

Written Testimony before the Senate Finance Committee
Subcommittee on Health Care

Hearing Entitled:

Alzheimer's Awareness: Barriers to Diagnosis, Treatment and Care Coordination

Testimony on

Enhancing the Affordability and Accessibility of Private Long-Term Care Insurance

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November 20, 2019

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Introduction

Thank you, Chairman Toomey, Ranking Member Stabenow, and Members of the Subcommittee. I am Marc Cohen, a Clinical Professor at the McCormack Graduate School at UMass Boston, the Co-Director of the LeadingAge LTSS Center @UMass Boston, and the Research Director at the Center for Consumer Engagement in Health Innovation at Community Catalyst, in Boston. I am also a former Founder and President of LifePlans, Inc., a Boston-based long-term care research, consulting and risk management company.

I appreciate the opportunity to testify on this panel. While Alzheimer's and related dementias represent among the most costly long-term care liabilities -- costing the nation over [\\$290 billion](#), of which out-of-pocket costs will total \$62 billion or [22%](#) of the total -- individuals with functional impairments also face significant financial exposure. In fact, the total cost of providing long-term care services and supports (LTSS) to the current cohort of individuals age 65 and over – including a valuation of care provided by family members – will exceed \$6.3 trillion. Slightly less than half of these costs will be incurred over the next decade alone.

These staggering national costs are driven by a large and rapidly growing population in need, extended life expectancies (even among those with impairments) and high costs of care. With median annual nursing home costs totaling [\\$92,000](#) and home care costing as much as \$46,000 per year, long-term care represents the single largest financial risk faced by older adults and their families. The share of the population that will have to purchase care and pay out-of-pocket can expect to spend up to \$140,000 (2015 dollars); public payers like Medicaid will have to pick up another roughly \$120,000. Thus, the total average public and private costs for those who need and have to purchase care exceeds [\\$250,000](#) per person.

In my testimony today, I will draw upon my more than 30 years of research on how the growth, development and revitalization of the private long-term care insurance market could help in this effort. I say “help” because my own view is that this challenge is far too great for any one sector – public or private – to handle on its own. Both sectors will have an important role to play. My research over the years has been supported by the Department of Health and Human Services, the SCAN Foundation, America's Health Insurance Plans, the Robert Wood Johnson Foundation, AARP, and the National Council on Aging (NCOA).

I would like to make a number of broad points today about the current market context and how to improve the affordability and accessibility of private long-term care insurance.

First, the challenge of LTC financing will only grow in the years ahead and the nature of the LTC risk – which is unpredictable, highly skewed, and potentially catastrophic – makes this liability perfectly suitable for risk pooling through insurance. We have an opportunity to move our financing system for middle class Americans away from a “private-pay safety-net based impoverishment model” toward an insurance-based approach. Private insurance can play its part in helping us move toward this goal.

Second, making private insurance more accessible is not only a question of its affordability, but also of its overall attractiveness and appeal to consumers. There are many [reasons](#) why the private market has underperformed. A multi-pronged approach designed to lower the costs of the

insurance and increase its attractiveness is needed. More specifically, a combination of actions designed to influence both demand and supply problems can lead to further growth in the market and help assure that private insurance plays a more meaningful role in financing care.

Finally, even in the context of market improvements, voluntary private LTC insurance is likely to represent only a modest piece of the solution to the financing challenge facing the country. Indeed, while my focus today is on the private market, I want to point out that there are efforts across the states aimed at developing public insurance approaches that provide interesting and unique opportunities to test new models for private and public insurance to work together. As I will explain below, public insurance models could very well spur growth in the private market, as sectoral roles become better defined and enable citizens to plan appropriately.

Background Market Challenge

Let me begin by making the observation that Americans are unprepared to absorb potential LTSS costs and roughly 70% of people retiring at age 65 will have some level of LTSS need. As well, [50%](#) will have a significant need requiring help with more than two functional limitations or with dementia-related issues and nearly [one in six](#) need care for more than five years and incur more than \$250,000 in expenses. Many of these individuals will have Alzheimer's or related dementias and thus face a particularly large financial challenge as well as family challenge. This is because they tend to require care for many years and most LTSS support is provided or supplemented by [family](#) and friends. This is a greater problem today due to smaller family size, the increasing employment of both spouses, the mobility of adult children, and strains faced by "[sandwich generation](#)" caregivers. These are all trends that portend less available family care in the future, even as the demand for care grows. Between 2015 and 2050, the ratio of potential caregivers to the population age 80 and over will decline from seven to one to only [three to one](#). And, this does not even account for the additional demand for care presented by the roughly [40 percent](#) of those who have LTSS needs that are under age 65.

