Chapter 5

Recent Trends in the Long-Term Care Industry

One thing certainly cannot be denied: that long-term care insurance is an industry that never stands still. It evolves in response to consumer demand, the financial markets and the regulatory environment. The last few years have witnessed an intensification of changes, as we'll review next.

Gender-Based Rates

For years, men and women have paid different rates for life and auto insurance as a result of the differing claims experience of our two genders. It should come as no surprise then, that some insurers—looking to more accurately price their products—have expanded this practice into the field of long-term care. Married women have seen their rates rise since they tend to outlive their husbands and a greater number rely more on formal care[1]. While married men tend to first turn to their wives for informal care, single women with no support system have seen the greatest increase (*as high as 40 to 80 percent more)*.

Are all carriers making this shift? Not all at once. Several market leaders took the plunge while other high-profile names have taken a wait-and-see attitude (some have steadfastly said they will not). A few states, such as Colorado and Montana, do not permit the practice at all.

Then there is this wildcard:

Gender-based pricing is designed to mitigate the need for future rate increases. How? Since women tend to incur more and longer claims, an insurance company could blend male and female rates into a single unisex rate to account for this, but could still get stung if more women

than expected tended to apply for their products. By charging each gender their own rates, it no longer matters how many of each gender apply. Problem solved. But, if one insurance company charges women so high a premium as to drive them away, into the arms of another insurance company (one still charging unisex rates), then that second carrier now incurs the very same problem we just described. Namely, more-than-expected women than men applying. (Again, this could happen because of an "externality in the market": a competing insurance company which raises the price only on females.)

How would the second company solve its new problem? It would have to switch to gender-based rates. Eventually, the entire market could flip.

In fact, that's what we've been seeing since the practice first began. In long-term care insurance, it doesn't pay to be an outlier. If you're the last carrier charging unisex rates, you'll soon receive all the single female business (because your rates will be the cheapest), which in turn will be bad for future claims. Before long, you'll have to flip like all your competitors, and before long the entire market will be homogenized again.

If we were to look for even more wildcards, we could point to a complaint filed by the National Women's Law Center against the Office for Civil Rights at the U.S. Department of Health & Human Services (HHS). They argue that charging women more for private long-term care insurance violates Section 1557 of the Affordable Care Act [which states that an individual shall not "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an executive agency or any entity established under this title (or amendments)."]

The NWLC's legal strategy is to tie discrimination to Medicaid (federal financial assistance), and Medicaid to state Partnership programs, which benefit private long-term care insurance. They are asking the Office of Civil Rights to end Partnership support for any carrier who employs gender-based pricing. We've discussed before how the Affordable Care Act excluded long-term care insurance from almost all discussion: it speaks almost entirely—and narrowly—to health insurance. This complaint seems unlikely to pan out.

In California, they are taking a more direct approach. There, a Mariko Yamada (D-Davis), a member of the California Assembly from Vallejo has proposed legislation (AB 1553) which would explicitly prohibit gender-based pricing within that state. As of this writing, it is held in the Assembly Insurance Committee, but if passed and signed into law, the bill would take effect in California on January 1, 2015, requiring policies with gender-based rates to revert to gender-neutral rates upon renewal.

On the one hand, as California Health Advocates' Bonnie Burns argues, "Women have always had a hard time figuring out how to pay for long-term care insurance from their lower incomes and resources. Gender discrimination will force even more women out of the market, shifting

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the cost of their care to their families and the state's Medicaid program."[2] On the other, if carriers were forced to return to gender-neutral pricing, it is not unlikely they would either: a) raise rates for everyone in California; or b) withdraw from the state entirely. Neither solution is of much help to Californians, who would end up reliant on Medi-Cal in the end.

Full Reveal Underwriting

For most of our history, long-term care insurance underwriting has consisted of information admitted on the application supplemented by medical information contained in the applicant's medical records (Attending Physician's Statement or APS). This was followed by cognitive exams for those over a certain age, intended to tease out those likely to develop dementia later in life, which give rise to the costliest claims. This requirement for cognitive examinations first began around age seventy-two, then was lowered to seventy, then sixty-five, then lower still.

