A Better Public-Private Approach to Resolving LTSS Financing Dilemma

Catastrophic Shared Stop-Loss

Adapting the Death Benefit in Life Insurance to Meet Long-Term Care Needs

June 10, 2016

OVERVIEW

Better utilization of existing products like retirement accounts and life insurance may be one of the most promising avenues to cover the cost of long term services and supports (LTSS), but also known as long term care). However, as with many solutions to the financing conundrum this private sector approach works best within the context of government involvement. Currently that backstop is Medicaid. We propose it would be better to construct a true catastrophic backstop.

The design below for a catastrophic, shared stop-loss program would provide LTSS/LTC for a majority of people by (1) creating a better back end protection as well as (2) allowing participants to tap into the death benefit found in life Insurance before accessing Medicare and Medicaid, thereby extending private coverage longer than current mechanisms. For purposes of distinguishing this new product we can call it Dual Purpose Insurance (DPI) since it acts as either coverage for long term care needs or as a death benefit, if not needed for long term care.

But first citizens of the United States must have some sort of catastrophic backstop to any long term care protections they buy or supply themselves:

>> A universal catastrophic backstop will combine public and private interests.

>> A universal catastrophic backstop would replace Medicaid – currently the catastrophic backstop individuals use today – but work more efficiently with the private market.

>> While any number of private sector products, from the home to retirement funds to life insurance can be tapped, we explore one of these (death benefits found in all life insurance policies) to show how this realignment would work.

>> To better use existing private sector products they have to function at little or no extra cost (or incentive to buy). For the death benefit, this means we need leverage of the death benefit inherent in all life insurance products with no extra effort or charge, that is, no additional costs for consumers to trigger the policy for long term care and not death insurance.

>> To make this simple, the cost of using the death benefit for long term care insurance instead of life insurance gets decided when (and if) the policyholder asks for this and not at time of purchase: The cost will be deducted from the death benefit.

>> We need to act now to make this available to the boomers. Most other proposals require the sale of a product, often to persons who are younger so the value has time to grow. This will help future generations; but if we want to protect seniors of today we must "re-purpose" existing products. (Most other life insurance-based proposals apply only to new sales, and with additional cost.)

>> Having said that, acting now also helps younger persons/new buyers. They too will have this protection against long term care costs. And without ruinous increases in the cost of public programs.

>> There should be no adverse selection with a universal solution because it includes everyone with no need to be tested for good health. (If underwriting had been required, the individual passed this at the time of purchase of the policy.) This is substantially different than LTC insurance which has to exclude persons with disabilities.

>> We would use the employer system as it is now, given how prevalent it is in delivering financial and insurance products to the citizenry. But we'd also employ agents and carriers. Everyone is involved. No one left out.

>> No new taxes. If we create a catastrophic backstop the savings to Medicaid will, in our opinion, exceed any of the costs associated with the creation of this program.

BACKGROUND

One does not need to build much of a case that there is both an immediate and increasing need for society to protect against and cover long-term services and support:

- The number of Americans who need LTSS: 12 million today, 27 million by 2050. And while 42% of people turning 65 will not use LTSS, 16% will spend $100,000 or more for it.

- Family members/unpaid caregivers – 66 million Americans (almost a third of the entire adult population) – are providing care. Many are giving up jobs and income and paying out of their own pockets to help. Financial losses can be devastating for all but wealthiest people.

This rising need occurs against a backdrop of significant governmental fiscal constraints. Spending by Medicaid, the primary LTSS payer, will grow 6% annually, faster than GDP. On top of this we see what many regard as market failure from the private sector. In some 30 years of sales, only 8 million people are covered by private long term care insurance, representing fewer than 6% of Americans over 40. If one could rely on individuals to cover the risk without insurance it might not be a concern, but 65% of Americans over 40 have little to no planning for living expenses in retirement, much less a catastrophic event.

