Initial Recommendations to Improve the Financing of Long-Term Care

February 2016

LONG-TERM CARE INITIATIVE

In December 2013, BPC launched a Long-Term Care Initiative under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, former Congressional Budget Office Director Dr. Alice Rivlin, and former Wisconsin Governor and Secretary of the U.S. Department of Health and Human Services Tommy Thompson. BPC's Long-Term Care Initiative seeks to raise awareness about the importance of finding a sustainable means of financing and delivering long-term services and supports, and to improve the quality and efficiency of publicly and privately financed long-term care.

ACKNOWLEDGMENTS

Supported by a grant from The SCAN Foundation—advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

Staff

Katherine Hayes
Director, Health Policy

G. William Hoagland
Senior Vice President

Nancy Lopez
Associate Director, Health Policy

Lara Rosner
Senior Policy Analyst, Health Project

Brian Collins
Senior Policy Analyst, Economic Policy Project

Marisa Workman
Policy Analyst, Health Project

Katherine Taylor
Project Assistant, Health Project

Authors

BPC staff produced this report in collaboration with a distinguished group of senior advisers and experts, for the Long-Term Care Initiative. BPC would like to thank Sheila Burke, Stuart Butler, Henry Claypool, Chris Jennings, Steve Lieberman, and Tim Westmoreland for providing substantial feedback, support, and direction.

Table of Contents

4 | **Executive Summary**

4 | Challenges in Financing Long-Term Care

5 | Recommendations to Address the Needs of At-Risk Populations

7 | Next Steps

8 | **Overview**

8 | Cost of Long-Term Services and Supports

9 | Utilization of LTSS

9 | Amount and Distribution of LTSS Spending per Person

10 | **Improving Affordability and Availability of Private LTCI**

16 | **Expanding Options at Home and in the Community for Older Americans and Individuals with Disabilities under Medicaid**

16 | HCBS Waivers

17 | State Plan Amendments

19 | **Improving Access to Affordable LTSS for Working Americans with Disabilities**

21 | **Addressing the Needs of Americans with Significant LTSS Needs**

24 | **Conclusion**

25 | **Next Steps**

Executive Summary

Challenges in Financing Long-Term Care

In April 2014, the Bipartisan Policy Center (BPC) released a report on long-term care, "*America's Long-Term Care Crisis: Challenges in Financing and Delivery.*" That report outlined the roles of Medicaid, private insurance, personal savings, and direct unpaid care provided by friends and family members in long-term services and supports (LTSS), and it raised concerns about the sustainability of these financing mechanisms. Specifically, the report noted that the demand for LTSS will more than double over the next 35 years and is fiscally unsustainable.

The 2014 report also acknowledged: "Due to the diversity of the LTSS population and the current political environment, it is extremely unlikely that a single solution will adequately address [the] challenges [outlined in the report]. For this reason, BPC's Long-Term Care Initiative plans to produce a set of recommendations that weave together the approaches of publicly funded programs, such as Medicaid, with private insurance products, while also improving the efficiency and quality of LTSS."

Over the years, federal policymakers have attempted to advance comprehensive proposals to address the need for, and financing of, LTSS for older Americans and individuals with disabilities. Although those efforts have proved unsuccessful — the most recent was one of the few parts of the Patient Protection and Affordable Care Act that was repealed — Congress has enacted incremental efforts over the years. These efforts include legislation to improve care for low-income individuals who meet the eligibility criteria to qualify for Medicaid, and for middle-income individuals who exhaust their personal or retirement savings to qualify

for LTSS under the Medicaid program. While some states have taken advantage of new opportunities to expand the availability of LTSS under Medicaid, others have not. This has resulted in significant variation in eligibility and benefits from state to state.

Congress has sought to encourage individuals to purchase private long-term care insurance (LTCI) by providing tax benefits for those who purchase policies that meet certain standards. The rationale for expanding private LTCI is to improve financial security for older individuals and to reduce or delay future reliance on Medicaid for middle- to upper-income individuals. Despite those efforts, sales of private LTCI continue to fall, largely because premiums are unaffordable and the traditional product design has proved to be unsustainable for carriers.

This report offers initial recommendations to help address the financing of LTSS. In late 2016 or early 2017, BPC will release additional recommendations for new approaches to finance LTSS and also to reform LTSS delivery and improve integration of care for persons with multiple chronic conditions and functional limitations.

BPC's work over the last two years led us to conclude that the challenges to achieving consensus on long-term care financing are numerous. Among them:

- Different opinions on the respective roles of public programs, the commercial private market, and individuals and their families;
- Concern about the costs and public funding of new programs and their financing;
- Lack of awareness about the costs and risks of needing LTSS and the incorrect belief that Medicare or Medicaid will cover LTSS needs;
- Concern that enacting a comprehensive LTSS program will supplant private spending for those who have the resources to pay for care or have services provided by unpaid caregivers; and
- Significant variation in the need for LTSS. For example, while more than half of Americans age 65 and over will need LTSS during their lifetimes, only 15 percent will have LTSS expenses exceeding $250,000 during their lifetimes.

As predicted in the 2014 report, these challenges lead BPC's Long-Term Care Initiative to the conclusion that, at this time, there is no single, comprehensive solution to address the growing demand for affordable LTSS that would be financially or politically viable. Instead, the initiative has concluded that a series of programmatic changes designed to target the needs of individual populations is the most viable approach in the current environment. The Long-Term Care Initiative recommendations place a heightened focus on the role of the private market, outline improvements to public programs such as Medicaid, and consider the potential for catastrophic coverage. Recognizing that incremental changes will not solve every problem with LTSS financing, those changes could make a meaningful difference for millions of Americans.

For those policymakers seeking solutions, a primary barrier has been the lack of information available on the costs and distributional impacts of various financing approaches. New information published in 2015 by the Urban Institute and Milliman has proved helpful in guiding our discussions and decision-making process. However, additional work is needed to help inform future discussions, particularly data related to the variation in need and use of services by different populations, especially individuals with disabilities who are under age 65. This report proposes a series of recommendations to improve financing of LTSS, informed by feedback from a broad range of stakeholder organizations and experts. Collectively, these recommendations could form the basis of a bipartisan agreement to address the increasing need for LTSS in the coming decades.

Recommendations to Address the Needs of At-Risk Populations

Increasing the Availability and Affordability of Private Long-Term Care Insurance to Extend Existing Resources

LTSS is an insurable risk, yet sales of private LTCI policies have faltered. Because neither the government nor individuals alone can meet all demands for LTSS financing, middle-income Americans should have a functional, sustainable private LTCI marketplace to help them pay for LTSS should they need it. If policymakers take action to stabilize the LTCI market and make it accessible to more Americans, those in need of LTSS will be able to extend the time they remain at home or in community-based settings.

- For the roughly half of Americans aged 65 and over who will experience a high level of LTSS need, establish a lower-cost, limited-benefit private LTCI product, called "retirement LTCI," which would also be more sustainable for carriers than traditional products.[1]
- This lower-cost product would be designed to cover two to four years of benefits after a cash deductible or waiting period is met. The product would also include coinsurance.
- To make these policies more affordable and to encourage Americans to plan for LTSS need while they save for retirement, employees may use funds in retirement accounts to pay retirement LTCI premiums (early withdrawals would be penalty-free).
- To efficiently expand coverage, recommendations include providing incentives for employers to offer retirement LTCI on an opt-out basis through workplace retirement plans and permitting the sale of retirement LTCI through state and federal insurance marketplaces.

Expanding Options at Home and in the Community for Older Americans and Individuals with Disabilities under Medicaid

Under Medicaid, states must provide nursing home care and other in-patient facility care to eligible individuals who need LTSS, however Medicaid coverage of services received at home or in the community varies significantly from state to state and these services are often unavailable altogether. In June 2012, the Supreme Court ruling in NFIB v. Sebelius effectively made optional an Affordable Care Act requirement to provide health insurance to a subset of low-income individuals through Medicaid expansion. Following state-level opposition and the Court's ruling, a requirement to expand home and community-based services (HCBS) to a federally defined minimum population would face similar opposition at this time. As states begin to see increased demand for LTSS, the combination of administrative simplification and financial incentives could lead states to expand services to meet those demands.

- Create incentives for states to expand the availability of HCBS by: (1) combining existing Medicaid waiver and state plan amendments (SPAs) authorities into a single streamlined SPA; and (2) extending existing enhanced federal matching to encourage states to take advantage of the new streamlined authority.
- Should a catastrophic program (discussed below) be adopted, states that offer expanded HCBS through the new SPA would have lower maintenance of effort requirements.

New Option for Working Individuals with Disabilities

Working Americans with disabilities often obtain LTSS to remain independent through the Medicaid program, however these individuals are at risk of losing access to these services if their earned income increases above a certain level.

- For these individuals with disabilities whose employment income would result in the loss of Medicaid coverage, the recommendations allow states to offer an innovative LTSS-only "buy-in."
- To make the buy-in more affordable, the LTSS-only plan is designed to "wrap around" employer-provided insurance, qualified health plans offered through insurance marketplaces, and Medicare.

Addressing the Needs of Americans with Significant LTSS Needs

- For individuals with significant LTSS needs, pursue concepts and elements for a public insurance program to: (1) address uninsurable long-term care costs; (2) protect Americans from the catastrophic costs of LTSS; and (3) provide relief to states, which along with the federal government face significant Medicaid costs in the coming years as baby boomers begin to need LTSS.
- Program costs should be fully financed so as not to add to the federal deficit over the long-term.

Next Steps

This report is informed by modeling done by the Urban Institute and Milliman, which provided new and significant insight into new insurance models and premium costs for LTSS. BPC leaders recognize that more can and should be done to improve the availability of LTSS. One area that could be better addressed is providing assistance for middle-income Americans who incur significant out-of-pocket expenses or forgo income to serve as caregivers for friends and family members. The following issues are areas that BPC's Long-Term Care Initiative will explore in the coming year, along with other options. These areas include:

- Further refining recommendations outlined in this report, including the relationship between a catastrophic insurance program and Medicaid and options for employers;
- Adding a limited LTSS benefit to Medigap and Medicare Advantage plans to reach a broader population with a basic benefit and to improve coordination among health services and LTSS;
- Expanding and refining federal tax credits for caregiving expenses; and
- Improving or expanding the availability of a respite-care benefit or other direct-service benefit in Medicare.

Overview

As stated in the Long-Term Care Initiative's 2014 report, long-term services and supports (LTSS) refer to the range of clinical health and social services that assist individuals who are limited in their ability to care for themselves.[3] These individuals include those with physical, cognitive, developmental, or other chronic health conditions. They often have difficulty performing one or more activities of daily living, which include bathing and dressing, and instrumental activities of daily living, such as medication management and house cleaning.[4] LTSS are provided in institutional settings, which include nursing facilities and residential facilities, and through home and community-based services (HCBS).