Most middle income Americans are not poor enough to immediately qualify for Medicaid-financed care, which makes them completely exposed to high out of pocket costs. It is important to note that roughly half of Americans age 65 to 74 have [no retirement](#) savings at all to deal with this risk. [Medicaid](#) covers care in nursing homes and pays for home and community-based care, but requires individuals to first "spend down" much of their savings in order to be deemed eligible to receive these benefits. Thus, while it ensures *access* to a level of care after paying an "*infinite deductible*," it does not insure against high or catastrophic costs. Moreover, due to budget constraints, even eligible individuals cannot always [access](#) needed care when they need it, but instead are placed on [waiting lists](#). Finally LTSS is approaching 30% to 45% of state Medicaid [budgets](#) and growing rapidly, putting pressure on states and in some cases, crowding out other critical policy priorities.

Because of limited market penetration, stand-alone private long-term care insurance -- which typically provides access to a "pool of dollars" which can be spent in a variety of institutional, home and community-based care settings -- has played only a modest role in paying for care. It pays well less than [10%](#) of the nation's LTSS bill. Today roughly seven million Americans have policies, which are paying benefits to roughly [300,000 individuals](#). And the cost of policies has been rising. A 60 year old purchasing a policy in 2015 spent roughly \$2,700 in annual premiums

for a policy – an increase of [42%](#) over the prior decade. Thus, such premium levels are now out of the financial reach of most middle-class Americans; less than [one-third](#) of new buyers are drawn from the broad middle class, that is, those drawn from the middle third of the income distribution.

But, affordability is not the only challenge. [Confusion](#) about public and private roles in paying for costs, myopia, mistrust of the insurance industry, adverse selection and high selling costs have all contributed to declining sales of private policies. In 2018, fewer than 60,000 individual policies were sold in the United States compared to an average annual sales of roughly 500,000 policies at the turn of the century. A positive trend, however, is that the decline in the sale of individual policies has also been accompanied by growth in combination or “[hybrid policies](#)” that add long term care coverage to other forms of insurance or financial product like riders to life insurance or additional LTSS coverage on annuity products. These policies have the attractive feature of paying out benefits to policyholders even if they never need to access the long-term care benefit. Currently there are roughly [750,000](#) such policies in-force and the market has shown significant growth over the last eight years. Like stand-alone policies, however, these products also appear to be attracting primarily upper income individuals so that here too, there are affordability challenges for most middle-class Americans.

Thus, those who cannot rely on the social safety net when they face significant LTSS costs, nor have enough income or assets to purchase care, also do not have an accessible insurance option available to them. They therefore face the risk of severe financial stress, often have to rely extensively on family members to provide care, or their care needs are not met.

While cost is the largest barrier to purchase, I want to draw your attention to other challenges associated with expanding the market that have resulted in “too little” insurance. On the demand side, consumers [misperceive](#) their own risks of needing LTSS, they underestimate the costs of those services and they do not understand the degree to which existing programs do or do not offer coverage against those risks.¹ Additionally, some may prefer to rely on Medicaid-financed care. For people who tend not to perceive there is a problem, private insurance does not seem like a reasonable option, even if they had the money to pay for it.

Second, decision-making around private long-term care insurance can be complicated. People have difficulty considering the future implications of today’s choices – especially when they are uncertain and unpleasant. When considering current products, consumers need to make decisions about future levels of daily coverage, how long such coverage should last, the amount of inflation protection, the size of the deductible and so on. Confusion about the product as well as overall cost has also contributed to lack of demand. As well, voluntary private insurance requires underwriting, which [excludes](#) many individuals from coverage. Moreover, large and unexpected premium increases for products has made some consumers mistrustful of insurers and wary of making purchase decision that are costly to reverse.