The most common exam used is the Minnesota Cognitive Acuity Screen (MCAS), described as "98.1 percent [effective] in determining the presence or absence of mild to moderate cognitive impairment". Debuting in 2000, the MCAS was developed and patented by Nation's CareLink (today known as Univita), and has been licensed for use by more than thirty-three LTCI insurers since its debut, and administered nearly one-half million times.[3]

The MCAS takes fifteen to twenty minutes either in person or over the phone, and focuses on nine key areas (Orientation, Attention, Delayed Word Recall, Comprehension, Repetition, Naming, Computation, Judgment, and Verbal Fluency). Among the strengths of the MCAS are its speed of administration, sensitivity to even the earliest signs of mild impairment, and its ability to discern between the various subtypes of nonAlzheimer's dementias which may comprise 20 to 25 percent of all cognitive impairments.[4]

The effect of this ability to conduct this exam over the phone was huge: it paved the way for Personal History Interviews or PHI's, which became another part of the underwriting standard operating procedure. Carriers needn't send an interviewer into the home at great cost, but might only perform a mini-cognitive exam (included during the PHI).

After a relatively brief flirtation with lax underwriting (via "simplified" in the worksite setting) which savvy agents lost no time in gaming, the pendulum swung back, with carriers mitigating risk in any number of ways. For instance, they lowered the maximum benefit available for sale (especially long benefits such as unlimited or even ten-year); reducing the maximum age to which they'd offer coverage (from ninety-nine to eighty-nine to eighty-four to seventy-nine to seventy-five); to increasing their underwriting assays.

The latter now include prescription screens (to verify the information on the application and/or reveal medications which were not acknowledged), MIB checks (to root out fraud or overinsurance), in-home face-to-face assessments to verify ADL's—an increasingly valuable check in

an age of remote sales—and finally the collection of blood and urine just like with applications for life insurance. The collection of labs in this fashion helps to more accurately screen for nicotine, as well as to profile cardiovascular risk (important since circulatory disorders and stroke are major causes of LTC claims).

In a bit of irony, we are already seeing unintended consequences from the introduction of labs, or more precisely the method by which they are collected. A few carriers have introduced a two-part application process, not unlike a ticket. Knowing that a health professional or nurse practitioner will be visiting the applicant to collect the blood and urine, carriers are increasingly removing health questions from the application itself. Why would they do this?

- It creates a faster, friction-free application process
- It's friendlier for nonLTCI specialists (e.g., financial advisors) who sell fewer policies per year
- It allows the nurse to come into the house later and ask the health questions—an individual who supposedly does a much better job of eliciting all of a client's health history than most agents would, and knows which questions to ask to best follow-up when a medical condition is raised.

What could go wrong? If the carrier employs a third party vendor whose assessors are unprofessional, ill-equipped, show up late or not at all, lack good communication skills, or in any other way damage the case, it can be disastrous. Further, the agent is increasingly removed from a position of being able to prescreen his applicant, which can result in the submission of *worse* risks to the company—the exact opposite situation desired.

Committees

National Commission On Long Term Care

We won't spend much time extensively discussing the ill-fated CLASS Act in these pages (RIP April 1, 2011 to March 1, 2013), except to note to readers that it was the Affordable Care Act's signature nod to long-term care—meant to be a voluntary program for America's working disabled. CLASS, which stood for Community Living Supports and Services was championed by the late Senator Edward Kennedy (a Democrat from Massachusetts) and folded into PPACA as a budgetary gimmick (because of the way CBO scores bills, CLASS appeared to raise money in its early years, without disclosing the claims it would have to pay in the latter years).

Once passed, CLASS quickly unraveled—then-HHS Secretary Kathleen Sebelius was tasked with enacting the program but soon realized it was actuarily unsound as written. The program was defunded (spending time as a budget zombie; neither entirely alive nor dead) before

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finally being repealed for good in 2013. The legislation which finally repealed CLASS created the National Commission on Long Term Care, a phoenix rising from the ashes.

Given six months to produce a report, meager financing, little staff and doomed by partisanship (Republicans were responsible for selecting six committee members, Democrats another six, and the President three), the National LTC Commission got off to a rocky start by wasting most of its allotted time on the selection process. When it finally came down to hearings over the summer of 2013, there was one glaring omission: no one from private LTC insurance was invited to publicly testify.