Cost of Long-Term Services and Supports

Regardless of setting, the cost of services can be significant, which is why many state and federal policymakers have been reluctant to take on the issue of financing LTSS. For example, in 2014 the average annual cost for a home health aide was approximately $45,800,[5,6] the cost for community-based adult day-care centers was on average $16,900 per year,[7,8] and the average annual cost to live in a nursing facility was approximately $87,600.[9] In 2013, national spending for formal LTSS (i.e., services from a paid provider) was about $310 billion, with Medicaid spending accounting for about $123 billion (51 percent) of this amount.[10] Formal LTSS spending for older Americans (65 years and up) was approximately $192 billion in 2011.[11]

The cost of providing services is estimated to rise, taking up a larger portion of federal and state budgets under the Medicaid program, and will significantly impact families' savings. According to the Congressional Budget Office, spending by the federal government, states, and individuals on formal LTSS for those aged 65 and older will increase from 1.3 percent of GDP in 2010 to 3 percent of GDP in 2050.[12] Data on current and projected LTSS spending for individuals under age 65 is limited. One estimate puts Medicaid spending for LTSS for the under-65 population at approximately $67 billion in fiscal year 2010, or about 0.5 percent of GDP in that year.[13,14]

A significant number of individuals receive unpaid LTSS from caregivers who are family members or friends. While many people who engage in caregiving consider it rewarding, caregiving takes a toll on the caregiver in terms of physical and mental health, missed work time, and forgone retirement savings.[15] Caregivers often must leave the labor market, forgoing income or incurring significant expense in providing care and eroding their ability to accumulate resources for their own retirement or future long-term care needs. Given these complexities, unpaid care is often a complement to, but not a complete replacement for, paid care. Valuing unpaid care is difficult and inherently uncertain. As such, most data do not reflect the cost of the unpaid care being provided to individuals by friends and family members. However, some estimates put the total economic value of unpaid caregiving at about $470 billion in 2013.[16]

Utilization of LTSS

About 12 million Americans are in need of LTSS. Approximately, 70 percent of Americans aged 65 and over will need LTSS at some point in their lives, with women aged 65 and over needing services for an average of 2.5 years compared with about 1.5 years for men. Just over half of individuals aged 65 and over will have a high level of LTSS need, meaning that they will need help with two or more activities of daily living for at least 90 days or will have severe cognitive impairment.[17] About 14 percent will have a high level of LTSS that lasts for five years or more. Of the 52 percent of individuals aged 65 and over who will have a high level of LTSS need, the average duration of LTSS need is about 3.9 years, with women averaging 4.4 years, and 3.2 years for men.[18]

Amount and Distribution of LTSS Spending per Person

There is notable variation in LTSS spending among individuals. While roughly half of individuals turning 65 today will not have any LTSS expenditures, others will have very high spending. Approximately 6 percent will have expenditures greater than zero but under $10,000.[19] On the other hand, about 27 percent will have LTSS costs of at least $100,000 over the course of their lifetimes, and costs will exceed $250,000 for about 15 percent.[20]

These expenditures are paid for in various ways. Individuals and their families pay for about 53 percent of their total LTSS expenditures out-of-pocket. The states and the federal government pay for about 34 percent of total LTSS expenditures through the Medicaid program. Other public programs, such as benefits available to veterans, cover about 10 percent of total LTSS expenditures, and private long-term care insurance (LTCI) accounts for less than 3 percent of expenditures.[21]

Improving Affordability and Availability of Private LTCI

Long-term care is an insurable risk, yet the private LTCI market covers a decreasing portion of Americans. Many carriers have stopped issuing new policies. Because neither government nor individuals alone can meet all demands for LTSS financing, the United States needs a functional, sustainable private LTCI marketplace. Making premiums more affordable will help reduce out-of-pocket spending or help provide relief to those who rely on unpaid caregivers, including the middle-income Americans who need assistance. Policymakers should take action to stabilize and make the LTCI market accessible to more Americans.

Problem: LTCI take-up is stalling because policies are too expensive, distribution is too limited, and the traditional design is not sustainable for carriers.

Take-Up of Private LTCI

Today, private LTCI accounts for a small proportion of LTSS spending. In 2012, there were about 5 million to 5.5 million individual LTCI policies in force and about 2 million to 2.5 million policies in the group market.[22] The number of insured lives has been relatively flat since the mid-2000s, and annual sales of individual policies have declined sharply since the early 2000s. The number of carriers issuing new policies has decreased significantly since the early 2000s.[23] Insurers made incorrect assumptions when establishing premiums for earlier generations of LTCI policies and found them to be unprofitable without substantial rate increases; many left the market due to continued uncertainty about whether the product will ultimately be profitable, among other reasons. There are about a dozen companies actively selling in the individual market, down from more than 100 in the early 2000s, and fewer than eight selling in the group market.[24]

Consumer purchase of private LTCI has been low for a variety of reasons, including the high cost of premiums, the need to pass medical underwriting, the complexity of LTCI benefit design, and limited opportunities to purchase coverage.

The Urban Institute projects that, under current policy, take-up of private-market LTCI will be less than 9 percent for Americans turning 65 in 2041 to 2045, modestly lower than current levels.[25] Despite the fact that slightly more than half of Americans entering retirement age will eventually experience the need for LTSS at a level that would be covered by most private-market LTCI policies,[26,27] few Americans take action to address this risk. More than half of respondents to a 2015 poll said that they had done little or no planning for their own needs for ongoing living assistance, and only 21 percent said they had done a great deal or quite a bit of such planning.[28] One-third had set aside money for potential future needs, and about a quarter had looked for information about LTCI. *For information on the regulation of private long-term care insurance, see Appendix I-A.*

LTCI Policy Design and Distribution

Consumers purchase private LTCI policies one of two ways: through the individual market, or in the group market. Individual-market consumers must complete a lengthy application and choose between complex benefit designs. Further, they must pass medical underwriting to purchase a policy. In the individual market, consumers generally purchase LTCI through an agent or broker. Since LTCI is a complex product to sell, LTCI agents and brokers earn commissions, typically structured as a significant percentage of the first year of annual premiums and a decreasing percentage over the next few years after sale of the policy. These commissions are then passed along to consumers and contribute to the high cost of premiums for private LTCI.

If available, consumers may opt into an employer-sponsored group LTCI plan. Although enrolling in group LTCI may involve a simpler process and lower commissions than the individual market, relatively few employers currently offer LTCI plans. Overall, about 20 percent of the workforce has access to employer-sponsored LTCI, with access dropping to 5 percent for those who work for companies with fewer than 100 employees.[29] The purchase of group LTCI is also low; where group coverage is offered, roughly 5 percent of employees participate.[30]

More efficient distribution methods would reduce premium costs while reaching segments of the population that are not yet served by LTCI. For example, LTCI could be integrated with employer-sponsored retirement plans or included as a benefit within Medigap or Medicare Advantage plans.

An actuarial analysis from Milliman found that changes to the design and distribution of LTCI could significantly reduce premiums. An alternative design that is distributed through workplace automatic enrollment (i.e., employees who participate in a retirement plan would be automatically enrolled in LTCI coverage but could opt out) would have annual premiums that are almost half the cost of typical current-market LTCI policies.[31] *For additional information on the Milliman analysis, see Appendix I-A.*

Recommendation: Establish lower-cost, limited-benefit retirement LTCI policies.

Rationale

Currently available LTCI policies are too expensive and complex for most consumers, and the traditional policy design has not been sustainable for carriers. The application process is lengthy and cumbersome and includes technical language that is not understandable to many consumers. For Americans who will rely on retirement income and a moderate level of savings to meet basic needs, catastrophic costs will require reliance on unpaid caregivers or require them to deplete their retirement savings in order to qualify for Medicaid. For those who can afford private insurance-based solutions for LTSS financing, affordable options are not available.

For middle-income individuals, new limited private insurance options can avert the need to rely on friends and family members

for care and have the potential to delay or avert the need to exhaust their retirement savings to qualify for Medicaid. As noted above, in many states, HCBS are not readily available and the only option for coverage is nursing home care. Over the past 20 years, societal preferences have shifted toward receiving LTSS in the home and community setting rather than in an institutional one, in large part due to the growth in beneficiary preferences for HCBS when appropriate.[32] Private insurance can help individuals remain in home and community settings for a longer period of time.

Detailed Recommendation

The LTCI market could be stabilized and expanded to include more middle-income Americans if a new form of lower-cost, streamlined policies were made available in addition to existing products. Statutory and regulatory barriers should be cleared to permit the sale of lower-cost, limited-benefit "retirement LTCI."[33] Retirement LTCI policies would be standardized, with three basic plan designs, each of which would have limited options for customization (please see table below for proposed specifications). Many features, such as the premium design and inflation protection, would be standard among all retirement LTCI. Product features would include cash deductibles, coinsurance, inflation protection, a nonforfeiture benefit, and an innovative non-level premium design that would be more sustainable for carriers and offer consumers the opportunity to benefit from lower-than-expected claims experience. Consumers would have choice among basic retirement LTCI features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible, simplifying decision-making.

This lower-cost product is designed to cover two to four years of LTSS need, after a deductible or exclusion period is met, and includes coinsurance. These policies will reduce but not eliminate: (1) the use of personal and retirement savings for out-of-pocket spending for paid services;[34] and (2) the reliance on friends and family members to provide unpaid care.

Retirement LTCI — Standard Plan Designs (Plan participants and Individual Retirement Arrangement (IRA) owners could take penalty-free withdrawals beginning at age 45 for payment of premiums for LTCI policies that conform to these standard designs, among other features detailed below.)

Default Pool-of-Money Benefit Options (Service Reimbursement)		
Plan A	Plan B	Plan C
$73,000 in service reimbursement ($100 daily benefit maximum, 2-year benefit period)	$164,250 in service reimbursement ($150 daily benefit maximum, 3-year benefit period)	$219,000 in service reimbursement ($200 daily benefit maximum, 3-year benefit period)
Alternative Benefit Options		
Plan A	Plan B	Plan C
$109,500 (Increase benefit period to 3 years)	$219,000 (Increase benefit period to 4 years)	$292,000 (Increase benefit period to 4 years)
Default Cash Deductible (Out-of-pocket spending before coverage begins)		
Plan A	Plan B	Plan C
$10,000 cash deductible	$25,000 cash deductible	$25,000 cash deductible
Alternative Deductible		
Plan A	Plan B	Plan C
n/a	$50,000 cash deductible	$50,000 cash deductible
Elimination Period (The number of days you must need nursing home or home health care before the policy pays benefits; Only applies if cash deductible is not met)		
Plan A	Plan B	Plan C
180-calendar-day elimination period	1-calendar-year elimination period	1-calendar-year elimination period

Notes: Proposed amounts shown for 2016; standard benefit maximum amounts and cash deductibles would be indexed to the employment cost index. Policyholders could qualify for benefits by meeting cash deductible or elimination period, whichever comes first. All plans include 20 percent coinsurance.

For additional details on retirement LTCI policies, see Appendix I-B.

Problem: The need for LTSS is one of the primary risks to retirement security, yet Americans cannot use their retirement savings to purchase LTCI when they are younger than age 60, at which time policies are more affordable and applicants are more likely to pass underwriting.

Median per-capita retirement savings among Americans aged 62 and older was about $20,000 in 2015 and is projected to rise to almost $41,000 in 2035; for the 75th percentile, per-capita retirement savings was about $99,000 in 2015 and is projected to rise to almost $168,000 in 2035.[35] While some retirees will have limited or no need for LTSS, for others, high LTSS need would deplete their retirement savings and overwhelm sources of retirement income, such as Social Security and defined benefit pensions.

Under current law, distributions from qualified defined-contribution retirement plans, such as 401(k) and 403(b) plans, are restricted for working-age plan participants. In general, participating employees who are under age 59 and a half cannot take funds out of the plan unless they experience an immediate and heavy financial need, in which case the participant may be eligible to take a hardship distribution.[36] These rules are intended to limit the use of retirement plan assets for pre-retirement consumption, which is sometimes referred to as "leakage."[37] Because of these rules, employees under the age of 59 and a half who are actively participating in a plan cannot use those retirement plan assets to purchase LTCI. Retirement-age participants can take withdrawals for any reason without early withdrawal penalties; however, LTCI premiums are higher if issued at older ages, and older applicants are more likely to be denied coverage due to underwriting.

