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Why State Support for the Long-term Care Insurance Industry Makes Good Financial Sense

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It would be easy to overlook the role of private long-term care insurance in the COVID-19 pandemic. It covers a little over 7 million policyholders and pays less than 5 percent of the nation's long-term services and supports (LTSS) bill. Further, it tends to attract buyers who do not fit the profile of individuals most vulnerable to the myriad of poor outcomes associated with the virus. And yet, for the millions of people who have had their policies for many years and may require needed care, policies offer benefits and financial protections that accrue not only to themselves and their families but also to state governments.

New analysis released today shows that there is significant benefit value contained in the private long-term care insurance policies in force today and that the oldest policyholders would face a risk of spending down to Medicaid if their policy values were jeopardized. These findings point to an important opportunity for state policymakers to adopt policy and regulatory approaches to support the retention of benefit value in current policies. Doing so would help to protect states' and individuals' financial resources.

Financial Challenges in the Long-Term Care Insurance Industry

Our nation's long-term care system relies heavily on personal savings and Medicaid to fund services such as home care, assisted living, and nursing homes. Private long-term care insurance, as a financing option for LTSS, developed and evolved in the 1970-80s as life expectancy increased, and with it, a recognition that longevity increases the likelihood of needing LTSS before death. Yet, while the market experienced significant early growth, it has been on a twenty year downward spiral, as a result of an unfavorable (i.e., declining) interest rate environment, higher than expected benefit costs, and lower than expected voluntary lapse rates. Some carriers have exited the industry entirely, whether voluntarily or via insolvency. Those carriers who have remained in the market sell policies at much higher premium levels, thus putting policies out of the reach of most middle-income Americans. As well, to deal with policies that were sold long ago, many companies have turned to premium increases to remain viable.

Policy value is vulnerable to erosion in both instances. When insurers increase premiums unexpectedly, policyholders may choose, rather than paying more for the same coverage, to reduce benefit levels or cancel their policy. Further, in "closing" blocks of business, that is, exiting the market for new sales but continuing to service policies that have already been sold, carriers may make business decisions that have negative implications for how these blocks are managed or invested in over time, which could increase the risk of large rate increases.

In the worst case, carriers become insolvent, creating unfunded liabilities that fall to state insurance guaranty funds. Contrary to their name, these funds do not always guarantee that policyholders will get back the full value of their policy. Some states limit the benefit value a policyholder can recoup.

Significant Financial Benefits Locked in Policies Sold Fifteen to Twenty-Five Years Ago

To begin to understand the magnitude of the potential costs associated with benefit erosion, we analyzed roughly 19,000 long-term care insurance policies representative of policies sold in 1995, 2000, and 2005. For a subset of 6,000 of these policies, policyholders completed detailed surveys capturing socio-demographic and attitudinal information linked to the specific policies that they purchased in these years. Our analysis shows that, not only is the potential for lost benefit value quite large, the individuals affected may be more financially vulnerable and at risk of having to rely on Medicaid than previously expected.

We found that among those who bought their policies in 1995, 2000, and 2005, by 2020 there remained $28, $72, and $117 billion in benefit value available to these policyholders, should they need LTSS. Given that

roughly half of them will likely need such care and services, this is a significant amount of value. (These estimates take into account individuals who may have died over the period or dropped (voluntarily lapsed) their policy).

Table 1: Aggregated National Policy Values

	1995	2000	2005
	n=6,568	n=4,294	n=7,943
Average Value of Policy at Time of Purchase	$201,675	$221,726	$272,288
Total Sales for Participated Companies	$232,660	$340,929	$255,236
Total Policy Values for Participated Companies (Participated Companies Counted for 75% Total Sales)	$46,921,747,379	$75,592,912,096	$69,497,725,492
Total Policy Values	$62,562,329,838	$100,790,549,461	$92,663,633,989
Average Value of Policy Today	$373,315	$369,482	$447,026
Total Sales for Participated Companies	$232,660	$340,929	$255,236
Adjusted Total Policy Values for Participated Companies (Participated Companies Counted for 75% Total Sales)(Adjusted for Lapse + Mortality)	$20,777,605,909	$54,864,705,742	$87,590,650,033
Adjusted Total Policy Values (Adjusted for Lapse = Mortality)	$27,703,474,546	$71,819,607,657	$116,787,533,377