Then, like a Supreme Court decision with its own dissent, the Commission issued both a formal report—and an unexpected minority opinion report. At issue: they failed to reach consensus over the *financing* of long term care (which many would argue was of paramount concern). Ultimately the Commission produced nothing actionable, but no one faulted them either, since most observers believed they were doomed from the start by their constraints.[5]

Long-Term Care Financing Collaborative (LTCFC)

Meanwhile, as everyone was paying attention to the National LTC Committee, something else was happening right under our noses: the formation of a relatively secretive committee on a parallel track. Called the LTC Financing Collaborative, its goal was to include all major stakeholders from the left and right, providers, vendors, academia, government, and those who were involved in CLASS—but this time to bring in a professional mediator and use the same facilitation skills used at the highest levels of government arms negotations in order to reach accord.

The three primary engines of the LTCFC were the Urban Institute, the Heritage Foundation, and the Jewish Federations of North America. If all went well, their hope was to release a major report in 2014 which would result in enactable legislation. They describe their goals as, among other things, "maximizing independence and autonomy for adults in need of both acute and chronic care, providing a safety net for those in our society in need, and preventing the middle class from impoverishing themselves."

Land This Plane

Contributing to the greater understanding of our nation's LTC financing challenges was a fascinating and ongoing project called Land This Plane, conducted by the Long-Term Care Think Tank (established in 2005), and sponsored by the Society of Actuaries.[6] Polling a broad cross-section of actuaries, public policy experts, regulators, and executives, the study was unique in utilizing something called the Delphi Method. This approach allows respondents to anonymously present their views, listen and react to opposing views. As subsequent rounds of polling progress, the most persuasive concepts gain popularity and a consensus can emerge.

The third and final report was published in March, 2014. Among its conclusions were the following:

- A system-wide overhaul of the LTC financing system is needed.
- Private insurance needs to be part of the financing solution.
- Social insurance is needed as part of the solution.
- The government needs to take an active role in the LTC financial solution.
- Consumer education and tax incentives are critical to the solution.
- Medicaid is overdue for major reform.
- LTC regulations and legislation need substantial revision.
- Incenting personal and family responsibility should be part of the solution.
- Use of retirement savings accounts to fund LTC protection should be incentivized.
- Improvements to LTCI products, marketing and sales are needed.

Having raised many questions, the study recommends the creation of a coherent, comprehensive national plan to define the role and responsibilities of the various stakeholders, and help provide a decision-making framework for consumers. Such a plan might be the work of a joint committee composed of government, industry and other key stakeholders.

The study also recommended continued evaluation of new funding options, including high-deductible catastrophic coverage, an LTC savings fund concept, and an economic impact study on the feasibility of providing tax-free and penalty-free withdrawals from tax-deferred savings vehicles. A national marketing and educational campaign was also suggested, as were updates to the NAIC Model Act and state Partnership regulations with the goal of making products more accessible to the middle class.

Bipartisan Policy Center (BPC)

When the Land This Plane study was just approaching the runway, another was preparing for takeoff, courtesy of the Bipartisan Policy Center (BPC). In December 2013, the BPC launched its Long-Term Care Initiative under the stewardship of several high-profile leaders: former Senate Majority leaders Tom Daschle (a Democrat from South Dakota) and Bill Frist (a Republican from Tennessee), former Director of the Congressional Budget Office Alice Rivlin, and former Wisconsin Governor Tommy Thompson.

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Intending to build on the lessons of CLASS, and the previous work done by the National LTC Committee, the BPC will produce a series of policy options, building consensus at a time of political discord and fiscal constraints. Ultimately, the BPC intends to make a "strong case for action"[7] culminating in a report in early 2015 containing actionable recommendations to improve the quality and efficiency of publicly and privately financed LTSS…

In its intial paper—which does a capable, stat-laden job as a backgrounder on the state of LTC financing in America today—the Bipartisan Policy Center rejects "a true social insurance option financed through a broad-based tax," opting instead for a series of solutions which include both public programs and private products.

In spite of this promising start, the BPC's report is sadly—almost irresponsibly—misinformed on the basics of how the Medicaid program actually works. As someone much smarter than I once said, "Those who cannot remember the past are doomed to repeat it."

Medicaid Program Integrity Act

So what's really preventing a proper solution to the financing of long-term care in America? Most seniors' net worth is held not in stocks, bonds or CD's, but in their homes. (Equity in the average home in 2013 ranged between $200,000 – $300,000). As an aside, it's for this reason that many attempts have been made to suggest Reverse Mortgages (RMs) as a potentially untapped source of funds to help solve the Silver Tsunami e.g., "Use the Home to Stay at Home" (See Chapter 18).