¹ In a national survey conducted in the summer of 2019 with adults ages 18+, over 70% of respondents felt it was not very likely or not at all likely they would ever need long term care in a facility (nursing home or assisted living) and two-thirds felt they would not likely need care at home. In the same survey, one-third of adults admit they do not know how LTC costs are paid for, while 42% believe that their health insurance, Medicare or Medicare supplemental coverage pays for long term care. “Directive Analytics Omnibus Study.” Conducted for ET Consulting. Summer 2019

Finally, people who believe that they can pay for some care, but are afraid of the catastrophic risk, can no longer purchase policies that cover the “tail risk” because almost all policies now place limits on the duration of coverage and companies do not sell [unlimited coverage](#) policies. Insurance companies have been unsuccessful at pricing products to insure this “tail risk” or uncapped liability, in part due to concerns about adverse selection.

On the supply side, given the lack of knowledge and understanding among the general public, it is not surprising that selling costs are typically high. Second, insurers face a variety of unpredictable phenomena that affect the pricing of policies such as risks associated with inflation rates, interest rates, people’s behavior regarding their desire to maintain the insurance, and changes in mortality and disability. These are not easy parameters to predict thirty years into the future. Many of these risks are hard to spread because they are common to the whole population—insurers have had to deal with this by de-risking the product and also charging larger risk premiums.

Because of the fact that all major determinants of pricing and profitability have gone in the wrong direction over the past two decades, there has been a major exodus of companies from the market, as returns on the product have been significantly below expectations. In the year 2000, a more than 100 companies were selling LTC insurance to consumers; currently, less than 20 companies are selling a meaningful number of stand-alone policies. Put simply, the market is shrinking rather than growing, and this at a time when more Americans are facing long-term care risks and costs.

This is occurring even as a growing number of people are benefitting from their policies as claimants. In 2017, nearly [81,000](#) new claims opened and the claim reserves that have been set aside for each claim to cover expected liabilities is over \$100,000. [Research](#) suggests that people who receive benefits from their policies are very satisfied, with half saying that in the absence of their policy they would receive less care, 60% saying they would have to rely more on their families for help, and upwards of 90% indicating that the insurance benefits are helping them meet their current care needs.

The underdevelopment and growing unaffordability of private insurance, and the absence of public insurance presents a fundamental problem: people have no way to plan effectively for what is actually a perfectly insurable risk. Their current options are inefficient, unattractive or both. If people rely on savings, they will likely save too little or too much, since they cannot easily predict whether they will face catastrophic LTSS burdens. If they rely on Medicaid, they must first expend significant personal resources, and only then qualify for coverage that in many places still limits the availability of in-home care. Even when people have budgeted carefully through their working lives, they can still end up impoverished, because they receive little or no help if they need significant amounts of care.

Enhancing Affordability and Demand

Since current strategies have not worked well in assuring broad consumer appeal and insurer enthusiasm, what can be done? To increase accessibility, efforts could be focused on lowering the net cost of the product through targeted subsidization, reducing selling costs and considering

changes to product pricing approaches to make them less costly, and enhancing the value proposition to consumers so that peoples’ “tastes” for insurance change and products are more attractive. A benefit of accomplishing these goals would be to induce companies to reconsider the market and potentially reenter and provide more affordable products.

Premium Cost Reduction

Affordability of policies has been viewed as one of the biggest barriers to greater penetration among middle income individuals. Changes to the underlying funding structure of products could lead to lower cost policies. Currently, products are level-funded, but they could be priced on a “[term-basis](#),” much like life insurance, and as part of the structure, gradually add in a pre-funded amount to become level-funded at say, age 65 or 70. This would necessitate clear consumer disclosures and protections, but this approach does have the virtue of making policies more affordable at younger ages when competing demands on resources are greatest. Having the premium become level when people are done working and more likely to be on fixed incomes also helps assure that policies will remain affordable at the time that they are needed most.

A related approach involves indexing both premiums and benefits to account for increases in the cost of services. Such an approach could be tied to actual changes in the cost of long-term care. This method has the virtue of reducing the uncertainty around the inflation risk, as well as lowering initial premiums, and makes the product more affordable for consumers. It also reduces the level of initial reserves that must be set up by the company, which in turn eases the amount of capital required to support the product. In addition, there is evidence that requiring a 5% annual benefit increase (such as had been done for early Partnership Policies) leads to over-insurance; that is, benefits in these policies are growing much more quickly than the costs of care. For that reason, providing greater flexibility regarding the level of indexing to be offered could lead to lower priced products that still protect consumers by assuring benefits keep pace with inflation in long-term care costs.