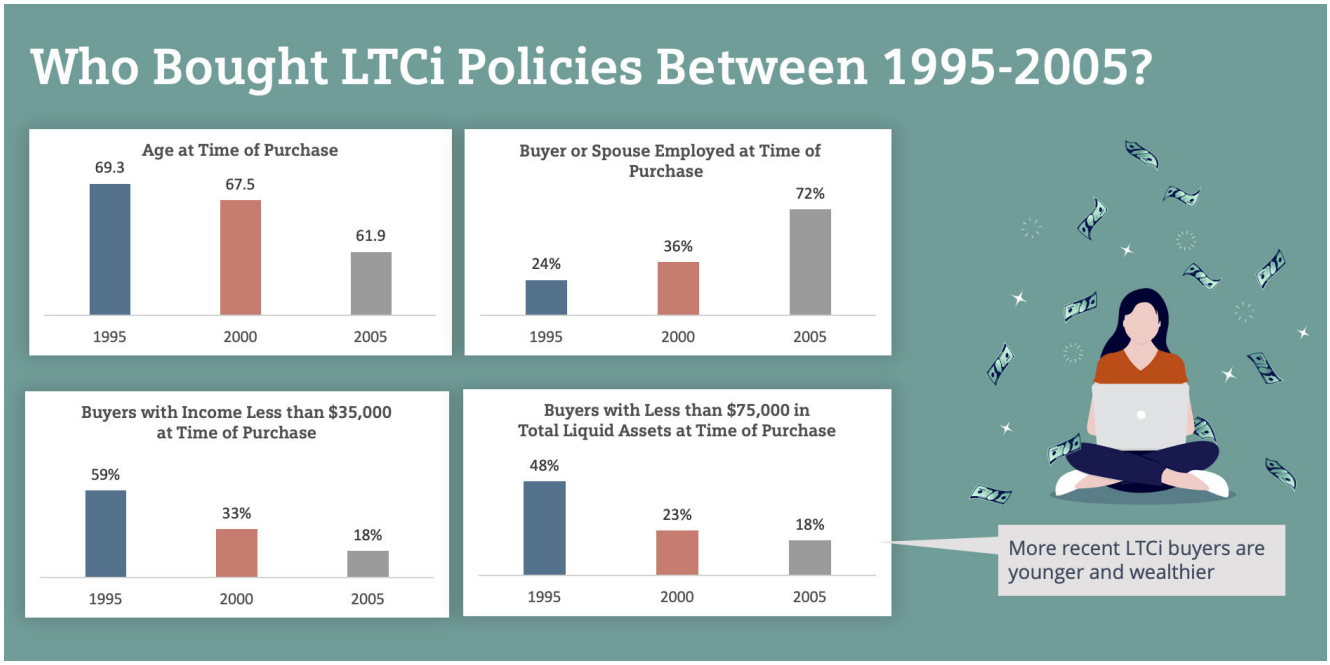
Using linear interpolation, we estimate that among individuals who bought policies between 1995 and 2005, nearly $800 billion in benefit value is available to pay for LTSS expenses. To put this in context, the Medicaid program spends just over $100 billion annually on LTSS for older adults and individuals with physical disabilities.

How These Older Policies Help To Protect Medicaid Programs

Further, we found that the financial risk profile of policyholders has shifted quite significantly over time. The individuals buying policies in the 1990s are more likely to be financially vulnerable than purchasers in the mid-2000s. They are also at greater risk of spend-down to Medicaid in the absence of the long-term care insurance coverage.

By analyzing the socio-demographic profile of individuals at the time that they purchased policies, and projecting their levels of income and assets forward to 2020 – based on a longitudinal analysis of the 1996-2016 Health and Retirement Survey – we were able to calculate the probability that an individual would need to deplete their resources, that is, "spend-down" to Medicaid eligibility, in the presence of LTSS needs. We found that there was a 22.5% chance of accessing the program for purchasers in 1995, a 13.4% chance for buyers in 2000, and a 10.1% chance for more recent purchasers (2005). Policy value among the 1995 purchasers is lower than for the 2000 and 2005 buyers, and the policyholders in this oldest group – in the absence of their current policy benefit value -- are especially vulnerable to Medicaid spend-down, based on demographics (See Figure 1).

Figure 1: Demographics and Financial Status of Buyers



State Options for Protecting Individuals and Public Resources

Medicaid programs face risks ahead that they can ill afford, if private policies in force today, particularly policies sold in the 1990s to middle-income buyers, are reduced or canceled through carrier insolvency. In such instances, there may be significant unfunded liabilities, which the state guaranty funds will have to manage. While state guaranty funds serve an important backstop, in the current model, it is not clear that reserves are strong enough to withstand the requirements needed to support these policyholders. This suggests a potentially significant risk to Medicaid budgets. In the face of this, states should move proactively to protect their budgets and residents.

The good news is that the National Association of Insurance Commissioners (NAIC) has recognized the financial risks associated with the in-force policies and formed a task force focused on improving protections and options for consumers, with several subgroups forming in the summer of this year to address reduced benefits options, multi-state rate review, and financial solvency. The task force will also consider changes to regulations. Individual state insurance commissioners and other state policymakers should keep an eye on this process and be prepared to adopt NAIC recommendations on regulating and strengthening the private long-term care insurance market. One step that states can take now, if they have not done so already, is adoption of 2017 modifications to the NAIC Model Act that expand the guaranty fund assessment base.

In August of this year, the U.S. Treasury Department made a series of recommendations on federal laws and regulations relating to the private long-term care insurance market in its Report of the Federal Interagency Task Force on Long-Term Care Insurance. Some of the recommendations focused on adjusting the federal regulatory approach to foster more product innovation and better streamline the regulatory environment across federal and state governments and across states. State regulators should

familiarize themselves with these recommendations and consider their implications for protecting in-force policies and as well as strengthening the market.

Most importantly, states need to consider alternative ways to finance long-term care outside of private insurance and the Medicaid program. For example, Washington has become the first state to pass its own version of public long-term care insurance. Other states, including Michigan and Illinois, are looking to create similar long-term care financing models, while California is considering a ballot initiative on a public long-term care financing program. Minnesota has been exploring options for private LTSS financing vehicles. These approaches hold out the opportunity of significantly boosting the private market by encouraging private insurance and public insurance to jointly reduce Medicaid liabilities and expand insurance-based protections for citizens.

While continued public and private activity may offer more options to a wider range of consumers looking to pay for long-term care coverage and address risks with insurance, continued challenges in the market leave consumers and Medicaid at risk. Addressing this risk sends an important signal to consumers who may be on the fence about what to do, that insurance-based approaches are worth considering.

Like so many things, COVID-19 heightens the need for intense focus on addressing our regulatory system's ability to ensure that policyholders retain as much private long-term care insurance benefit value as possible. As this study shows, there's too much money on the table to let it slip and too much at stake both for individuals and the largest public payer of care – Medicaid.

Acknowledgement

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