Let's turn to Medicaid. Not only is it typically the largest budget item of most states, but LTC usually constitutes one-third of all Medicaid payments. What can be done to limit Medicaid's exposure and help staunch the financial bleeding?

Unfortunately, due to the Affordable Care Act the answer is: nothing. The law included language called Maintenance of Effort or MOE. Plainly, this means states are not allowed to tighten their income or asset rules. So, even though lowering these limits would have the effect of eliminating loopholes which currently permit the middle-class and affluent to use-up a program intended for our neediest, states are legally prohibited.[8]

One of these loopholes is our absurdly high home equity exemption. Remember how most net worth is held in our homes, in an amount maxing out around $300,000? Would you believe that Medicaid (our safety net for the poor) exempts home equity up to $543,000 (indexed amount in 2014)? In fact, thirteen states and the District of Columbia have elected the higher option of $814,000!

Obviously, eliminating these two issues would go to great lengths to solve our systemic mess. Representative Charles Boustany, MD (a Republican from Louisiana), who has introduced LTCI-friendly legislation in the past—has introduced probably his most promising bill yet: the Medicaid Program Integrity Act of 2013.

Although it aims squarely at remedying the aforementioned problems, the odds of passage in both the House and Senate— and surviving a Presidential veto, are slim. Still, it's already received support from some of the private industry's most powerful voices. We'll keep an eye on this one…

Rate Increases

Unless you've been living under a rock, you've probably seen or heard sensational headlines about long-term care insurance rate increases. (Companies have to justify such actuarily-sound and necessary requests with each state insurance department, whose job is to approve in whole or in part—or reject these requests.) But what's been causing this raft of rate increases in the first place? We can point to many underlying factors:

- Persistently low interest rates (companies aren't earning as much on their investments)
- Better than expected mortality (policyholders are living longer)
- Worse than expected morbidity (policyholders' health is generally worse than anticipated)
- Higher than expected persistency (policyholders renew their policies with great consistency)

Let's look at this last point in more detail.[9] For example, starting with a block of 50,000 policies, this is what happens as an insurance company revises its assumptions:

Incorporating a 5 percent lapse-rate:[10] Of the 50,000 policies sold, the assumption calls for 18,000 still to be in force twenty years later. Actuaries predict 35 to 50 percent of policies to claim benefits. Using the more conservative 35 percent figure, 6,300 policyholders can be expected to claim around $269 per day[11], or $1.7 million per day in total benefits. Multiply by 1,000 days (average claim length) and you have $1.7 billion of exposure for this block, at a minimum.

Incorporating a 1 percent lapse-rate: Of the 50,000 policies sold, 41,000 are still in force after twenty years. If 35 percent go on claim, we'd expect 14,350 claimants on claim at $269 per day, or $3.86 million in total daily benefits. Using the same 1,000 days average claim length, the insurer could see $3.86 billion of exposure based on a change in this single assumption.

In this example, the insurer faces more than $2 billion in additional claims—on just over 50,000 policies. Now consider that the largest LTC carriers have blocks of over ONE MILLION in-force policyholders!

The good news? People who purchase LTC insurance recognize the value of this coverage and are keeping it for life. The other good news is that rate increases signal that the companies are paying claims. Isn't that what we want them to do?

Meanwhile, what does the future hold? One of our market leaders proposes a new model. Its CEO has said in so many words, “Let’s admit to ourselves, the way we’ve done things for the past thirty years hasn’t been working. It’s just too hard to accurately forecast the four levers (morbidity, mortality, interest and persistency) three decades in advance.”

Instead, he proposed that we treat long-term care insurance akin to auto and health: let’s accept that rates are going to rise every few years—but modestly—perhaps just a few percent. Most important, let’s get the regulators on board. Part of the reason insurance companies tear their hair out is uncertainty whether State Insurance Commissioners will approve rate requests (or in what amounts).

Helping to articulate this point, a rule of thumb was observed that for every five years an actuarily justified rate increase is delayed, the increase necessary to bring pricing back to original assumptions must be *doubled* (assuming risks stay the same). In other words, what begins as a reasonable 5 percent increase doubles to 10 percent in five years, then 20 percent in ten, then 40 percent in fifteen, then 80 percent in twenty.

Unfortunately, some regulators are unwilling to rely on projections. They are explicitly telling insurers to wait until experience catches up—but that only exacerbates the size of the rate increases required, a size which backfires on the carriers in the form of criticism.