Should policymakers decide to invest resources to subsidize the purchase of private policies, an approach that could increase sales would be to provide targeted middle-class tax benefits to people who would otherwise not be able to purchase policies. Strategies could include direct targeted tax subsidies or also a reshaping of benefits like inclusion of LTC insurance in cafeteria plans and FSAs, treating premiums as qualified 401k expenses, that is, no early withdrawal penalties and no income tax on withdrawn monies spent on LTC insurance premiums. Given the change in the nature of the products on the market, the premium associated with the long-term care coverage on combination products would also need to be subject to such treatment.

The reshaping of benefits must also recognize that many people do not participate in such savings plans – roughly [55%](#) of employees have a workforce retirement plan – and this is also evidenced by the fact that median value of household liquid assets for 80% of the household population age 50 and over is less than \$100,000.² Thus, for tax benefits to be effective, they

² Author’s analysis of the 2016 Health and Retirement Survey. Financial assets consist of retirement plans (IRA, Keogh accounts), stocks, mutual funds, investment trusts, checking, savings, money market accounts, government savings bonds, T-bills, bonds, bond fund other savings

need be targeted correctly to the sub-set of individuals with such savings plans who could not otherwise afford policies and the benefit would have to be high enough to induce purchase. Prior [studies](#) of state-based tax incentives showed very little impact, in large part because the value of the tax benefit was so small.

As well, current Federal tax incentives have little to no effect on insurance rate take-up among the middle class because of changes brought about by the [Tax Cuts and Jobs Act](#), which dramatically increased the standard deduction. The main way taxpayers receive federal tax benefits for long-term care insurance is by taking an itemized deduction for medical expenses, which can include private long-term care insurance premiums. The Joint Committee on Taxation estimated that the number of filers who itemize will fall from 46.5 million in 2017 to just over [18 million](#) in 2018, meaning that about 88 percent of the 150 million households that file taxes will take the increased standard deduction.

Reducing Selling Costs

The high selling costs of policies is often cited an important cost challenge so finding new ways to distribute the product is important. For example, the insurance could be made available as part of other [health care](#) offerings. Moreover, in addition to the special supplemental benefits available to the chronically ill allowed under the [Chronic Care Act](#), greater coverage for LTSS could be permitted to become part of a Medicare Advantage (MA) offering. As well a “forced choice” of a modest option at the time of enrollment to either traditional Medicare or to an MA plan would increase exposure to the insurance. It could also be offered with one or more of the approved Medigap insurance plans currently selling on the market. These options would assist individuals who have put off making their planning choices before retirement, and would help support lower marketing cost policies.

The insurance exchanges could also provide individuals with the opportunity to examine and purchase private LTC insurance. Finally, it is worthwhile to consider requiring employers to offer coverage as an optional benefit to employees; the plans could be set up so that employees must opt out and the expenses associated with setting up such a plan would be recognized as expenses. Alternatively, employers could be required to provide education and information on private LTC insurance as part of the standard employee benefits package.

Enhancing Consumer Confidence, Knowledge and Changing the Value Proposition

One of the issues that has led consumers to lose confidence in the industry, has been the significant rate increases that have occurred over the last decade. These [increases](#) have resulted due to a variety of factors -- some of them within the control of the insurance company and some of them outside that control. Either way, it is clear that for consumers to feel comfortable with the product, they need to have a sense that they know what they will be paying for it over the long-term. This presents a difficult challenge to insurers, yet some of the recommendations regarding product structure discussed above can be helpful.

An additional and innovative approach taken by LTC Partners – the administrator of the Federal Long-Term Care Insurance Program (FLTCIP) -- is to build in rate stability through product design. Their new plan includes a “[premium stabilization feature](#)” (PSF). The feature is designed

to reduce the need for future premium increases by building into the base premium some additional protection. This protection can be used to offset an enrollee's future premium payments under specific conditions or it will provide a refund of a premium death benefit. In some sense, like the life-LTC or life-annuity combination products, this assures that individuals are likely to receive some financial benefit from their policy or have complete rate stability during the life of the policy. It does, however, cost more than policies that do not have this feature. The company is betting on the fact that consumers are willing to trade off a somewhat higher premium for the premium stability and/or death benefit.