Recommendation: Allow working-age retirement plan participants aged 45 and older to use retirement savings, without early withdrawal penalties, to purchase retirement LTCI.

Rationale

The potential need for LTSS is a significant risk to retirement security and should be addressed as part of retirement planning. Furthermore, many middle-income Americans may have difficulty paying LTCI premiums from employment income. They may have other obligations, including mortgages, children's educational expenses, health, and general living expenses. Further, many families are called on to help finance a parent's living or long-term care expenses. Many of these same Americans have saved for retirement and have funds in 401(k)-type workplace retirement plans and IRAs. These funds are meant to be used for retirement security needs, including regular income and to meet emergency consumption needs. Because LTSS is a major threat to retirement security, it would be desirable for individuals to be able to use retirement savings to obtain insurance to help meet potential LTSS needs. Integration of LTCI with employer-sponsored retirement plans would have the benefit of engaging workers with the need to plan for potential future LTSS expenses using a familiar vehicle, such as a 401(k) plan or an IRA. Such a change, if carefully crafted to encourage appropriate levels of insurance, could improve financial security in retirement for those who ultimately need LTSS, with a limited impact on overall retirement savings. It would also provide an opportunity to promote innovative approaches to increase participation and better meet LTSS financing needs.

Detailed Recommendation

Employees aged 45 and older in defined-contribution retirement plans, such as 401(k) and 403(b) plans, should be allowed to take distributions from the plan solely for the purchase of retirement LTCI for themselves and/or a spouse. Distributions for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.

For IRA owners aged 45 and older, early distributions for the purchase of retirement LTCI would also be exempt from early withdrawal penalties. This tax treatment would maintain the spirit

of tax deferral, which is that contributions to defined-contribution retirement plans and IRAs are excludable or deductible from income tax, while distributions from the plans and IRAs are subject to income tax. The purpose of this approach, which should be roughly revenue-neutral over the long term, is to allow plan participants and IRA owners to more effectively use their retirement savings to protect against a major risk to financial security in retirement; it is not intended to subsidize LTCI with a large new tax expenditure.[38]

For additional details on statutory and regulatory modifications to permit the use of qualified retirement plan and IRA assets to purchase retirement LTCI policies, see Appendix I-B.

Problem: Take-up of LTCI will remain low as long as opt-in frameworks are the primary mode of enrollment. Even if the above recommendations are adopted, employers that sponsor retirement plans are unlikely to implement opt-out enrollment into LTCI without stronger incentives, including provisions to limit fiduciary liability.

Even where the LTCI application process is more streamlined today, take-up remains low when offered on an opt-in basis. For example, where group coverage, which typically includes a shorter, simpler application, is offered, very few—roughly 5 percent—employees participate.[39] An approach that would enroll employees by default in an LTCI policy, with the opportunity to adjust coverage levels or opt out entirely, could improve participation, as it has in other contexts, such as initial 401(k) plan enrollment and in private disability income insurance. However, even if the recommendations above to enable the use of retirement plan assets for LTCI are implemented, there would still be formidable barriers to plan sponsor adoption of automatic enrollment into LTCI, including administrative hassle for employers and concerns about fiduciary responsibility. Employers that sponsor plans are held to high standards to protect consumers, but these standards have sometimes discouraged innovations that improve retirement security.

Recommendation: To make retirement LTCI policies more widely available, provide incentives for employers to offer them through workplace retirement plans on an opt-out basis.

Rationale

Automatic enrollment has been shown to be an effective means to increase participation in retirement savings plans, and research has also demonstrated that defaults can powerfully influence consumer behavior, whether because of inertia or because employees view a default setting as an implicit recommendation.[40] Ideally, this approach could be applied to LTCI for retirement plan participants, who would have savings to fund the premiums after employment ends and throughout retirement. Default enrollment of individuals into an appropriate LTCI policy design has the potential to expand coverage in an efficient manner. It could also improve the risk pool for LTCI, making the approach more viable for carriers, and it could enable Americans to obtain coverage without underwriting.

Detailed Recommendation

Plan sponsors should be offered a safe harbor and expanded “catch-up” contributions if the sponsor automatically enrolls certain plan participants (who would have the ability to opt out) into a retirement LTCI policy. Since this approach has never been tried for LTCI, there can be no guarantee that it will be successful. However, if carefully designed and implemented, there is a good chance that automatic enrollment could yield a significant increase in LTCI take-up. The proposed safe harbor would limit fiduciary liability for plan sponsors that implement automatic enrollment according to certain standards.

For additional details on the proposed auto-enrollment safe harbor and increase in catch-up contribution limits, see Appendix I-C.

Problem: Individuals without employer-sponsored coverage have limited options and face higher costs to obtain LTCI.

Most Americans do not have access to group coverage at work, and the broker distribution network for individual coverage is shrinking as carriers have left the market. This leaves Americans who do not have access to group coverage with more limited options to insure for their LTSS needs. Selling and other administrative costs are also high in the individual market because LTCI is a complex product that is time-consuming to sell.

Recommendation: Allow retirement LTCI policies to be sold on state and federal health insurance marketplaces.

Rationale

The existing distribution channels for LTCI are not reaching many of the Americans who could benefit from insurance, including those without access to employer-sponsored coverage and those who save for retirement in IRAs. For these reasons, an additional, efficient distribution channel is needed for LTCI. This approach could also help to raise awareness of the risk of needing expensive LTSS, as customers who purchase health insurance through exchanges learn about the availability of retirement LTCI on the exchange.

Detailed Recommendation

To provide another avenue for lower-cost distribution of LTCI for the general public, all health insurance marketplaces would have the option to facilitate sales of retirement LTCI policies. Participating marketplaces could accept distributions from workplace retirement plans and IRAs for the payment of retirement LTCI premiums from savers aged 45 and older.

Expanding Options at Home and in the Community for Older Americans and Individuals with Disabilities under Medicaid

Problem

Medicaid is a program designed to provide medically necessary acute and long-term care services for low-income populations and is jointly funded by the states and the federal government. According to Congressional Budget Office projections, federal LTSS expenditures under Medicaid were $74 billion in 2014 and will reach $113 billion per year in 2025.[41] While states are required to cover institutional LTSS services, HCBS are optional.

In recent decades, there has been a shift away from institutional delivery of care to HCBS. In 2013, about half of Medicaid LTSS dollars were spent on institutional care, and half were spent on HCBS.[42] The availability of HCBS varies significantly from state to state. In Mississippi, HCBS made up about 25 percent of the state's LTSS spending, while Oregon spent nearly 80 percent of LTSS dollars on HCBS.[43]

A number of factors have driven the shift from facility-based services to HCBS. One of the more significant was a Supreme Court decision in 1999, Olmstead v. L.C., in which the Court held that requiring individuals with intellectual and developmental disabilities to live in institutions as a condition of receipt of services under Medicaid violated the Americans with Disabilities Act.[44] The Court held that, where appropriate, and at the request of an individual, the state must make services available in the community. Recognizing the cost to states, the Court permitted states to maintain waiting lists for services, provided that waiting lists moved at a "reasonable pace." [45]

HCBS Waivers

Generally, states have increased the availability of HCBS through the use of waivers of federal Medicaid requirements. For example,

Medicaid services must be comparable across different categories of eligible individuals (e.g., children with behavioral health needs, and adults who need home health aide services), and services must be offered statewide.[47] Through the use of waivers, such as section 1915(c) of the Social Security Act, states have the ability to provide a defined set of HCBS to target populations, without making services available to all eligible individuals in the state. Under this waiver authority, states may provide HCBS to individuals who require an institutional level of care, so long as states demonstrate to the Centers for Medicare and Medicaid Services that they would spend no more than would have otherwise been spent on institutional care. More than three million individuals receive HCBS each year through approximately 300 waivers.[48]

State Plan Amendments

Over the last decade, Congress has enacted a series of state plan amendments (SPAs) designed to make it easier for states to expand HCBS. *For a description of these SPAs for HCBS, see Appendix II-A.* The existing 1915(c) waiver process may be preferable in the short term because it permits states to cap the number of individuals eligible under a proposed expansion, allowing states to predict costs in advance. Over time, particularly if SPAs are consolidated and streamlined, states may have greater incentive to use SPAs. As outlined below, this streamlined HCBS option is designed to provide most of the same benefits as the waiver process, but would not require states to negotiate waivers with the Department of Health and Human Services (HHS) secretary. Under the current structure of HCBS, the combination of several SPAs and the waiver authority has resulted in an unnecessary level of complexity that is often difficult to navigate for administrators and beneficiaries alike.[49]

Recommendation: Create incentives for states to expand the availability of HCBS by streamlining and simplifying existing authorities under current law waivers and SPAs and extend enhanced federal matching to encourage states to take advantage of the new streamlined authority. States should retain the ability to use the existing waiver process, and existing HCBS SPAs should be grandfathered in. Finally, once operational, the HHS secretary should make recommendations to Congress on whether to repeal existing SPAs.

Rationale

Streamlining and consolidating existing waiver authority into a single SPA would assist states seeking to expand the availability of HCBS. Combining features of existing SPAs would permit states to offer HCBS in a way that moves toward eliminating Medicaid's bias for institutional or facility-based care, give states the flexibility and predictability they need to expand services to best address the needs of varying populations, and maintain essential provisions of federal law that allow individuals to direct their own care. Specifically, the streamlined SPA would draw from features in existing law — sections 1915(i), (j), and (k) of the Social Security Act — to combine the best features of each option.

Detailed Recommendation

Drawing from 1915(i), (j), and (k), the streamlined waiver would:

- Permit states to offer services to individuals who do not require an institutional level of care;
- Permit states to cover individuals with incomes up to 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI FBR).[50] In 2016, 300 percent of the SSI FBR for individuals will be about $2,199 per month or approximately 225 percent of the federal poverty level (FPL);
- Require the development of a personalized care plan for eligible individuals based on assessment of functional and community-integration needs;
- Permit states to cover any item or services that the HHS secretary has approved for coverage under an HCBS waiver, including rehabilitative and respite care as well as those currently included in the Community First Choice Option

(Section 1915(k)), which prioritizes self-directed care within the community;

- Extend the 6 percent enhanced federal matching assistance percentage from 1915(k) and the Money Follows the Person Rebalancing Demonstration;[51]
- Allow states to disregard Medicaid's comparability of services requirement[52] to permit states to design benefit packages meeting needs of specific populations, to gradually grow the benefit over time, and/or to design preventive HCBS packages for individuals who are not yet at an institutional level of care;[53]
- Direct the HHS secretary to include quality measures, focusing on improving or maintaining quality of life. Measures should include both outcome measurement and process measures. However, process-related measures should be meaningful to the health and functional status of the patient;[54]
- Allows states to set eligibility and estimate enrollment numbers so when that projection is reached, they can stop enrollment (with current beneficiaries continuing to receive care and grandfathered in should the eligibility change), as permitted under section 1915(i), the so-called, "Wisconsin trigger"; and
- Allow states to develop payment rates for services in accordance with applicable state plan requirements. In addition, states would be eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' No Wrong Door system,[55] as well as for ombudsman activities. This allows for states to establish administrative structures that ensure individuals are informed about how to access Medicaid HCBS, furthering the efforts of rebalancing the LTSS system and promoting person-centered care in the community.

