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Factors contributing to the decline in sales of private long-term care insurance

1. Flawed pricing assumptions
    a. Persistency and voluntary lapse rates – fewer people dropping policies
    b. Mortality - involuntary lapses
    c. claims incidence – higher number of people filing claims
2. Irrational market conditions made it difficult for responsible insurers to compete
    a. Predatory Pricing
    b. Unsound underwriting practices – "jet issue", broker administration of cognitive screen
    c. Agent/Broker driven compensation models – excessive bonuses, "heaped commission"
3. Challenging environmental factors
    a. Low interest rates
    b. Rigid product requirements (HIPAA, IRC 7702b, NAIC Model Act and Model Regulations)
        i. Inflation protection requirements
        ii. Two ADL threshold triggers all policy benefits
        iii. Elimination and benefit period limitations
    c. State DOI approval practices
    d. Insurers unable to get rate increases as necessary
4. Diminishing insurer supply
    a. Insurers exiting new sales (14 insurers reported new individual sales to LIMRA in 2012, and only one group insurer actively selling)
    b. Popular product features no longer offered; limited-pay, lifetime benefits, home-care only
    c. Disenfranchised distribution
    d. Heavy surplus strain on new business coupled with scarce reinsurance capacity makes it difficult to continue selling, and creates a prohibitive barrier for new entrants
5. Declining consumer demand
    a. Confusion as to whether Medicare or health insurance will pay
    b. Premium becoming unaffordable for those who need it most (middle market)
    c. Medicaid option via asset transfer or "spend-down"

Ideas to encourage product innovation and planning for aging with dependency

1. Alternative funding sources and incentives to raise demand and attract new suppliers
    a. Allow tax exempt and penalty free distributions from qualified retirement plans to fund LTC insurance premiums (401K, 403B, IRA, Roth IRA)
        i. pretax and employer co-funded dollars would materially reduce disposable income impact of LTC insurance premiums for working populations
        ii. Distribution from fully funded retirement plans would allow payment of premiums without finding new discretionary funds
    b. Amend IRC Section 125 (cafeteria plan) to include LTC insurance
        i. Pretax dollars to fund premiums
        ii. Improved access to products through payroll deduction and online enrollment
        iii. Simplified plan designs and lower distribution costs
    c. Lift or remove Health Savings Account (HSA) contribution cap

    d. Federal “above the line” income tax deduction for premium (see CO, MD, MN, MT, NM, NY, ND, OR statutes) – current HIPAA rule allows deduction after itemization if non-reimbursed medical expenses exceeding 7.5% of AGI.
2. Health insurance concepts
    a. Standardized Supplements to Medicare Advantage and Fee for Service Medicare
        i. Options that emphasize post-acute and custodial home-based care
        ii. Nursing facility only option (catastrophic risk mitigation)
        iii. Apply CMS Innovations Duals demonstrations to non-Medicaid population
    b. Mandate offer of LTC insurance by Medicare Advantage suppliers (Isreal model)
    c. Care Managed LTC – these principles could be applied to “LTC supplement” or to existing LTC insurance products
        i. Preferred networks for skilled and non-skilled providers
        ii. In and Out of network, Usual and Customary reimbursement rates
        iii. Coinsurance risk sharing (High Deductible Health Plan model)
        iv. Premium Incentives for healthy behaviors
        v. Annual data capture on risk factors to facilitate early and targeted interventions
3. Modifications to existing LTC insurance products
    a. Attained age pricing (Fee for Service Medicare Supplement insurance model)
    b. Relax inflation protection requirements (Qualified LTC, Partnership LTC)
    c. Prohibit regulatory limitations on Short-Term Care and high-deductible LTC
    d. Dependency-tiered benefit trigger and reimbursement model (European model)
4. Financial planning linked-Benefit products
    a. Life, Critical Illness, Disability and Annuity products combined with LTC benefits
        i. Address “what if I never need it” objection commonly cited by non-buyers
        ii. Encourage life-long saving and planning by associating the financial risks of aging to other insured risks (premature death, disability, longevity)
        iii. Establish policy surrender-value for consumer protection
        iv. Draw new suppliers and distributors to the market
5. Offer LTC insurance through Health Insurance Exchanges

Closing Thoughts

Education and awareness makes a difference. States conducting “own your future” awareness campaigns have higher levels of requests for product information. Industry research identified the attributes of buyers as “positive realists”. Demand is strong amongst groups demonstrating the characteristics of buyers.

Much can be learned from the failures of the pioneers of private LTC insurance. Insurers entering the market today can do so with sound pricing and underwriting practices. Active sellers are achieving sustainable growth, bad actors have left the market. A vibrant private LTC insurance market remains possible.

The convergence of acute, post-acute and sub-acute care, the movement toward “accountable care” holds great promise for addressing chronic care needs as an extension of healthcare with new emphasis on home-based support and holistic care planning. The Duals and Bundled Payment for Care Improvement initiatives are opportunities to test new models of care.