The barriers to the long term care insurance industry are not going away. For instance the low interest rate environment may continue for the foreseeable future. The increasing premiums and tighter underwriting for new policies is not likely to increase sales. For this reason the LTC insurance industry has moved in two new directions. One is to seek approval to sell short term long term care insurance. The notion here is to drop the price so people will be more inclined to buy the product. Leaving aside the problem that this also means policyholders might have inadequate protection, there is no reason to assume consumers will see the value of such insurance any more than they do with full blown long term care insurance.

The other route the industry has taken is to tie the sale of long term care insurance to life or annuity coverage. These are viewed as more highly prized products. And we agree. In fact, since 2014 sales of life and annuity-based products are greater than stand-alone long term care insurance. As a funding mechanism this is not a bad idea but it increases the cost of the product, making it unclear whether it

will be successful in the kind of volume needed to truly cover most Americans at risk. Indeed, since the sales of traditional LTC insurance are down in the same period it is likely this life variant only replaces the other, yielding no net increase in persons with long term care insurance protection.

CATASTROPHIC BACKSTOP

Given that current private sector solutions have not taken care of much of the problem, attention has turned to the various ways the public programs work. Given limitations on Medicare, this means Medicaid. For individuals needing greater care, Medicaid becomes last resort for final coverage. Indeed, most long term care financing today comes through this program even though everyone recognizes it is not structured well for this.

There is a way to offer this fuller protection outside the Medicaid system. Several recent report suggest a different option –

The Bipartisan Policy Center, in coordination with other groups addressing long-term care financing, has used an Urban Institute model around two approaches to a public, catastrophic insurance program for Americans aged 65 and older with differing features:

> Because most private-market carriers no longer offer lifetime or long duration policies that would pay for services beyond five or six years, a viable insurance-based approach to finance catastrophic, back-end LTSS expenses would most likely require public-sector involvement. Only the wealthiest Americans are capable of self-insuring through savings for the most expensive LTSS needs, such as many years of round-the-clock services for a person with dementia. For the 15 percent of Americans turning 65 who will ultimately use more than a quarter of a million dollars in paid LTSS, the answer is typically Medicaid, which requires spending down virtually all non-housing assets. Only a public program could provide insurance for this catastrophic back-end LTSS risk.

BPC report, at page 22… http://bipartisanpolicy.org/library/americas-long-term-care-crisis/

Another group, the LTC Financing Collaborative, also supported a government role in expanding protection against catastrophic risk. They also required a private component:

> The Collaborative supports a strong government role in expanding protection against catastrophic risk. Such a proposal might require consumers to pay for the first two or three years, after which they'd receive a limited daily benefit for life. While this benefit would not likely cover all LTSS costs for those with very high levels of care needs, it would provide a solid base to help pay these expenses.
>
> We recommend that the definition of "catastrophic risk" should be tied to an individual's lifetime income, and that eligibility thresholds be designed to avoid creating disincentives to saving. In such a model those with lower lifetime incomes would be eligible for catastrophic benefits sooner than those with higher incomes. Research exploring such a phased catastrophic insurance appears promising, though the concept remains at an early stage of development.

> … We reviewed two possible alternatives for financing catastrophic LTSS insurance, including a universal design and a voluntary alternative. Universal catastrophic insurance produces the greatest increase in enrollment, provides new resources to replace or add to out-of-pocket spending, and reduces Medicaid LTSS spending relative to the current baseline obligations. The amount of high-level LTSS need over long durations will continue to grow. We believe LTSS expenditures made within an insurance framework will provide better outcomes for people who need LTSS. A universal catastrophic design is also the design that is most likely to meet the test of fiscal sustainability.

LTCFC, at pages 12-14… http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf

We should be clear that favoring catastrophic coverage plans is not the creation of a new government *concept*. That concept already exists in Medicaid. Instead a catastrophic program merely reorganizes how that risk is structured. With this new partnership between individuals, insurers and the government (which financially acts as a reinsurance entity) we bring more private dollars into play and greatly reduce the use of Medicaid. From our perspective whether a new Medicare Part E is created or a new program is left to policymakers. However, in the abstract it seems adding this to Medicare would make sense since CMS is already structured to run large programs of this nature and the ability to integrate with Medicaid provides added efficiencies.