Recommendation: Should a catastrophic program (discussed below) be adopted, states that offer expanded HCBS through the new SPA would have lower maintenance-of-effort requirements.

See recommendation on exploring a public-catastrophic option below in Section V.

Improving Access to Affordable LTSS for Working Americans with Disabilities

Problem

Individuals with disabilities frequently require access to a broad range of LTSS to enter, remain in, or rejoin the workforce. Private health plans and Medicare often lack coverage for many of these services, such as specialized durable medical equipment, transportation, personal assistance services, and other work-related assistance. Low-income Americans with disabilities often obtain access to services through the Medicaid program as a result of eligibility for the Supplemental Security Income program, but lose access to these services if earned income increases, creating disincentives for employment.[56] According to some studies, losing Medicaid coverage is a work disincentive equal to or greater than the loss of income for individuals with disabilities.[57]

Under current law, states may implement Medicaid "buy-in" (MBI) programs for individuals who would otherwise lose that coverage. Specifically, states may offer Medicaid acute and LTSS coverage to employed individuals with disabilities with incomes below 250 percent of FPL ($29,425 for an individual). States may also offer MBI coverage to employed individuals with disabilities between the ages of 16 and 64 who experience increases in income or medical improvement causing them to lose Medicaid eligibility.[58] *For additional information on existing Medicaid buy-in authority, see Appendix II-B.*

Recommendation: Expand options for individuals with disabilities by permitting states to offer a "buy-in" for LTSS-only services to wrap around health insurance, such as employer-sponsored coverage, Medicare, and coverage offered through state and federal insurance marketplaces.

Rationale

If adopted by states, the Enhanced Medicaid Buy-In (EMBI) option would be available to individuals with earned income equal to or above 250 percent of FPL (in 2015, $29,425) and who have proof of health insurance coverage. States would allow individuals to participate in the EMBI until they reach the Social Security Administration's full retirement age. States that adopt this new option would be prohibited from imposing an asset test and would charge a sliding-scale premium based on income, ranging from 2 percent to 10 percent of income.

Additional requirements would assure the program is targeted to individuals based on need. Higher-income earners with manageable expenses would lose eligibility for the EMBI once the cost of services delivered fall below 20 percent of adjusted gross income (AGI). For example, an EMBI participant with AGI of $150,000 and less than $30,000 of EMBI-paid LTSS spending would lose eligibility for the program. In addition, incomes from trusts or settlements must be used to offset the cost of services; for example, an individual who received a settlement of $5,000 per month to pay for support services that would otherwise be covered by the EMBI would be required to pay the EMBI program the $5,000, in addition to the income-based premium.

The EMBI proposal is likely to attract participants with high LTSS costs, which will be partially offset by premiums. However, participation is likely to be much lower than that in existing MBI options. The total cost of the program to the federal budget will depend on state adoption, participation rates of eligible workers with disabilities, the cost of LTSS for these workers, and the income generated by these workers (which determines the offsetting premiums).

Addressing the Needs of Americans with Extraordinary LTSS Needs

Problem: Americans with catastrophic LTSS expenses typically have no alternative to impoverishing themselves and spending down to Medicaid.

Improvements in private LTCI and improvements in Medicaid are not sufficient to address the needs of individuals with extraordinary LTSS expenses, such as those in excess of $250,000. The vast majority of Americans do not have adequate personal and retirement savings to pay for significant LTSS costs out-of-pocket, and many do not have friends and family to provide unpaid care. These costs are not sustainable for states and the federal government under the Medicaid program, and these costs are uninsurable in the private LTCI market. A public insurance approach for Americans who experience catastrophic LTSS expenses is worthy of consideration because it could improve the availability of LTSS in preferred settings and increase financial security for families.

Recommendation: Pursue the concepts and elements of a public insurance program to protect Americans from catastrophic LTSS expenses, while assuring that it does not add to the federal deficit.

Rationale

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.[59] Only a public program could provide insurance for this catastrophic back-end LTSS risk.

In coordination with BPC's initiative and other groups addressing long-term care financing, the Urban Institute modeled two approaches to a public, catastrophic insurance program for Americans aged 65 and older with differing features. A voluntary approach was projected to generate very low take-up. Participation in an unsubsidized version was estimated to reach about 11 percent; a version with low-income subsidies was projected to have participation from about 20 percent of the population.[60]

A mandatory public insurance program that provided catastrophic coverage to more than 90 percent of older Americans would pay benefits totaling roughly $411 billion (in 2015 dollars) annually by 2050, or more than half of the projected cost of Medicare Part A.[61,62,64] Roughly one-third of individuals turning 65 would eventually qualify for benefits under the mandatory catastrophic program, which would pay $81,500 for each enrollee who receives benefits under the program in 2050.[64] In the same year, such a program would reduce out-of-pocket spending by $130 billion and reduce Medicaid spending by $154 billion.[65] There is substantial uncertainty in these projections, which are sensitive to assumptions, such as the duration of services needed by claimants, and the modelers were unable to estimate the cost of a program that would also cover catastrophic LTSS needs for Americans under 65 years of age.

A catastrophic public insurance program also faces significant political challenges. After the repeal of the Community Living Assistance Services and Supports (CLASS) Act, a limited, voluntary public LTCI program that was included in the Patient Protection and Affordable Care Act, there seems to be little appetite on Capitol Hill to develop new social insurance programs.

Detailed Recommendation

Despite these challenges, a catastrophic public program is worthy of future policy development work. While it is unlikely to be on the near-term agenda of lawmakers, such a program would fill a gap without any plausible alternatives, it would generate substantial savings for Medicaid, and it would improve the financial security of Americans.

Given the early stage of the modeling work and the uncertainties of the cost of such a program, it would be premature to recommend detailed specifications. However, if a public-policy consensus develops that it is important to protect Americans against catastrophic LTSS needs, any potential new public, catastrophic LTCI program should be designed with the following guidelines:

- Americans should have clarity about their personal liability for LTSS expenses.
- Any potential catastrophic program should broadly cover Americans of all ages.
- A new program should complement private-market LTCI, such as through the approaches recommended above, to help Americans finance front-end LTSS expenses.
- State Medicaid programs, which would continue to finance front-end LTSS expenses for Americans who could not otherwise afford services, would receive very large financial benefits from such a new program, and it is unlikely that Congress would be willing to absorb state contributions without some form of maintenance of effort. This maintenance of effort could, however, be adjusted based on a state's level of commitment to expanding HCBS for low-income populations.
- The net additional cost (after the federal share of Medicaid savings) of any public catastrophic LTSS program should be fully offset. A variety of financing approaches could be considered, including:
    - A dedicated payroll-tax financing approach, similar to Social Security or Medicare Part A. This approach would

ensure all Americans with earnings contribute, but it might lack public support because, unlike Medicare and Social Security, only a small percentage of Americans would ultimately receive benefits from the catastrophic LTSS program. If adopted, it is important that any dedicated funding approach be sufficient to offset program costs on a sustainable basis, including over a long-term projection period and in the individual years toward the end of such a period.

- A general-funding approach, which could be offset through changes to the tax system, such as broadening income or consumption-tax bases or increasing tax rates, changes to spending programs, such as adjustments to Medicare and Social Security, or a combination of both. These types of changes are invariably controversial, and it would be important to ensure that revenue and/or savings from such changes would be commensurate with growth in catastrophic LTSS program costs over time.

Together, these recommendations offer a path forward to improve insurance financing of LTSS. Some could be done in the near term with minimal or no cost to the public. Others will take longer and require more development. Most importantly, there is a great and growing need among Americans that the next attempt to improve LTSS financing be successful. Policymakers should attempt to advance solutions that will help to meet this need.

Conclusion

The current political and budgetary environment compels BPC's leaders to offer recommendations that build on and improve public- and private-sector solutions to financing LTSS, rather than suggesting a comprehensive program. Financing is the most significant hurdle to improving the availability of LTSS, and it is critical to the development of an LTSS delivery system. Experts suggest that the caregiver workforce is insufficient to deliver the services and supports necessary to meet future needs, and unless the nation addresses the means of financing care, wages will continue to be low, and there will be little incentive for individuals to choose a career as a caregiver. Over the course of the coming year, BPC leaders will continue to refine and improve these recommendations and will explore ways to better integrate clinical services, LTSS, and community-based services to assure improvements in the delivery of care.

Next Steps

Middle-income Americans especially need additional LTSS financing options. The following concepts for future policy development would help to address the needs of middle-income individuals. The following approaches were not the subject of the Urban/Milliman modeling project. BPC's Long-Term Care Initiative will examine these and other concepts in more depth and issue more specific recommendations in 2016.

Explore possibilities to add an LTSS benefit to Medigap and Medicare Advantage plans to reach a broad population with a person-centered basic benefit and improve coordination among health services and LTSS.

The vast majority of older Americans who are not eligible for Medicaid are enrolled in either a Medicare supplemental plan, commonly known as Medigap, or a Medicare Advantage plan. These plans have many potential advantages as a chassis for LTSS benefits. If offered on a guaranteed-issue basis at age 65, they could reach a large market of individuals who do not have other LTCI coverage, could offer a benefit designed to help policyholders remain in their homes, and could coordinate care across acute health services and LTSS, with the potential to generate savings for Medicare. For example, if an LTSS benefit serves to prevent accidents and resulting injuries, then savings from avoided hospitalizations and other medical care would accrue to the Medicare program, beneficiaries, and supplemental plans.

Consider development of a tax credit for caregiving expenses.

Much paid LTSS is financed by out-of-pocket spending, as most Americans do not have private LTCI coverage and are not eligible for Medicaid. Existing tax benefits for LTSS spending are primarily

available to those with catastrophic needs. A targeted tax credit could help middle-income Americans pay for some of the initial costs of LTSS. Even a limited tax credit, however, could have a significant budgetary impact and might need to be considered as part of more comprehensive tax reform.

Consider establishing a respite-care benefit within Medicare.

Respite care is temporary, paid or unpaid care provided to an individual with LTSS needs to give the individual's usual caregiver some time off. This care can be provided within the home, community, or a facility. Medicare does not pay for respite care other than a limited benefit for Medicare beneficiaries enrolled in hospice. Future work would examine possibilities to expand Medicare coverage for respite care and consider the budgetary impact of this proposal.

Consider in-plan approaches to offering LTCI within retirement plans.

The retirement LTCI proposal in this report is intended to be funded by distributions from employer-sponsored retirement plans and IRAs. An alternative approach not considered in this report would be to allow for LTCI as an investment option within workplace retirement plans. Future work would examine the possibilities of potential cost (revenue loss), coverage take-up, and distributional impact of an in-plan approach to LTCI. Like all policies BPC considers, we believe there should be a commitment to ensuring that there is a commitment to offsets that ensure little to no impact on the federal deficit.