From now on, the CEO proposed, regulators would need to approve new products timely (within ninety days) and rate increase requests as well (within six months). If not, he warned it may prove impossible to do business in those states.[12]

Medicare Developments

It was recently reported that slower growth in healthcare spending would extend the life of our Medicare Hospital trust fund by an additional two years, to 2026. The same report extended our Social Security Disability trust fund (which pays monthly benefits to disabled workers and their families) through 2016, while Social Security itself is still expected to run out of money (i.e., pay out more in benefits than it takes in) in 2033.

Can we rejoice in the extra two years of solvency? Not exactly. There’s simply too much uncertainty that goes into these projections. For instance:

- New medical technology could emerge, which would likely drive up costs.
- Congress could act, such as deferring the scheduled physician payment cuts, which would drive up costs.
- We’ve experienced lower-than-expected spending on Medicare Part A services, but there’s considerable debate why.

Projections were also based on lower projected costs in the Medicare Advantage (Part C) program, which remains highly popular among the public, even as the Obama Administration attempts to cut it in an attempt to fund health care reform.

For their part, the Administration credits the Affordable Care Act with putting Medicare on more stable footing. Ex-Secretary Kathleen Sebelius was proud that "Medicare spending changes in the law include reduced payments to hospitals and other Medicare providers, lower reimbursements to Medicare Advantage plans, and efforts to cut program waste."

Unfortunately, these spending changes came at a cost: At this rate, Medicare provider reimbursements are expected to dip below those paid by Medicaid, which are themselves notorious for reimbursing hospitals, doctors and nursing homes for *less* than the cost of providing care. Should this happen, we can expect even fewer providers accepting Medicare beneficiaries, leading to our growing problem of access.

Jimmo

Another major change came in the form of the so-called Jimmo Settlement, which affected the improvement standard long associated with Medicare reimbursements. We've previously discussed Medicare's role as post-acute and rehab player—ask anyone and they will tell you that the day you stop showing improvement, Medicare will cut you off. Stories are legion; everyone has one.

On January 18, 2011, a class action suit was filed in Vermont in order to correct this erroneous and widespread standard. Joining the plaintiffs were the Alzheimer's Association, National Multiple Sclerosis Society, Paralyzed Veterans of America, Parkinsons Action Network, and United Cerebral Palsy. The action was settled October 16, 2012 and approved January 24, 2013. Over a year later, much of the public and provider community remains in the dark about the change (which is not a change at all).

After all, the Jimmo Settlement was possible because there *never was* an improvement standard. Here is the exact text from the CMS Manual (originally from December 2013, revised in January 2014):

> "Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves."

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Examples of prohibited rules of thumb include lack of restoration potential or an individual being stable or chronic.

> "…Coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of nonskilled personnel."

CMS is conducting a national education campaign, and expecting many appeals on cases currently in the system or previously adjudicated.

Budget and National Plan

These days, when the President talks, Congress usually draws a line in the sand and dares him to cross it. Not too long ago, President Barack Obama served up a proposal for fiscal 2014 (the United States' fiscal year begins October 1 that included five major changes to Medicare. Let's examine each of these in greater detail:

- **Higher Cost Sharing for New Medicare Beneficiaries**: The current Part B premium is $147 per month. The President proposed three incremental increases of $25 to the Part B deductible between 2017 and 2021 for a total of $75 which would effectively increase a beneficiary's cost-sharing. Designed to encourage more responsible use of healthcare, opponents say it's too much of a burden on seniors living on fixed incomes—last year nearly 50 percent of Medicare beneficiaries lived on less than $22,500 per year.

- **Wealthier Beneficiaries Pay More**: Currently, individuals with incomes over $85,000 (couples over $170,000) must pay higher Part B and Part D premiums, ranging from 35 to 80 percent of their Part B & D premiums, depending on income. The President's proposal is to raise this income-related rate to 40 percent minimum and 90 percent maximum. He would maintain the current income thresholds until one-quarter of all beneficiaries were paying the higher rates. The hope is that Medicare's finances would be strengthened by asking wealthier participants to pay a greater share, while opponents fear the rich may opt-out entirely, leading to a worse situation than before.

- **Doughnut Hole Closing Faster:** While the Affordable Care Act already included language which would close the unpopular doughnut hole by 2020, the

President's budget would accelerate this move by five years, to 2015. Funding for this would come from drugmakers, who oppose the move.

