partition their risks more explicitly into macroeconomic risks they cannot control, and risks they do control through claims management, premium pricing, investment performance, and negotiations with providers. These risks are carrier-specific, and more easily (and appropriately) spread by a private reinsurer. Therefore, the risk-corridor program would help structure the risk in the market, leading to lower and more-efficient premium pricing.

Chapter 6. Conclusion

As the baby boom generation continues to age and life expectancy continues to rise, LTSS has become the largest source of out-of-pocket spending risk for American households. The high costs of LTSS and the lack of private insurance means that many middle-class families are being forced to spend down their assets and impoverish themselves in order to qualify for Medicaid LTC insurance. And since Medicaid traditionally has a bias toward financing institutionally based LTSS, the varying needs and preferences of Americans for HCBS are being neglected. In addition, increased reliance on Medicaid poses significant fiscal challenges for the federal and state governments. The growing financial risks for Americans and the pressing fiscal challenges call for reforms that will improve financial security for families and that will foster greater efficiency in LTSS delivery.

This discussion paper calls for an expansion of LTC coverage through a voluntary program, rather than a mandate, and through the private market. Specifically, I make three policy recommendations. First, I propose establishing government-provided subsidies to households, which would vary with income and health measures, to help more Americans purchase a private LTC plan. The benefit would take the form of a federal cost-share for LTSS claims. Within this subsidy program, I advocate for the CMS to standardize plan options

and features. Second, I propose that CMS create a shared-risk-corridor program among insurers, beneficiaries, and the government in order to foster consumer confidence and help insurance carriers manage difficult financial risks. Third, I contemplate a range of opportunities to expand access to and demand for LTC Advantage, including plan standardization, modifying ERISA to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, and conducting demonstration projects to test models for efficient financing of LTSS within Medicare.

These proposals do not necessarily require more overall financing; rather, they require a financing system that redirects much of what is currently spent in aggregate out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance protection. The structure of the proposals also attempts to mitigate adverse selection (i.e., when only the most risk-averse and least-healthy individuals purchase LTC insurance, thereby driving up costs) and carrier moral hazard (i.e., when insurance carriers underprice premiums or engage in risky investing behavior). Overall, if these proposals were undertaken, the LTC market would achieve a considerable increase in risk protection for middle-class American families and would mitigate the fiscal pressures that our country's entitlement programs currently face.

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Endnotes

1. This advantage has been recognized by other private LTC financing proposals, such as the proposal by Frank, Cohen and Mahoney (2013).
2. Mandating participation offers a straightforward way of solving two problems that plague LTC finance—adverse selection and poor financial planning by consumers. Many proposals build in mandatory participation for this reason, despite the political challenge of its implementation (Burman and Johnson 2007; Chen 2007; Knickman 2007; U.S. Senate Commission on Long-Term Care 2013 [Approach B]).
3. Financing Approach A in U.S. Senate Commission on Long Term-Care (2013) also proposes use of a portion of Medicaid spending finance for a subsidy for private insurance, in the form of a direct premium subsidy. That proposal does not include the ability for the individual to return to Medicaid if the private policy is exhausted. This solves the second-payer effect that contributes to crowd-out. As discussed in section 3.I.B.ii, some people will experience LTC needs that exceed the benefits period of the private policy. Without additional provisions, the proposal leaves individuals exposed to the catastrophic risks of long-term disability.
4. More generally, woodworking effects may arise if the subsidy does not precisely capture the individual's true future Medicaid LTSS spending. For example, the subsidy may encourage individuals who would have utilized very little Medicaid LTSS (perhaps because they prefer informal care) to take the subsidy for private insurance purchase. The subsidy encourages these individuals to “come out of the woodwork.” At the same time, individuals who anticipate high Medicaid LTSS spending may decline LTC Advantage, giving the program no Medicaid savings. The budget implications of woodworking effects can be addressed by offering HCBS-only plans with smaller subsidies and by calibrating the subsidy schedule to achieve budget neutrality.
5. Goda (2011) reports two different sets of elasticity estimates: one based on the introduction of new state tax incentives for LTC insurance purchase and a second using cross-state differences in the size of the tax break. Interestingly, the implied after-tax price elasticity reported in the first set of results is larger, pointing to possible diminishing returns in consumer responsiveness to subsidies. The diminishing return could simply reflect consumer preferences, or could be due to marketing and promotional effects associated with the introduction of new government subsidy programs, and smaller responsiveness to price in states that offered more generous incentives. I incorporate diminishing returns in this simulation in order to report conservative estimates.
6. To simplify the model, I assume that individuals entering the program are 50 to 64 years old; that individuals have a 2-percent death rate each year after the age of 65; and that LTC needs begin at age 70, with expected claims risk rising 10 percent per year until age 84. Annual spending is defined as the sum of subsidy payments to all individuals with coverage. Estimates of total expected LTC spending and Medicaid savings due to LTC insurance coverage by wealth decile come from Brown and Finkelstein (2008). Net spending is the difference in annual subsidy payments and realized Medicaid savings accruing that year.

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Highlights

Wesley Yin of the University of California, Los Angeles proposes changing how long-term care (LTC) insurance is financed in the private market so that individuals can have more-affordable and more-complete insurance against LTSS expenses, and so insurance firms can manage their risks more efficiently.

The Proposal

Long-Term Care Advantage Program. This program would offer a progressive cost-sharing subsidy to help individuals purchase private LTC insurance. This subsidy would be paid directly to the insurer to offset future LTSS claims, thus lowering an individual's effective LTC insurance premium.

Shared-Risk-Corridor Program to Manage Risk and Stabilize Premiums. This program would help insurers manage systematic and unavoidable financial risks. Qualifying losses and gains—from business cycles and changing market-wide disability and lapse rates—would be shared with the federal government and, in limited ways, with consumers.

Additional Opportunities to Boost Access and Demand for the Long-Term Care Advantage Program. A range of policy options would improve the functioning of the private LTC insurance market. These options include plan standardization, modifications to the Employee Retirement Income Security Act to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, policies to encourage employers to offer private LTC insurance plans, and demonstration programs through the Centers for Medicare and Medicaid Services to test models for efficient financing of LTSS, primary care, and acute care delivery through Medicare.

Benefits

This proposal aims to improve the financial security of middle-class Americans facing uncertain but likely LTSS needs as well as to foster greater efficiency in both public and private LTSS delivery to better meet the needs of beneficiaries. First, the cost-sharing subsidy would increase LTC coverage rates, thereby achieving a meaningful increase in risk protection. Structuring the LTC Advantage program as a cost-sharing subsidy would eliminate the dampening effect that Medicaid's current design has on demand for private LTC insurance. Second, the risk-corridor program would lower premiums, foster premium stability, and encourage insurer entry into and competition within the market. And third, the menu of supporting policy options would improve the functioning of the private LTC insurance market in addition to improving consumer choice, plan competition, and coordination in health-care and LTSS delivery. Overall, this proposal would redirect much of what is currently spent on out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance protection.



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