Appendices

Appendix I-A: Regulation and Design of Private LTCI Policies

Federal Tax Benefit for Qualified LTCI

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided tax benefits to private LTCI policies meeting certain standards. The law directed the secretary of the Department of Health and Human Services to work in concert with the National Association of Insurance Commissioners (NAIC) to establish minimum federal standards for "qualified long-term care insurance" policies.[66] These requirements are included in the NAIC Model Act and Model Regulations.[67,68] These standards require private LTCI carriers to guarantee renewal of policies, prohibit cancellation of policies for reasons other than nonpayment of premiums, require carriers to offer policyholders the option to purchase 5 percent-compound inflation protection (consumers may decline to purchase inflation protection), require carriers to offer policyholders the option to purchase a nonforfeiture benefit, and prohibit duplication of Medicare benefits. Policies must begin paying benefits when an individual meets a level of need outlined in statute[69] and must meet per-diem payment requirements. By the early 2000s, tax-qualified policies constituted the vast majority (90 percent) of LTCI policies sold.[70]

Benefits paid to policyholders are excluded from the individual's taxable income. In addition, premiums for qualified LTCI plans may be counted toward deductible medical expenses for individual tax-filing purposes.[71] Employer contributions toward premiums for qualified LTCI can be excluded from an employee's taxable income and are not counted as part of the wage base used to determine the employee's payroll tax. However, few employers contribute to employees' LTCI premiums. Under certain conditions, self-employed individuals can deduct premiums for qualified LTCI from income (up to a specified amount).[72]

Many states also offer tax benefits for the purchase of private LTCI. Some states allow individuals who purchase LTCI and qualify for the federal medical-expenses deduction to also receive this deduction on their state return, while other states offer a unique deduction or credit, and some states offer both the federal carry through and a unique tax benefit.[73]

Long-term Care Partnership Program

The Deficit Reduction Act of 2005 expanded a four-state demonstration program permitting states to sell "Long-term Care Partnership Plans." Individuals who purchase Partnership-qualified LTCI can become eligible for Medicaid coverage without meeting the usual Medicaid spend-down requirements. In particular, the "asset disregard incentive" allows Partnership participants to keep $1 of assets for every $1 received in LTSS benefits from a Partnership-qualified LTCI policy.[74] Currently, 41 states offer Partnership-qualified plans, and about 28 percent of new sales in 2010 were for Partnership policies.[75] Forty states provide reciprocity honoring Partnership policies sold in other states.[76]

Private LTCI Premiums

In order to purchase private LTCI, individuals must first meet certain requirements related to health and functional status, known as medical underwriting. For example, an individual who has a functional impairment or chronic medical condition, such as diabetes or heart disease, is largely ineligible for private LTCI coverage. The initial LTCI premium amount is based on the individual's age at the time of purchase (i.e., premiums are higher for those who purchase a policy at an older age) and incorporates assumptions about the percentage of policies that will "lapse" for nonpayment of premiums, interest rates, morbidity, and mortality. For typical policies, premiums remain level throughout the life of the policy unless a state insurance regulator approves a carrier's request to increase premiums; in this case, the carrier must demonstrate to the regulator that initial assumptions proved inadequate to finance benefits.

Carriers must receive approval from state insurance regulators to increase private LTCI premiums. Insurance carriers have raised the

concern that as elected officials or political appointees, insurance regulators are often reluctant to approve increases in premiums. While the current process was intended to protect consumers from experiencing increases in premiums, they argue that the result has been to delay premium increases until they become substantial, rather than permitting smaller, periodic updates. This process can cause large onetime premium increases for consumers who were not expecting them and may not be able to afford the higher premiums. Especially large premium increases not only affect current policyholders but also may make news headlines and dissuade others from purchasing LTCI.

Initial LTCI premiums have also risen over time (especially as carriers have revised assumptions about interest and lapse rates), and the top reason that individuals give for not purchasing a private LTCI plan is that it is too expensive (61 percent of respondents).[77] The increase in premiums has occurred across age groups, but particularly for those aged 55 to 64. For this group, average annual premiums have increased from $919 in 1995 to $2,255 in 2010 (or an increase of 145 percent), and for those aged 75 and over, premiums have increased from $2,146 in 1995 to $3,949 in 2010 (or an increase of 84 percent).[78] In 2015, Milliman estimated that the annual premium for a typical LTCI product currently available on the market is $2,420 if purchased at age 50, $2,814 if purchased at age 55, $3,380 if purchased at age 60, and $4,496 if purchased at age 65.[79]

Regulation of Private LTCI

States and the federal government play different roles in the regulation of private LTCI. The federal government provides tax benefits for the purchase of "qualified long-term care insurance" that meets minimum federal standards, typically referred to as "tax-qualified" LTCI.[80] The federal government has also established a public-private partnership, called the state long-term care insurance partnership, through which individuals may retain a certain level of assets and still qualify for Medicaid. As mentioned above, partnership plans were designed to encourage individuals to purchase LTCI and avoid or delay spending down to Medicaid.[81]

States have the primary responsibility for regulating sales of private LTCI. They license carriers to offer insurance in their states, set insurance standards above and beyond minimum federal standards (for tax-qualified policies), and enforce standards. Further, state regulators may approve or deny LTCI carriers' requests to offer new products for sale or to increase premiums for existing policyholders.

Private LTCI Benefit Design

Private-market LTCI products can have a complex benefit design, with many parameters left up to the consumer's choice. These parameters include:

- Type of care covered (e.g., home care and/or nursing facility care);
- Maximum daily benefit amount;
- Benefit type (e.g., cash or, more typically, service reimbursement);
- Benefit period (generally between two and five years);
- Amount and type of inflation protection (e.g., none, simple, compound); and
- Duration and type of elimination period (i.e., the period of time between when the policyholder experiences a high level of need for LTSS and when the policy begins to pay benefits).

It is difficult for consumers to estimate the amount of coverage that they might need and to choose among different types of inflation protection. In some cases, consumers are asked to make decisions on parameters that have a limited, if any, effect on the premium; in other cases, consumers do not understand the terms of their policies. For example, consumers who select a policy with a six-month elimination period may not understand that the policy will not pay benefits until six months after the individual has met the benefit trigger (e.g., needing help with two or more activities of daily living).

Impact of Alternative Policy Design and Distribution on Pricing

An actuarial analysis from Milliman found that a policy design typical in the current private market would have annual premiums of $2,420 if issued at age 50.[82,83] Milliman estimated that an alternative policy design with a longer elimination period (or equivalent cash

deductible), premiums that increase regularly, lower commissions typical for the group market, and distribution using workplace automatic enrollment (i.e., employees who participate in a retirement plan would be automatically enrolled in LTCI coverage but could opt out) would have annual premiums starting at $1,329, a reduction of almost half, if issued at age 50 under a pessimistic scenario in which more than 90 percent of workers opt out.[84] If a lower proportion of workers opt out of the coverage, premiums could be significantly lower.[85]

Appendix I-B: Specifications for Retirement LTCI

Reforms to the private insurance market to make plans more affordable will require trade-offs. Changes to the product design, such as the use of cash deductibles or longer elimination periods, could reduce premium costs for consumers but would require greater out-of-pocket spending or assistance from friends and family. If the private LTCI market is to remain viable, regulators must strike a balance between affordable premiums and a meaningful benefit that would provide sufficient financial protection for policyholders who experience LTSS needs.

Cash Deductibles and Coinsurance

All retirement LTCI plans would allow policyholders who experience a high level of need (i.e., are unable to perform at least two activities of daily living due to a loss of functional capacity or who require substantial supervision due to severe cognitive impairment) to access benefits after meeting either a dollar-amount cash deductible or a time-based elimination period. Cash deductibles would provide policyholders with clearer expectations about their potential exposure to out-of-pocket spending on LTSS and would be particularly appropriate for those who have accumulated savings in defined-contribution retirement plans, which could be used to meet the deductible.[86] Those who rely on unpaid services, likely from family members, would also be able to access benefits under the policy after a period of time, even if they have little or no out-of-pocket spending on LTSS. While the proposed elimination periods are longer than typically used in private-market LTCI, they, along with the cash deductibles, would substantially reduce premiums, as would the incorporation of 20 percent coinsurance in all retirement LTCI plans (i.e., if the insured individual uses $100 of covered services, the plan would pay $80 and the policyholder $20).

Inflation Protection

It is not uncommon for LTCI to be purchased 30 to 40 years before services are used, over which time the cost of an equivalent intensity and duration of LTSS is all but certain to rise. Because of this, a regular update to benefit levels to account for expected growth in the cost of services is an essential consumer protection. However, the variety of inflation protection available in the current market creates unnecessary confusion, and most buyers are probably not well-positioned to forecast LTSS cost growth. All retirement LTCI policies would incorporate standard inflation protection; the maximum daily or monthly benefit would be updated annually for growth in the employment cost index, which is a measure of economy-wide growth in labor costs. While no measure of inflation is perfect, LTSS is labor-intensive, making wage indexation an appropriate proxy that is likely to roughly keep up with LTSS costs over long periods of time.

Non-Level Premiums

As noted above, level premiums have created an expectation among many consumers that premiums will never change, even though no such guarantee is made. And because actuarial assumptions, even if slightly off, can result in substantial variance in cost over the 30- to 40-year life of a typical policy cohort, carriers have often sought large rate increases after many years of losses, generating surprise and sometimes anger among consumers and regulators. Premiums for retirement LTCI would operate differently than in the current market; non-level premiums would have two components. First, premiums would be intended to grow annually at a modest rate. Instead of calculating premiums that are intended to remain level after issue, premiums would be updated annually for growth in the consumer price index (CPI-U) from issue until the policyholder reaches age 75, at which point premiums would remain level. Consumers, including those in retirement age, already experience recurring expenses that

increase over time (e.g., Medicare premiums), and price indexation of premiums is a reasonable approach for consumers given typical sources of retirement income and savings.[87] Second, carriers would be required to revise premiums for retirement LTCI, up or down, based on updated actuarial assumptions at regular intervals using a streamlined process with state regulators.[88] Every three years, premiums would be updated for changes to assumptions on interest rates, investment rates, and lapse rates. Because it takes longer to develop reliable experience for mortality, morbidity, claim severity, and claim duration, premiums would be updated every six years to incorporate the latest assumptions for those factors. These updates would be required and would continue until the policyholder reaches age 85. Updates could result in premium reductions if experience is better than the original assumptions for pricing. With this more sustainable approach, errors in original assumptions would be corrected more quickly than under current processes. Smaller, more frequent adjustments and the ability for consumers to gain from improvements in experience could build more confidence in LTCI products among regulators and the public.

Nonforfeiture Benefit

All retirement LTCI policies would include a nonforfeiture benefit. Lapsed policyholders (i.e., those for whom a policy is cancelled due to failure to pay premiums), who ultimately meet the criteria for benefits (i.e., unable to perform two or more activities of daily living or severe cognitive impairment; satisfaction of the deductible or elimination period) could claim benefits limited to premiums paid.

Tax and Partnership Qualification

All retirement LTCI would also be tax-qualified, which would require limited exemptions from the current statute.[89] In states that have adopted long-term care Partnership programs, in which LTCI meeting certain standards would qualify policyholders to exempt additional assets from resource tests should they eventually rely on Medicaid-covered LTSS, all retirement LTCI policies would be deemed Partnership-qualified.

Buyers could choose among basic coverage amounts, durations, and deductibles. Plan A would be intended to meet two to three years of LTSS needs in a home setting. Plans B and C would be geared toward more substantial home or facility-based needs for three to four years. Standard plan designs and customizable features would include:

Retirement LTCI: Standard Plan Designs (Plan participants and IRA owners could take penalty-free withdrawals beginning at age 45 for payment of premiums for LTCI policies that conform to these standard designs, among other features detailed above.)