Given the many and stellar players around this issue of a catastrophic plan we suggest adoption of the various ideas coming out of these groups. For us, the essence of these proposals is that:

• Americans would have clarity about their personal liability for LTSS expenses, which they need to cover on the front end. Most designs suggest the catastrophic backstop comes in to play after 3 years.

• The private insurance market (broadly conceived) is encouraged to expand their products and options to help Americans finance front-end LTSS expenses.

• State Medicaid programs would still cover the poorest individuals, as they do now, who cannot afford private insurance or similar options (for instance home equity) for front-end coverage.

• The program would operate as Medicaid does today, with an income test so the well-off are not subsidized.

As stated by another major organization active in finding a “Pathway” to this LTSS issue:

> … the [modeling] results clearly demonstrate that coverage and cost are optimized at higher levels of participation in a particular insurance model. This suggests that a mandatory, universal insurance approach that covers catastrophic events is the most effective pathway to

pursue. It could have the biggest impact and the greatest potential to meet LeadingAge's objectives to establish a fairer and more rational LTSS financing system.

LeadingAge, at page 12…
http://www.leadingage.org/uploadedFiles/Content/Members/Member_Services/Pathways/Pathways_Report_February_2016.pdf]

PARTNERSHIP CATASTROPHIC COVERAGE

Until such catastrophic coverage is created we have to consider options to protect individuals now. A model does exist for this -- in conjunction with Medicaid -- the unique New York State Partnership. The Partnership program was the brainchild of the Robert Wood Johnson Foundation. The idea was that one could substitute long term care insurance for Medicaid. In the typical model the person has dollar for dollar credit. If they buy $100,000 worth of long term care insurance then they don't have to spend down to Medicaid's requirement ($2000) but rather have $102,000 as their floor.

This Medicaid link only applies to assets. The income test usually employed by States is not waived so a person who might run through their private insurance might still not qualify for Medicaid because they have too much income. On the other hand, most person accessing private insurance will delay the point in time they might need Medicaid so having private insurance, whether a Partnership plan or not, has value for that person. The partnerships are authorized in over 40 states with over 90 percent of the US population.

NEW YORK STATE PARTNERSHIP

It should be noted that a variant of the Partnership program along the lines of catastrophic coverage already exists: the New York State Partnership program. Instituted in 1989 it now has over 26 years of experience. All but New York are based on the design that the policyholder can alter the spenddown rule by having an equivalent amount of long term care insurance. What New York does that is unique is to say that if the policyholder has insurance for at least 3 years of nursing home care (6 years of home care, or any combination) then essentially there is no spenddown requirement and all assets are protected. Even with backstop coverage over and above what is provided in other states, the savings in New York State are quite substantial ($34M for Medicaid in 2014 alone) and only 440 (out of over 104,000 policies sold) have tapped Medicaid after running through their insurance. This could be required across the country and act as a solid next step.

Pertinent to this idea is that private insurance is no longer offering their equivalent of catastrophic protection. Lifetime coverage has presented pricing uncertainties that insurance carriers have chosen to solve by eliminating this option. Only Medicaid provides what one could call a catastrophic backstop at this time, and only the New York version does so in a more universal fashion.

FRONT END COVERAGE

Individuals must protect the front end. This is true now and would still be true with either improved Medicaid protection or a catastrophic plan.

One of the critical issues not often discussed is that even the best products/solutions have to get into the hands of the consumers to make a difference. Some products jump off the shelf; not so long term care coverage. The LTC industry often says this is a product that has to be sold; it is not often bought.

In this environment many have decided to focus attention on what can be done with existing products. This includes home equity, retirement savings and life insurance. (Also Medicare: Minnesota and others are looking at adding a small home care benefit to Medicare/medigap policies sold in their state.)