There is a need for a major targeted public education campaign to eliminate confusion about risk, who pays for services, misunderstandings about product coverages, and others. The campaign could target people beginning at age 40 and could accompany communications about social security benefits with warnings regarding the consequences of ignoring the LTSS risk and the availability of products to cover risks. To date, efforts at education have fallen short, as witnessed by the continued misunderstandings about what the public sector does and does not pay for and about the potential liability facing individuals as they age.

Even with the actions that I have discussed thus far, it is clear to me that without an expanded federal and/or state role -- specifically, the development of some level of public insurance -- the needle is still not likely to move enough to protect the majority of middle class Americans. Because Medicaid is the largest LTSS public payer and states pay roughly half the costs, they feel the pain most acutely. It is therefore not surprising that a number of states are actively exploring and/or developing [state-based](#) social insurance initiatives or other strategies for addressing the problem. They have concluded that the costs of waiting are becoming higher than the costs of taking action.

For example, [Washington State](#) passed the nation's first long-term care social insurance program -- the Long-Term Care Trust Act -- which provides a benefit that pays up to \$100 a day for about one year (\$36,000) for a qualifying individual. Given the total risk faced by individuals, this public program leaves a great deal of room for the private insurance market to expand by supplementing or wrapping around the state coverage. Private policies could top off the public benefits and/or pay additional benefits when the public insurance benefits are used up. This would have the effect of making private policies far more affordable -- as they would be covering less risk -- and it could also make it easier to sell private insurance in the context of the public program. An important requirement would be to assure that eligibility criteria for the public and private insurance coverage is in sync so that consumers can be assured of continuity in coverage.

As well, one program design gaining some traction among [researchers](#), [policymakers](#), and [stakeholders](#) is the establishment of a public program to cover catastrophic or "back-end" LTSS costs alongside steps to encourage private insurance take-up rates to protect against "up-front" risks. The intent with this design is twofold: first, to target publicly-financed benefits to expenses that exceed amounts that middle income (along with higher income) people can reasonably be expected to manage -- either with private insurance or personal resources; and second, to enhance the attractiveness and purchase of the limited coverage private insurance products that insurers prefer, by positioning them as gap fillers that, in combination with public insurance, facilitate relatively comprehensive protection against LTSS costs. Again, this will

likely have the effect of reducing selling costs for private insurance, as the lines between public and private responsibility will be clearly delineated. The Society of Actuaries is currently funding a study of how a catastrophic state-based plan might impact both the private market and Medicaid savings using the state of Minnesota as the trial case for study.

The hope is that in the context of a public program that pays for catastrophic costs, private insurance will become more affordable, people's "tastes" for insurance will change, the confusion that is in part encumbering market growth will diminish, and more companies will enter the market to provide new products to cover front-end risk. An analogous situation arose after the Federal government began insuring acute care costs through the Medicare program. In 2016, [30%](#) of Medicare beneficiaries, about 9 million people, had Medicare Supplement policies sold by private insurance companies that fully or partially cover Part A and Part B cost-sharing requirements, including deductibles, copayments, and coinsurance.

Experience from other [industrialized countries](#) suggest that private insurance products almost always fill important coverage gaps in the presence of publicly funded programs, the [latter](#) almost never insuring 100% of the risk. Most importantly, there would be a clear delineation of public and private sector roles. This should enable consumers to make informed decisions about the risk they are responsible for and it should also make the market environment attractive enough to encourage greater carrier participation. Such a market would be characterized by more affordable and accessible insurance, greater consumer knowledge and understanding, and a shared role for covering this major uncovered risk.

In closing, there are many ways that we can make private insurance more accessible and affordable and the solutions that are put forward need to reflect the magnitude of the problem that we face. While all of the specific steps that I have discussed are helpful, and worthy of consideration, a joint-public-private approach is most likely to move the needle and make a difference for middle class people. Clearly, those families who will face the difficult issue of paying for Alzheimer's or related dementias would benefit the most from being insured when such an event happens, and we should keep them in mind when we consider steps to improve the market.

I appreciate the opportunity to testify about these important issues and I would be happy to answer any questions that the Committee might have.