Default Pool-of-Money Benefit Options (Service Reimbursement)		
Plan A	Plan B	Plan C
$73,000 in service reimbursement ($100 daily benefit maximum, 2-year benefit period)	$164,250 in service reimbursement ($150 daily benefit maximum, 3-year benefit period)	$219,000 in service reimbursement ($200 daily benefit maximum, 3-year benefit period)
Alternative Benefit Options		
Plan A	Plan B	Plan C
$109,500 (Increase benefit period to 3 years)	$219,000 (Increase benefit period to 4 years)	$292,000 (Increase benefit period to 4 years)
Default Cash Deductible (Out-of-pocket spending before coverage begins)		
Plan A	Plan B	Plan C
$10,000 cash deductible	$25,000 cash deductible	$25,000 cash deductible
Alternative Deductible		
Plan A	Plan B	Plan C
n/a	$50,000 cash deductible	$50,000 cash deductible
Elimination Period (The number of days you must need nursing home or home health care before the policy pays benefits; Only applies if cash deductible is not met)		
Plan A	Plan B	Plan C
180-calendar-day elimination period	1-calendar-year elimination period	1-calendar-year elimination period

Notes: Proposed amounts shown for 2016; standard benefit maximum amounts and cash deductibles would be indexed to the employment cost index. Policyholders could qualify for benefits by meeting cash deductibles or the elimination period, whichever comes first. All plans include 20 percent coinsurance.

Use qualified retirement plan and IRA assets to purchase retirement LTCI.

This proposal would permit employees aged 45 and older in qualified defined-contribution retirement plans to take distributions from the plan solely for the purchase of a qualified retirement LTCI contract ("retirement LTCI"), for themselves and/or a spouse.[90] Distributions for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.

For IRA owners aged 45 and older, early distributions for the purchase of retirement LTCI would also be exempt from early withdrawal penalties.[91] This tax treatment would maintain the spirit of tax deferral, which is that contributions to defined-contribution retirement plans and IRAs are excludable or deductible from income tax, while distributions from the plans and IRAs are subject to income tax. The purpose of this approach, which should be roughly revenue-neutral over the long term, is to allow plan participants and IRA owners to more effectively use their retirement savings to protect against a major risk to financial security in retirement; it is not intended to subsidize LTCI with a large new tax expenditure.[92]

Enlist the help of the NAIC to facilitate a standard market for retirement LTCI among states that choose to make it available to their residents.

In addition to changes to federal law and regulation, many of the features of the proposed retirement LTCI policies and the automatic enrollment process would not be possible without changes to state law and regulation.[93] For example, some states do not allow longer elimination periods, many do not allow non-level premiums beyond age 65, and many consumer-disclosure provisions require the signature of the applicant, which would interfere with the automatic enrollment process. Additionally, a streamlined rate-adjustment process would facilitate the non-level premium approach in order to implement premium updates on the required three-year and six-year cycles. While states should be able to decide whether their residents would benefit from access to this new LTSS financing option for retirement plan participants and IRA owners, the nation would benefit from uniformity among the states that do allow this innovative approach. Like they have in the past, federal policymakers should charge the NAIC with developing proposed changes to the long-term care model state law and regulation, within a limited period of time, which states could voluntarily adopt.

Appendix I-C: Automatic Enrollment in Long-Term Care Insurance

Automatic enrollment has been shown to be an effective means to increase participation in retirement savings plans, and research has also demonstrated that defaults can powerfully influence consumer behavior, whether because of inertia or because employees view a default setting as an implicit recommendation.[94] The concept holds considerable promise to help more Americans to be better prepared for other risks in retirement, including longevity risk and the risk of needing expensive LTSS. Employer-sponsored retirement plans have many features that make them well positioned to serve as vehicles for automatic enrollment into LTCI should policy changes like those proposed above be implemented. For example, retirement plan participation may continue beyond the term of employment, and plan savings could be used to pay LTCI premiums both during the working career and throughout retirement. Also, information that is already available to plan sponsors and servicers, including the age of participants and savings amounts within the plan, could be used to identify appropriate default LTCI policies.

Since this approach has never been tried for LTCI, there can be no guarantee that it will be successful. However, if carefully designed and implemented, there is a good chance that automatic enrollment could yield a significant increase in LTCI take-up. Barriers to plan-sponsor adoption of this approach would need to be addressed, including concerns about fiduciary responsibility. If premiums were low and default coverage were appropriately targeted, participants would be less likely to opt out, which would in turn improve the risk pool and make the approach more viable for carriers. The proposed retirement LTCI policies should have significantly lower premiums than typically available in the current market, especially when plan sponsors facilitate group coverage, which has much lower commissions and other selling costs. And notices to participants must be clear and understandable both in describing the need for

and the design of LTCI coverage, while making options to adjust coverage or opt out entirely simple and easy to act on.

In order to expand the population with some financial protection from the risk of needing LTSS, policymakers should establish a safe harbor to limit fiduciary responsibility for plan sponsors who implement annual automatic enrollment of a subset of retirement plan participants into a default qualified retirement LTCI contract with the ability for participants to opt out.[95] As an incentive, the catch-up contribution limit (in 2016, participants aged 50 and over may contribute an additional $6,000 to the plan above and beyond the normal annual employee contribution limit of $18,000) should be doubled to $12,000 for participants of plans that have implemented safe-harbor automatic enrollment into LTCI.

This new safe harbor would prescribe certain standards for the automatic enrollment process and the default plan design. Since underwriting would not be possible with a passive enrollment process, default policies could not be underwritten, but carriers could opt to include a vesting period of no more than ten years (i.e., no claims would be paid during the vesting period, even if the policyholder would otherwise qualify for benefits). Plan sponsors would select an age range, an asset range, and default plans for automatic enrollment, subject to limits. The age qualification for automatic enrollment should be at least a ten-year range, beginning no lower than age 45 and ending no higher than age 65; for example, ages 50 through 59 would be an acceptable range, as would ages 45 through 60. Asset qualifications for automatic enrollment would vary between plan types (see table for details), but in all cases, participants would need at least $50,000 of assets in the plan to be eligible for automatic enrollment.[96] Plan sponsors could also limit automatic enrollment to actively at-work participants, as defined by a minimum of 30 hours per week at the time that the automatic enrollment takes place. Any plan sponsor could pick Plan A or Plan B as defaults. Plan sponsors with employees who live in high-service-cost areas, as defined by the HHS secretary, could pick Plan C as a default.

Eligibility for Automatic Enrollment into Default LTCI by Participant Assets (within the plan)

Minimum plan assets no lower than	
Plan A	Plans B and C
$50,000	$100,000 or whenever eligibility for Plan A auto-enrollment ends
Minimum plan assets no higher than	
Plan A	Plans B and C
$100,000	$150,000
Maximum plan assets no lower than	
Plan A	Plans B and C
$100,000	No Maximum
Maximum plan assets no higher than	
Plan A	Plans B and C
$150,000	No Maximum

Note: All thresholds indexed to the employment cost index.

Automatic enrollment would be implemented once each year. For example, during the annual enrollment date, a plan sponsor could automatically enroll all participants who meet age criteria with plan assets between $50,000 and $125,000 into the default Plan A, and those with plan assets above $125,000 into the default Plan B or C. Plan participants could select a different plan or an alternative benefit period or cash deductible, or they could decline coverage (i.e., opt out) entirely. Plan participants who wish to upgrade to additional coverage (e.g., switching from Plan B to Plan C) would be subject to underwriting. Participants who select a less expensive plan design (e.g., switching from Plan B to Plan A or switching from the $25,000 cash deductible to the $50,000 cash deductible) could

make the change without underwriting. Participants could add a spouse to coverage, but the spouse would need to pass underwriting.

The U.S. Departments of Labor, Treasury, and HHS would establish model notifications for plan sponsors to use with participants as part of the automatic enrollment process. These notifications would educate participants about the functionality, cost, and benefits of retirement LTCI; the potential impact of the risk of needing LTSS on retirement security; the lack of coverage of LTSS by Medicare; the tax treatment of distributions; benefits from the expanded catch-up contribution; and how to opt out or change coverage parameters if the participant is not satisfied with the default plan. As a condition of the safe harbor, eligible participants would be notified at least twice in advance of the annual automatic enrollment process.

Appendix II-A: HCBS State Plan Amendments

Section 1915(i) State Plan Amendment — States define specific criteria based on need in order to control enrollment and costs, and states are required to set a different level of care for HCBS than institutional services. This allows states to serve people in the community who are at risk for needing institutional care before their need reaches that level of care. States may estimate the number of individuals eligible and stop enrollment once the estimate is reached.

Section 1915(k) State Plan Amendment — Permits states to provide home- and community-based attendant services and supports on a statewide basis (no population-targeting allowed). Individuals served through 1915(k) must be eligible for medical assistance under the state plan, must meet an institutional level of care, and must be part of an eligibility group that is entitled to receive nursing-facility services. States that pursue 1915(k) receive a six-percentage-point increase in Federal Medical Assistance Percentage. States may not limit enrollment.

1915(j) State Plan Amendment — States may offer self-directed personal-assistance services (PAS), which provide the option for states to offer self-directed personal care. Individuals can choose and train their PAS providers. The self-directed PAS state option is provided under the Medicaid state plan and/or section 1915(c) waivers that the state already has in place.

Appendix II-B: Medicaid Buy-in

The purpose of the MBI program is to ensure that working persons with disabilities do not lose access to critical LTSS that they need to live and work due to an increase in earnings. However, most of the existing MBI programs have relatively low income and asset limitations (although higher than standard Medicaid). Many states limit income eligibility to no greater than 250 percent of FPL, which is the highest allowed under the Balanced Budget Act of 1997 MBI state option. States adopting the Ticket-to-Work state option can offer the MBI to higher earners, but most states typically limit these MBI programs to 300 to 450 percent of FPL.

States have flexibility to design their MBI programs to meet their population needs and resource availability. Under both the Balanced Budget Act of 1997 and Ticket-to-Work and Work Incentives Improvement Act programs, states are permitted to impose additional requirements, such as more liberal income and resource methodologies or more restrictive eligibility criteria than that used by Supplemental Security Income. Additionally, a state may impose premiums or other cost-sharing charges on a sliding scale based on income.[97] This flexibility has led to considerable variation in program design and outcomes among the states.[98] For example, Oregon's MBI program has a maximum income limit of 250 percent of FPL, while Connecticut's maximum limit is 450 percent of FPL ($52,965 for an individual), and Minnesota has no upper-income limit.[99] States also determine assets and income in different ways; for example, some states disregard retirement accounts, health savings accounts, or approved employment accounts as assets.[100]

Currently 46 states have established MBI programs: 28 states administer MBI programs using the Ticket-to-Work and Work

Incentives Improvement Act authority; 17 states use the Balanced Budget Act authority; and one state, Massachusetts, uses 1115 waiver authority. States without the MBI programs include Hawaii,[101] Alabama, Tennessee, Florida, and the District of Columbia.[102]

More than 400,000 individuals with disabilities have participated in the MBI program over the past decade. In 2011, the total earnings among all participants were about $1.15 billion.[103] Research has shown that the MBI programs are not only good policy for Medicaid but are also beneficial to the participants.

Medicaid provides services and supports often unavailable through other payer sources; MBI beneficiaries often wrap their MBI benefits around other insurance benefits, including private health insurance for higher-income MBI beneficiaries.[104] Specifically for a subset of workers with disabilities who have moderate or high incomes (i.e., above 250 percent of FPL), the MBI program provides a pathway to critical Medicaid services, especially LTSS. Research has found that service use among higher-income MBI participants is concentrated on several service types (e.g., prescription drugs, personal care/LTSS, and durable medical equipment).[105]

End Notes

1. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*. Vol. 34 Iss. 12, 1. 2015. doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf+html.