All these efforts are premised on the fact that the "base" product, whether it be a house or life insurance or retirement accounts, are ones people need little coaxing to buy. So while other policy proposals envision creating new products for sale to younger persons, our proposal provides access now when it is needed.

But while all these approaches are getting new attention, all require some sort of change(s) in and to the existing legislative and regulatory structure. This proposal concerns the use of life insurance. But any of the other alternatives may work for some of the population and should be explored. While Legislative and regulatory changes would be helpful it may not be required.

LIFE INSURANCE DEATH BENEFIT

Life insurance is extensive, an important point if one is seeking products to tap today: As many as 90 percent of all Americans at one time had such protection. While fewer do today (partly because older Americans drop the coverage when the need is no longer there) the number of individuals with life coverage is 78 percent, so still substantial. The average face value is $130,000. Fully 55% of these are permanent or whole life; the rest are term products, mostly through their employer.

We should mention that life insurance already can -- to some extent -- be re-purposed for long term care needs. There are two methods but neither is fully utilized. One is acceleration: when an individual meets the long term care insurance trigger for ADL or cognitive impairment the life policy can be accessed prior to death. The other mechanism is viatication: the policyholder simply sells the policy to a third party and collects the money before death. Both of these have costs and legal restrictions that limit their utility. In addition, with viaticals, one can argue the insurer loses control over the policy to an outside vendor that is betting against them on the life and death of the insured.

A third aspect is that one can access the benefit via a loan. The "loan" market currently exists to access the death benefit but only for the cash value. This proposal goes after the whole death benefit (minus the discount for present value).

It will not take much to create a better qualifying life insurance product either in the individual or group market. Essentially, all that is needed are some small changes that recognize life insurance (term or otherwise) can be used for LTSS without significant added cost by the insurer, or any choice by the consumer at time of sale, taking any costs off the top at point of utilization. Making sure the actuarial value is priced correctly is necessary going forward. As mentioned at the outset we call this Dual Purpose Insurance.

We believe discussions between state regulatory authorities and the life insurance industry should take place to identify how we can re-purpose the insurance currently held. Given that there are certain lapse assumptions in life insurance (as there are in long term care insurance) there is a cost consequence to the insurer to pay out long term care claims and not as a death benefit. The insurer cannot give the full value of the life coverage to the consumer. But we believe actuarial analysis will show the cost is minor, say in the 10 percent range. (We say this because these kinds of analyses have already been done for accelerated life products.) Thus, a person with that average $130,000 life policy should be able to use over $100,000 for long term care.

Some other thoughts on delivery: Absent a government mandate to buy the product, the best way – and the current method – of delivery is through the employer. For new sales, we envision that in the employer (group) market there would be automatic (passive) enrollment of the base plan. This is usually done anyway since we are talking about a minimal term life product. That also means we are not adding a new burden to employers; they do this already as part of their suite of benefits. However, employers can also purchase tax-qualified Stop-Loss Insurance in place of traditional term insurance, which generally offers a death benefit equal to one year's salary (at no extra cost to employer). Today, at least $50,000 of employee term life insurance is tax-qualified for employers. That amount covers more than half the individuals that will need some long term care.

But to truly reach all Americans we also need a robust individual market: These same products would be offered by companies and agents as other life and annuity products are now. We believe those looking toward retirement will be particularly interested: When the need for life insurance wanes, the need for long-term care insurance increases. But this insurance is a consumer choice, with no mandate they buy. We believe insurance companies are interested in developing and providing pay-out products for older consumers and this offers a new way to reach them. With DPI flexibility every option can be covered: individual situations, regional long-term care needs, and so forth.