- **Provider Cuts**: Although the President's plan would eliminate the 2 percent payment cut to providers which began earlier this year as part of across-the-board sequestration, there are other provisions which anger hospitals. Currently, if a hospital is unable to collect a debt from a Medicare beneficiary (e.g., nonpayment of deductibles and coinsurance), Medicare will reimburse 65 percent of those debts. The President's plan would reduce that rate to 25 percent over three years.

- **Changes to Medicare Supplements:** Beginning in 2017, so-called first-dollar Medigap plans will include a 15 percent surcharge. The President believes that overly generous insurance encourages over-utilization of healthcare services.

All told, the President's budget is designed to reduce Medicare's spending growth by $371 billion over the next ten years. AARP has already voiced its opposition, while House Republicans and Democrats have both produced budget blueprints of their own.

National Plan

As a result of the National Alzheimer's Project Act (NAPA), the National Alzheimer's Plan (or simply National Plan) was created in 2012 in order to "accelerate research toward treatment and prevention of Alzheimer's, and to improve care, services, and support to people with Alzheimer's, families and caregivers."

Among its chief methods of accomplishing these goals were heavy investment in research and creation of a robust new website (www.alzheimers.gov[13]) to serve as a focal point for caregivers. These were funded by $156 million in federal funding ($130 million toward research, and $26 million to improve public awareness, provider education, caregiver support and data collection).

In a twist, both the site's developers and the promotional launch campaign targeted caregivers more than recipients. This was a shrewd move. Caregivers cite stress, financial strain, and disruptions to career and family. Firsthand experience may be the trigger which spurs caregivers to plan for themselves.

Given the the predominance of Alzheimer's disease and other cognitive impairments as the most frequent causes and most expensive types of long-term care insurance claims, one would expect a natural partnership between private long-term care insurance and the National Plan. As a matter of fact, *the National Plan includes a recommendation that consumers get more information about private long-term care insurance options*, and encourages Americans to educate themselves about long-term care services.

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In its second year, the government maintained its funding level of $156 million, and in 2014 President Obama increased this level by an *additional* $122 million. While admirable, we must keep this in context: Americans spend $200 *billion* each year caring for Alzheimer's patients and others with cognitive impairments.

Language

In the beginning, there were Nursing Homes.

No one had to *frame* them or substitute euphemisms for the term, because in the early 1970s, they were the only game in town. By the late 1980s, the term Nursing Home had begun to assume a negative connotation and we saw the rise of Nursing Facilities as more palatable, but it wasn't until the 1990s and its explosion of Assisted Living literally from out-of-nowhere that permitted a full-fledged cavalcade of new vocabulary to emerge.

By the 1990s, you couldn't give away Nursing Facility insurance for free, but you could talk about Long-Term Care, and you could definitely pique someone's interest talking about plans which paid for either Assisted Living or Home Care. It's all in the words you use…

Fast forward to today, and even the words Long-Term Care (LTC) have begun to assume some of the old patina of negativity once reserved for Nursing Home Insurance, so the industry is once again afoot to replace its language with something more benign. Enter Extended Care and Long-Term Health Care.

So where, in all of this, does LTSS fit in?

Nowhere, and everywhere. Essentially, LTSS equals LTC. The only difference is that Long-Term Services & Supports is the modern terminology used almost exclusively by universities, researchers, think tanks and the government, while LTC is a product of the private market.

Wherever it occurs within the Affordable Care Act—blessed by the highest law of the land—the term is inked and dried as LTSS. Government has weighed in: henceforth we shall know these as long-term services and supports. CLASS used the term; the National LTC Commission repeated it; now the Bi-Partisan Commission does the same. Read any paper by a Ph.D and you will find the same term.

But the public doesn't know the term: a Google keyword search verifies that no one searches for this term because no one outside of the ivory tower is familiar with it. The fact that insurance companies continue to market their products as LTC further re-inforces how far apart private and public markets are.

You can learn a lot by the language people use…

Skin in the Game

The following excerpt comes to us courtesy of an article[14] in LifeHealthPro regarding cost-sharing:

> "The Obama administration wants the NAIC and the states to change the rules governing Medigap plans C and F, which hold purchasers' out-of-pocket costs to especially low levels. Officials say Medicare enrollees who buy Medigap Plans C and F now have no incentive to be good health consumers. The Obama administration wants the plans to add "nominal cost-sharing" features, to get the users to shop for care more carefully."