2. BPC's Commission on Retirement Security and Personal Savings is exploring options to expand access to and increase savings in workplace retirement plans, which factor heavily into the ability of individuals to self-insure for some LTSS. More information available: http://bipartisanpolicy.org/commission-on-retirement-security-and-personal-savings/

3. G.E. Alkema. *Current Issues and Potential Solutions for Addressing America's Long-Term Care Financing Crisis*. The SCAN Foundation, March 2013.

4. Ibid.

5. Cost was calculated using the rate of $20/hour, 44 hours/week.

6. Erica L. Reaves and Marybeth Musumeci. *Medicaid and Long-Term Services and Supports: A Primer*. Kaiser Family Foundation, May 8, 2015. Available at: http://goo.gl/Uh5xv5.

7. Cost was calculated using the rate of $65/day, five days/week.

8. Ibid.

9. Ibid.

10. Erica L. Reaves and Marybeth Musumeci. *Medicaid and Long-Term Services and Supports: A Primer*. Kaiser Family Foundation, May 8, 2015. Available at: http://goo.gl/Uh5xv5.

11. *Rising Demand for Long-Term Services and Supports for Elderly People*. Congressional Budget Office. June 2013. Available at: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf.

12. Ibid.

13. Estimate does not include spending for LTSS offered through Medicaid managed care.

14. Based on BPC calculations from: *Medicaid's Role in Providing Assistance with Long-Term Services and Supports*, Tables 2-4 and 2-5. MACPAC. June 2014. Available at: https://goo.gl/6BS7K4. And: The Budget and Economic Outlook: An Update. Congressional Budget Office. August 2011. Available at: https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/08-24-BudgetEconUpdate.pdf.

15. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect

Trade-Offs for Older Americans and Federal Spending." *Health Affairs*. Vol. 34 Iss. 12, 1. 2015. Doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf+html.

16. Susan C. Reinhard et al. *Valuing the Invaluable: 2015 Update. Undeniable Progress, but Big Gaps Remain*. AARP Public Policy Institute. July 2015. Available at: http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

17. "Long-Term Services and Supports for Older Americans: Risks and Financing." ASPE Issue Brief. July 2015. Available at: http://aspe.hhs.gov/sites/default/files/pdf/106211/ElderLTCrb_0.pdf.

18. Ibid.

19. Ibid.

20. Ibid.

21. Ibid.

22. Marc A. Cohen. "The Current State of the Long-Term Care Insurance Market." Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference. March 2014. Available at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf.

23. Ibid.

24. Leslie Scism. "Long-Term-Care Insurance: Is It Worth It?" *The Wall Street Journal*. May 2015. Available at: http://goo.gl/2GmMgT. And: Marc A. Cohen. "The Current State of the Long-Term Care Insurance Market." Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference. March 2014. Available at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf.

25. Melissa M. Favreault and Richard W. Johnson. "Microsimulation Analysis of Financing Options for Long-Term Services and Supports." The Urban Institute. 2015. Available at: http://goo.gl/iCNAk1.

26. Tax-qualified LTCI policies, under 26 U.S. Code Section 7702B, defines a "chronically ill individual" eligible for benefits as someone who is either unable to perform at least two activities of daily living for at least 90 days due to a loss of functional capacity or who requires substantial supervision due to severe cognitive impairment.

27. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*. Vol. 34 Iss. 12, 1. 2015. doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf+html.

28. "Long-Term Care in America: Americans' Outlook and Planning for Future Care." The Associated Press/NORC Center for Public Affairs Research. 2015. Available at: http://goo.gl/noN3O2.

29. Jeremy Pincus, Katherine Wallace-Hodel, and Katey Brown. *Size of the Employer and Self-Employed Markets Without Access to Long-Term Care Coverage Options*. The SCAN Foundation. March 2013. Available at: http://goo.gl/JrgMeK.

30. BPC staff communication with Milliman.

31. Christopher J. Giese and Allen J. Schmitz. "Premium Estimates for Policy Options to Finance Long-Term Services and Supports."

2015. Milliman. Available at: http://www.thescanfoundation.org/sites/default/files/milliman_report_- _premium_estimates_for_policy_options_to_finance_ltss.pdf.

32. Erica L. Reaves and Marybeth Musumeci. *Medicaid and Long-Term Services and Supports: A Primer*. Kaiser Family Foundation, May 8, 2015. Available at: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

33. Many statutory and regulatory barriers, federal and state, would need to be addressed to enable the sale of retirement LTCI. In the case of state barriers, the HHS secretary would work in concert with NAIC to amend the NAIC Model Law and Regulation for LTCI. A fuller discussion of the statutory and regulatory issues is included in Appendix I-B.

34. BPC's Commission on Retirement Security and Personal Savings is exploring options to expand access to and increase savings in workplace retirement plans, which factor heavily into the ability of individuals to self-insure for some LTSS. More information available: http://bipartisanpolicy.org/commission-on-retirement-security-and-personal-savings/

35. DYNASIM3, The Urban Institute. 2015. Prepared for BPC's Commission on Retirement Security and Personal Savings. Notes: Retirement account assets include IRAs, Keoghs, and employer-sponsored defined-contribution plans, such as 401(k) and 403(b) plans. The projected growth in retirement account assets is in part due to an ongoing transition from defined-benefit pensions to defined-contribution retirement plans. Projections assume no changes to current policy; legislative initiatives in Congress and the states to expand access to and contributions in workplace retirement plans could affect these projections if they were implemented. Older Americans rely on other assets in addition to retirement accounts to help meet consumption needs in old age. Median per-capita total assets for the population aged 62 and older, including home equity, retirement accounts, and financial assets outside of retirement accounts, was about $84,000 in 2015 and is projected to reach almost $125,000 in 2035. The 75th percentile had about $284,000 in per-capita total assets in 2015, which is projected to reach almost $403,000 in 2035.

36. Some defined-contribution plans do not allow for hardship distributions at all or only allow them for certain situations. When hardship distributions are allowed, a 10 percent early withdrawal penalty applies, in addition to any income taxes owed, and participants are prohibited from making additional contributions to the plan for six months. For background, see: https:// www.irs.gov/Retirement-Plans/Retirement-Plans-FAQs-regarding-Hardship-Distributions.

37. While distributions are heavily restricted for active plan participants, those who have left employment may cash-out their plan contributions and earnings at any time. Workers who cash out their retirement savings when changing jobs account for a substantial share of leakage. For more background, see: Alicia H. Munnell, and Anthony Webb. "The Impact of Leakages from 401(k)s and IRAs." Center for Retirement Research at Boston College. 2015. Available at: http://goo.gl/vrdzEj.

38. This tax treatment was also recommended in a recent discussion paper. See: Yin, Wesley. "Strengthening Risk Projection through Private Long-Term Care Insurance." Brookings. 2015. Available at: http://goo.gl/sLI1Cw. Others have suggested alternative approaches, such as allowing tax-free or partially tax-exempt distributions to purchase LTCI. While such an expansion of tax expenditures is unlikely to be politically viable on a standalone basis for cost and distributional reasons, these approaches might be considered as part of comprehensive tax reform.

39. BPC staff communication with Milliman.

40. See, for example, Brigitte C. Madrian, and Dennis F. Shea. "The Power of Suggestion: Inertia in 401(k) Participation and Savings

Behavior." NBER Working Paper, no. 7682. 2000. Available at: http://www.nber.org/papers/w7682. And: Jack VanDerhei. "The Impact of Automatic Enrollment in 401(k) Plans on Future Retirement Accumulations: A Simulation Study Based on Plan Design Modifications of Large Plan Sponsors." Employee Benefit Research Institute Issue Brief, no. 341. 2010. Available at: http:// www.ebri.org/pdf/briefspdf/EBRI_IB_04-2010_No341_Auto-Enroll1.pdf.

41. Congressional Budget Office. "Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline." Available at: https://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf.

42. Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves. *Medicaid Home and Community Based Services Programs: 2012 Data Update*. The Kaiser Commission on Medicaid and the Uninsured. November 2015. Available at: http://goo.gl/rP0S83.

43. Steve Eiken, Katie Sredl, Brian Burwell, and Paul Saucier. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending*. Truven Health Analytics. 2015. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

44. 527 U.S. 581 (1999).

45. Ibid.

46. 42 U.S.C 1396a(a)(10)(B).

47. 42 U.S.C. 1396a(a)(1).

48. Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves. *Medicaid Home and Community Based Services Programs: 2012 Data Update*. The Kaiser Commission on Medicaid and the Uninsured. November 2015. Available at: http:// kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/.

49. BPCs Governors Council has recommended changes to the existing waiver process. For more information, see (http://bipartisanpolicy.org/library/reforming-medicaid-waivers-governors-council-perspective-federalism-today/) and the new state flexibility paper (http://bipartisanpolicy.org/library/health-insurance-coverage-state-flexibility/)

50. In 2016, the FBR is $733 per month for individuals, or less than 120 percent FPL.

51. Money Follows the Person is a rebalancing demonstration focused on providing grants to states so that they may improve their ability to transition individuals with chronic conditions from institutionalized care back into the community where they can receive HCBS.

52. Section 1902(a)(10)(B) requires comparability of amount, duration, or scope of the medical assistance to eligible beneficiaries.

53. Section 1915(i) includes the following services: case management, homemaker, home health aide , personal care, adult day health, rehabilitation, respite, other services as approved by the secretary, and other partial hospitalization and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

54. While there are currently initiatives to develop recommendations for strengthening the quality measures for HCBS, these measures have not yet been established. The secretary should provide interim quality measures until consensus is reached.

55. States must have a system where individuals and families can apply online, via telephone, mail, and in person for health insurance. The application process is convened through a single entity, regardless of the type of insurance they may ultimately enroll in (e.g., Medicaid, CHIP, marketplace).

56. Matthew Kehn. "Enrollment, Employment, and Earnings in the Medicaid Buy-in Program, 2011." Final Report. *Mathematica Policy Research*. May 20, 2013. Available at: http://goo.gl/GOzJv7.

57. Donna Folkemer, Allen Jensen, Robert Silverstein, and Tara Straw. Medicaid Buy-In Programs: Case Studies of Early Implementer States. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. May 2002. Available at: http://aspe.hhs.gov/basic-report/medicaid-buy-programs-case-studies-early-implementer-states.

58. Kaiser Family Foundation. *Keeping Medicare and Medicaid When You Work: Medicaid Buy-in Programs online version*. Available at: http://kff.org/other/keeping-medicare-and-medicaid-when-you-work/.

59. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*. Vol. 34 Iss. 12, 1. 2015. doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf+html.

60. Melissa M. Favreault and Richard W. Johnson. "Microsimulation Analysis of Financing Options for Long-Term Services and Supports." The Urban Institute. 2015. Available at: http://goo.gl/I2HALv.

61. All dollar amounts are in 2015 dollars. Estimates are for a catastrophic insurance program with coverage that begins after a two-year elimination period or a $120,000 cash deductible; the cost of the program would be lower if it had a longer elimination period or larger cash deductible.

62. In 2050, the estimated cost of the mandatory catastrophic program is equivalent to 1.2 percent of GDP or 2.6 percent of taxable payroll.