We support a vigorous private insurance market. This could occur in several ways. For instance, the New York Partnership model where participants who buy a higher level of coverage (three years of nursing care, six years of home care) are automatically eligible for lifetime coverage, as needed. This alternative could be directly sold to the public in the individual market or we could have employers make the higher level of coverage available as an option to the employee, at the employee's own expense. The other way is for carriers to offer expanded policy options to existing LTC insurance. For instance, caregiver and respite needs are a major issue. Carriers could offer policies with these benefits. Another important aspect is that life insurance does not increase the benefit – compound inflation protection -- over time the way LTC insurance does. Going forward, new purchasers would be advised to buy inflation protection or otherwise cover the "gap" between what they hold and what they believe they need to protect themselves appropriately.

CONCLUSION

We can do better for our citizens. The proposal above suggests a new catastrophic program should be created to provide for all others except people with the highest income. Covering the first several years will also keep government spending down and help protect Medicaid. But, again, while there should be a catastrophic backstop THIS IS NOT CRITICAL to the life insurance concept.

AUTHORS

Morris Tenenbaum, CNHA, FACHCA
Morris Tenenbaum, a second generation Licensed Nursing Home Administrator, has been actively involved in operating Long Term Care (LTC) facilities for over 40 years. His focus has been on coupling quality and award winning practices with the efficient operation of the nursing home in the proprietary side of the Long Term Services and Supports (LTSS) arena.

He is currently President and Chief Executive Officer of Kings Harbor Multicare Center, a 720 bed, Centers for Medicare & Medicaid Services (CMS) five star rated facility. There he has collaborated with local medical centers and a major medical school to bring innovative and creative programs including: geriatric fellowship rounds, Accountable Care Organization (ACO) Partnerships as well as being a clinical site for medical students. Kings Harbor is a multifaceted facility providing onsite dialysis as well as specialized programs ranging from Subacute Care to Dementia Care. Kings Harbor is recognized as an industry leader and recipient of various awards including the CODMAN Award from JCAHO.

Morris is also very active in the LTSS community. On the national level he has served on the Finance Committee of the American Health Care Association (AHCA) for the last 6 years. On the state level he is Chairman of the Foundation for Quality Care, a not for profit entity whose mission is to improve quality of care through education and research. Morris is active in the New York State Health Facilities Association (NYSHFA) and sits on the Legislative and Payment Services Committees. On the local level he is on the board of the Southern New York Association and New York Healthcare Alliance, a trade organization representing 16,000 beds in the New York City area. He serves as a Committee Member of the Joint Local 1199 SEIU and Management, NDIC (New Directions and Innovations Committee), He has authored many articles (Reviving the Class Act: Dual-Purpose Life Insurance (Death Benefit/Long Term Care) and A Better Public-Private Approach to Resolving LTSS Financing Dilemma Catastrophic Shared Stop-Loss: Adapting Life Insurance to Meet Long-Term Care Needs.

John Cutler, Esq.
Over the last 25 years, in both the public and private sectors, John Cutler has developed and applied unique expertise in the areas of health care, Medicare, long term care insurance, disability, aging, and insurance benefit design. Since his retirement from the federal government in 2015 he has maintained a consulting business and is a Senior Fellow for the National Academy of Social Insurance as well as a special advisor to the Women's Institute for a Secure Retirement (WISER).

From 2000-2015 he served in various offices at the US Office of Personnel Management (OPM). His work on the Multi-State Plan Program at OPM helped stand up insurance products on the health care Marketplaces nationwide. Prior to that he was a Senior Policy Analyst at OPM and was the architect and Project Leader for the Federal Long Term Care Insurance Program. From 2005 to 2006, Cutler was detailed to the Center for Planning and Policy Development with the U.S. Administration on Aging (AoA).
Cutler joined the federal government in 1997 as a Health Policy Analyst in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at HHS. Prior to that he worked for at AARP (1989-1997), with responsibility for regulatory and compliance matters involving AARP's long term care and Medigap insurance, life insurance as well as other products.

Cutler holds a BA degree from the University of Virginia in Government and Foreign Affairs and a Juris Doctor from the University of Georgia. He is a member of the Bar in the District of Columbia.