When your insurance is so good that it covers nearly everything, it leads you to become an irresponsible, cost-unconscious consumer. So say the economists. (In fact, they literally said "Forcing uninsured people to buy health insurance will not necessarily be good for them.")

They go on… "The Obama administration has also talked about the possibility of raising $2.5 billion over ten years by imposing a surcharge on the Medicare enrollees who buy the "near first-dollar" Medigap products. The government would collect the surcharge by adding an amount equal to about 15 percent of the average Medigap policy premium onto a Medigap policy owner's Medicare Part B premium."

This is a fascinating development: first-dollar coverage already costs more. Having said that, the Government wants to increase the organic cost of first-dollar coverage by an extra 15 percent for another reason entirely: moral hazard. Believe it or not, they're not wrong.

This author has elswhere predicted that, like unlimited benefit periods, first-day elimination periods (i.e., first-dollar coverage) will soon go the way of the dinosaur. The reason? Private insurers are finding exactly what the government is fearing. In LTCI, policyholders with zero-day elimination periods DO claim at higher-than-anticipated rates. There is a strong economic rationale that one of the ways we can help suppress healthcare costs in America is for each of us to have greater "skin in the game". We expect to see greater use of coinsurance (as in health insurance) in the design of future long-term care solutions.

Carrier Exits

For those of you who haven't seen Woody Allen's miraculous *Midnight in Paris*, I'm about to spoil the takeaway: each era waxes nostalgic about the age before. Finding ourselves jaded and cynical today, we call forth fond remembrances of a golden yesteryear.[15]

Now more than ever, long-term care insurance stakeholders and observers alike are failing to step outside the movie and recognize that today is our Golden Age. It was Pangloss in Voltaire's novel *Candide* who observed, "Everything is for the best, in this best of all possible worlds." The eternal optimist might have been describing why the present period of inevitable

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market contraction is a self-leveling mechanism designed to bring equilibrium between buyers and sellers.

The oft-repeated claim that market penetration rests at a paltry 9 percent began as a disingenuous throwaway from studies about LTC financing. A more revealing approach is that taken by Jesse Slome, of the American Association for Long-Term Care Insurance.

He has posited that long-term care insurance penetration may be as high as 50 percent. How can this be? Slome deduces that even though the total U.S. population may have reached 310 million, we need only concern ourselves with the viable pool of candidates for our product. Start with the 112 million Americans between ages forty and sixty-nine. Because most of these won't become serious about LTCI planning until their fifties, let's narrow it to eighty-eight million.

But, our market must health-qualify, be able to afford the premiums, have assets to protect and be planners. That's a lot of narrowing! Slome takes out 5 to 9 percent for health, another 18 percent who are impoverished and another unemployed subset who are disinclined to financial planning: in the end our total market is probably fifteen million, of which ten million policies have been sold, and eight million are in-force (the balance having lapsed or the insured having passed away). Note: Other reliable sources put the total number of in-force policyholders lower than Slome, at closer to five million, but these numbers are always tricky to work out.

What is the proper number of carriers for a market of fifteen million? Is it ten, a hundred or something in between? Like water seeking its own level, I suspect nature will provide its own answer without the help of sensational journalists, hand-wringing consumers or doomsday analysts.

Our long-term care insurance market puts on roughly 170,000 new lives per year, worth about $400 million in annualized new business premium. This is spread among no less than fifteen carriers. The fundamental question: Can a pool of fifteen million prospects sustain this many competitors?

Not long ago, I found myself calming the nerves of a rattled producer with whom I've worked for more than a decade. His knee-jerk reaction to the bevy of seeming bad news was that the number of carriers in the market has shrunk. Really? When I compared the list of carriers my firm represented a decade ago versus today, it turns out *we actually represent more carriers now*. I suspect agents feel a sense of uneasiness due to the carriers who have stolen our hearts and skipped town in the intervening years.

LTC insurance is not exempt from the universal theory called The Long Tail, which posits a concentration of production from the leaders and decreasing amounts as you stretch into the pocket niches. In fact, in 2000 the top five carriers accounted for 41 percent of covered lives, already a lot. By 2013 the top five carriers had dominated to such a degree that 76 percent of new buyers had purchased from one of these five.

Does anyone believe that the only thing preventing sales is the lack of more free quotes? What do you think would happen if 104 carriers suddenly flooded the market and began offering LTC products again? Would it be a rennaissance? Would it induce so much pent-up demand that our phones began ringing off the hook? Would our industry triple its sales and grow to $1.2 billion overnight?