63. The Hospital Insurance part of the Medicare program is projected to cost $762 billion, expressed in 2015 dollars, by 2050, and the entire Medicaid program, including state and federal shares, cost $470 billion in 2014. (It should be noted that, under current law, the Hospital Insurance Trust Fund is projected to become insolvent in 2030; policy changes to address this projected insolvency could affect these figures.) The Trustees' projections are available at: https://www.ssa.gov/OACT/tr/2015/lr6g9.html.

64. Ibid, 44, 46.

65. Ibid, 51.

66. PL 104-191, Sections 321-327

67. *Long-Term Care Insurance Model Act*. National Association of Insurance Commissioners. October 2009.

68. *Long-Term Care Insurance Model Regulation*. National Association of Insurance Commissioners. October 2014.

69. Under 26 U.S. Code § 7702B, as modified by HIPAA and subsequent legislation, an individual is eligible to receive long-term care insurance benefits if the individual has been certified by a licensed health care practitioner as: (1) being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; (2) having a level of disability similar to the level of disability described in clause (1); or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

70. Research Findings: *Long-Term Care Insurance in 2002*. America's Health Insurance Plans. June 2004.

71. Larry Rubin et al., *An Overview of the U.S. LTC Insurance Market (Past and Present): The Economic Need for LTC Insurance, the History of LTC Regulation & Taxation and the Development of LTC Product Design Features*. Society of American Actuaries. 2014. Available at: https://www.soa.org/Library/Monographs/Retirement-Systems/managing-impact-ltc/2014/mono-2014-managing-ltc.aspx.

72. David Baer and Ellen O'Brien. *Federal and State Income Tax Incentives for Private Long-Term Care Insurance*. AARP Public Policy Institute. November 2010. Available at: http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf.

73. Ibid.

74. Mark R. Meiners. "Long-Term Care Insurance Partnership: Considerations for Cost-Effectiveness." Center for Health Care Strategies, Inc. March 2009. Available at: http://www.chcs.org/media/LTC_Partnership_Cost_Effectiveness_Brief.pdf.

75. *Who Buys Long-Term Care Insurance in 2010-2011*? America's Health Insurance Plans. March 2012. Available at: https://goo.gl/RZdHlx. And: Long-Term Care Insurance Partnership Information Center. "Partnership State Status—50 State Status Update." American Association for Long-Term Care Insurance. Count as of March 2014. Retrieved November 2015. Available at: http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved.

76. The Partnership for Long-Term Care. Partnership Maps. Retrieved November 2015. Available at: http://goo.gl/uYfRvA.

77. Marc A. Cohen. "The Current State of the Long-Term Care Insurance Market." Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference. March 2014. Available at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf.

78. Ibid.

79. Christopher J. Giese and Allen J. Schmitz. "Premium Estimates for Policy Options to Finance Long-Term Services and Supports." 2015. Milliman. Available at: http://www.thescanfoundation.org/sites/default/files/milliman_report_-_premium_estimates_for_policy_options_to_finance_ltss.pdf.

80. PL 104-191, Sections 321-327.

81. PL 109-171, Section 6021.

82. Typical current-market LTCI policy design for modeling assumed a full underwriting process with moderate standards for issuing a policy, benefits triggered for policyholders unable to complete two or more activities of daily living or severe cognitive impairment, pool-of-money design, $180 daily maximum service-reimbursement benefit, three-year benefit period, 90-service-day elimination

period, 3 percent-compound inflation protection, level premiums (i.e., premiums are not intended to change but are not guaranteed and may be adjusted if significant adverse experience develops), commissions and other selling costs typical for the individual market, and waiver of premium during claim (i.e., when on claim, policyholders do not owe any premium payments).

83. Christopher J. Giese and Allen J. Schmitz. "Premium Estimates for Policy Options to Finance Long-Term Services and Supports." 2015. Milliman. Available at: http://www.thescanfoundation.org/sites/default/files/milliman_report_-_premium_estimates_for_policy_options_to_finance_ltss.pdf.

84. The alternative LTCI policy design for modeling assumed automatic enrollment of actively at-work individuals, no underwriting, a five-year vesting period (i.e., no claims could be made until five years after the policy is issued), benefits triggered for policyholders unable to complete two or more activities of daily living or severe cognitive impairment, pool-of-money design, $180 daily maximum service-reimbursement benefit, three-year benefit period, one-calendar-year elimination period or $60,000 to $65,000 cash deductible, inflation protection according to an index of the cost of LTSS projected to grow at 3.5 percent annually, premiums intended to grow 2 percent annually from the issue age until age 65, commissions and other selling costs typical for the group LTCI market, and no waiver of premium benefit (i.e., premiums continue to be owed when the policyholder is on claim). Because of the non-level premium structure, the $1,329 projected annual premium at an issue age of 50 would grow to $1,789 (in nominal dollars) once the policyholder reaches age 65.

85. Ibid

86. Out-of-pocket spending on services that would be covered by the policy had the deductible been met would count toward the cash deductible, and deductible thresholds would be updated annually at the same growth rate as benefit inflation protection (described in the next item).

87. Social Security benefits are indexed to a version of the consumer price index, and default retirement plan investment options typically use an asset allocation that is intended to help maintain purchasing power during retirement.

88. Carriers that experience significant adverse conditions could continue to use existing processes to revise rates outside of these intervals (i.e., carriers would not be able to use the streamlined update process outside of the three-year and six-year intervals).

89. For example, for coverage to be tax-qualified, carriers must offer policyholders the option of 5 percent-compound inflation protection. Since all qualified retirement LTCI contracts would be required to include inflation protection based on an index (the employment cost index), this requirement would be waived.

90. These proposals would require modifications to the Employee Retirement Income Security Act, the primary federal law governing employee benefit plans, and the Internal Revenue Code (the Tax Code), which governs distributions from qualified plans and IRAs. The U.S. Department of Labor, U.S. Department of the Treasury, and the U.S. Department of Health and Human Services all would participate in developing various regulations to define qualified retirement LTCI contracts, allow in-service distributions for their purchase (subject to a ceiling), allow employers to adjust withholding for participants who use in-service distributions to purchase qualified retirement LTCI, allow employers to report in-service distributions on W-2 forms in lieu of a 1099 from the plan servicer, allow plan participants and IRA owners to count distributions before age 70 to pay retirement LTCI premiums toward future required minimum distributions (RMDs) that begin at age 70 and a half (i.e., an individual who takes distributions totaling $15,000 between ages 55 and 70 to purchase retirement LTCI could credit those toward meeting their first $15,000 of RMDs), and

clear other regulatory barriers, such as nondiscrimination rules. These in-service distributions should be allowed for all qualified defined-contribution plan types, including 401(k), 403(b), and 457 plans, as well as the Thrift Savings Plan for federal employees. Availability of this option for participants would be at the discretion of the plan sponsor (i.e., plan sponsors would not be required to allow in-service distributions for the purchase of retirement LTCI).

91. Distributions from Roth accounts before age 59 and a half to pay for retirement LTCI premiums would be exempt from income taxation on earnings and any related early withdrawal penalties.

92. This tax treatment was also recommended in a recent discussion paper. See: Yin, Wesley. "Strengthening Risk Projection through Private Long-Term Care Insurance." Brookings. 2015. Available at: http://www.brookings.edu/research/papers/2015/06/16-risk-protection-through-private-long-term-care-insurace-yin. Others have suggested alternative approaches, such as allowing tax-free or partially tax-exempt distributions to purchase LTCI. While such an expansion of tax expenditures is unlikely to be politically viable on a standalone basis for cost and distributional reasons, these approaches might be considered as part of comprehensive tax reform.

93. In addition to the aforementioned modifications to Employee Retirement Income Security Act and the Tax Code, availability of retirement LTCI for federal employees may also require changes to the statute and regulations that govern the Federal Long Term Care Insurance Program, which offers coverage to federal and U.S. Postal Service employees and retirees, active and retired members of the armed services, and certain relatives, and it is regulated by the United States Office of Personnel Management, as well as the Thrift Savings Plan, which is the defined-contribution retirement savings plan for federal employees and members of the armed services.

94. See, for example, Brigitte C. Madrian and Dennis F. Shea. "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." NBER Working Paper, no. 7682. 2000. Available at: http://www.nber.org/papers/w7682. And: Jack VanDerhei. "The Impact of Automatic Enrollment in 401(k) Plans on Future Retirement Accumulations: A Simulation Study Based on Plan Design Modifications of Large Plan Sponsors." Employee Benefit Research Institute Issue Brief, no. 341. 2010. Available at: http:// www.ebri.org/pdf/briefspdf/EBRI_IB_04-2010_No341_Auto-Enroll1.pdf.

95. Safe harbors limit the fiduciary risk for plan sponsors. For example, the qualified default investment alternative regulation offers plan sponsors a safe harbor for automatically enrolling participants into a default investment option as long as it is one of the following: (1) a fund that adjusts its asset allocation from more aggressive to more conservative investment options as the participants age toward retirement (known as a target-date fund); (2) a fund that includes an asset allocation appropriate for the participant group as a whole (known as a balanced fund); or (3) a professionally managed account that implements a customized asset allocation appropriate for the participant. For example, if a participant sues a plan sponsor, arguing that it was inappropriate to be defaulted into a target-date fund during the automatic enrollment process, the plan sponsor can use the safe harbor as a defense. Plan adoption of automatic enrollment and target-date funds increased significantly after the finalization of the qualified default investment alternative rule.

96. The safe harbor would establish allowable methods to compute participant assets in the plan, such as vested assets on a certain day or an average over a period of time, such as the previous year.

97. Ibid.

98. Matthew Kehn. “Enrollment, Employment, and Earnings in the Medicaid Buy-in Program, 2011.” Final Report. *Mathematica Policy Research*. May 20, 2013. Available at: http://goo.gl/qsCyJM.

99. Donna Folkemer, Allen Jensen, Robert Silverstein, Tara Straw. Medicaid Buy-In Programs: Case Studies of Early Implementer States. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. May 2002. Available at: http://aspe.hhs.gov/basic-report/medicaid-buy-programs-case-studies-early-implementer-states.

100. Ibid.

101. Hawaii recently passed Medicaid Buy-In legislation and is currently developing a Medicaid Buy-In proposal for the Centers for Medicare & Medicaid Services.

102. MACPAC. *Medicaid Buy-In Pathways*. Available at: https://www.macpac.gov/medicaid-buy-in-pathways/.

103. Medicaid.gov website. *Medicaid Employment Initiatives*. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html.

104. Annette Shea. “Medicaid Buy-In Background Info for BPC.” Administration for Community Living. PowerPoint slides emailed September 11, 2014.

105. Denise Hoffman, Kristin Andrews, and Valerie Cheh. “Characteristics and Service Use of Medicaid Buy-In Participants with Higher Incomes: A Descriptive Analysis.” *Mathematica Policy Research*. May 31, 2013.

Notes

Notes

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

bipartisanpolicy.org | 202-204-2400
1225 Eye Street NW, Suite 1000 | Washington, DC 20005

- @BPC_Bipartisan
- facebook.com/BipartisanPolicyCenter
- instagram.com/BPC_Bipartisan
- flickr.com/BPC_Bipartisan

BPC Policy Areas

- Economy
- Energy
- Finance
- Governance
- Health
- Housing
- Immigration
- National Security

1225 Eye Street NW, Suite 1000 | Washington, DC 20005

202-204-2400 | bipartisanpolicy.org