On the contrary, the laws of supply and demand are so incontrovertible that we have exactly as many carriers as can be supported by the number of applicants purchasing—and when out of balance we experience economic evolution which is no more nor less dramatic than any other maturing industry.

Our product is known for unusually high acquisition costs, coupled with a long tail during which claims are paid and profits are recouped. Income is derived from only two sources: premiums and interest. Depending on the age of the applicant, the ratio starts at 50/50, more or less. When interest rates are low, premiums must be increased dramatically. Given these inputs, carriers for whom LTCI is not a core product may soul search periodically whether the opportunity cost of deploying their resources into other product lines isn't too high. (Conversely, when interest rates rise—as they inevitably will—you can expect to see carriers jump back into the field from the comfort of the sidelines.)

This business goes to the survivors. For the carriers and producers who remain, the world is our oyster. We need only stand before the silver tsunami and wait—which is why sideline watchers may return when the water gets warm. In the meantime, let's rejoice in how far we've come. Whether you are a consumer or producer, there has never been a better age for long-term care insurance than today.

I've read the words of pessimists who fear the worst, but I also believe today is the Golden Age. We have a tendency to romanticize the past, which is fine if you don't mind dying from a simple infection or undergoing surgery without anesthesia—holy cow!

As in *Midnight in Paris*, come live in the present with me, and we'll be just fine.

Endnotes

1. "80 percent of men die married; 80 percent of women die single." Source: "Gender-distinct Pricing: New Directions," by Claude Thau, 9/11/13, LifeHealthPro. http://www.lifehealthpro.com/2013/09/11/gender-distinct-pricing
2. "Yamada bill seeks to stop insurers from implementing gender-based pricing," Rachel Raskin-Zrihen, Times Herald. February 4, 2014. http://www.timesheraldonline.com/news/ci_25057074/yamada-bill-seeks-stop-insurers-from-implementing-gender
3. "The Minnesota Cognitive Acuity Screen and LTCI," Stephen D. Forman, ProducerseSource. http://www.producersesource.com/featured-middle-left/the-minnesota-cognitive-acuity-screen-mcas-and-ltci/
4. Ibid.
5. Among its recommendations, the Commission stated, "Policy interventions that provide or enable catastrophic insurance might well encourage Americans with modest financial resources to strengthen preparation for their LTSS needs

through a more robust private insurance and personal savings. In turn, public policy changes to make long-term care insurance (LTCI) products more affordable and attractive, including allowing more variety in the structure of policies, would encourage private LTCI purchase.

6. The complete report, incuding questions, poll results, and survey responses can be found at "Land This Plane: A Delphi Research Study of Long Term Care Financing Solutions" sponsored by Society of Actuaries, prepared by John O'Leary, O'Leary Marketing Associates, March 2014. http://www.soa.org/Research/Research-Projects/Ltc/research-2014-ltp-ltc.aspx.
7. "America's Long-Term Care Crisis: Challenges in Financing and Delivery", Bipartisan Policy Center, April 2014.
8. That is, as long as they participate in the Medicaid program. States could withdraw from Medicaid entirely. Some, like Nevada, have examined the pros and cons of such a move from an economic standpoint, but it's unrealistic to imagine any state would follow-through on such a nuclear option.
9. Source: "Long Term Insurance Sales Strategies," Issue May 2013, Vol. 4, Number 5. "Explaining Rate Increases on Older Policies," copyright 2010, American Association for Long-Term Care Insurance.
10. Ibid. "At a 5 percent ultimate lapse rate, only 36 percent of the policies are in force after 20 years and only 21 percent after 30 years. With a 1 percent lapse rate, 82 percent are in force after 20 years and 74 percent after 30 years."
11. Most older policies will have included 5 percent compound inflation, so a typical $100 per day benefit will have grown to $269 per day after twenty years.
12. Prepared remarks for Genworth Chief Executive Officer Thomas J. McInerney for delivery before the Intercompany Long Term Care Conference on March 18, 2014.
13. Not to be confused with www.alz.org, the website of the Alzheimer's Association.
14. LifeHealthPro, Allison Bell, October 24, 2012.
15. Portions of this section "Carrier Exits" appeared previously as "Your Next Sales Idea: The Golden Age of Long Term Care Insurance" and "Your Next Sales Idea: The Tyranny of Choice".