

U.S. DEPARTMENT OF THE TREASURY

Long-Term Care Insurance: Recommendations for Improvement of Regulation

Report of the Federal Interagency Task Force
on Long-Term Care Insurance



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Acknowledgments

The Federal Interagency Task Force on Long-Term Care Insurance consists of representatives from the U.S. Department of the Treasury (Treasury), the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), and the Office of Management and Budget (OMB). Secretary Mnuchin and Treasury Assistant Secretary Michael Faulkender would like to thank the following individuals for their service as members of the Task Force and their contributions to this report:

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Abbreviations

<u>Acronym</u>	<u>Abbreviation</u>
ACI	Annual Compound Inflation
ADLs	Activities of Daily Living
AGI	Adjusted Gross Income
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CMS	U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
Code	Internal Revenue Code
DOL	U.S. Department of Labor
DRA	Deficit Reduction Act of 2005
EBSA	U.S. Department of Labor, Employee Benefits Security Administration
EPDV	Expected Present Discounted Value
ERISA	Employee Retirement Income Security Act of 1974
FIO	U.S. Department of the Treasury, Federal Insurance Office
FLEC	Financial Literacy Education Commission
FSA	Flexible Spending Arrangement
HDHP	High-Deductible Health Plan
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRS	Health and Retirement Study
HSA	Health Savings Account
IADLs	Instrumental Activities of Daily Living
IRA	Individual Retirement Account
LTC	Long-Term Care
LTCI	Long-Term Care Insurance

AcronymAbbreviation

LTCI Model Act

NAIC Long-Term Care Insurance Model Act

LTCI Model Regulation

NAIC Long-Term Care Insurance Model Regulation

LTCSA

Long-Term Care Savings Account

LTSS

Long-Term Services and Supports

MA

Medicare Advantage

NAIC

National Association of Insurance Commissioners

NAIC 2017 List

Long-Term Care Federal Options Presented by the NAIC in April 2017

NHEA

National Health Expenditure Accounts

Partnership program

Partnerships for Long-Term Care Federal-State Program

SECURE Act

Setting Every Community Up for Retirement and Enhancement Act of 2019

SOA

Society of Actuaries

SSA

U.S. Social Security Administration

Task Force

Federal Interagency Task Force on Long-Term Care Insurance

Treasury

U.S. Department of the Treasury

Executive Summary

Introduction

In July 2018, the U.S. Department of the Treasury (Treasury) convened a federal interagency task force on long-term care insurance (Task Force) in response to recommendations in Treasury's October 2017 Report on Asset Management and Insurance (Insurance Report).¹ The Insurance Report identified the challenges of financing long-term care (LTC) as a matter of national interest requiring a coordinated response from the federal government, while affirming the primary role of the U.S. states as insurance regulators in the United States. Accordingly, the Insurance Report recommended that Treasury convene the Task Force to develop policies to complement reforms at the state level relating to the regulation of long-term care insurance (LTCI). The Insurance Report stated that the Task Force should coordinate its work with the ongoing work of state insurance regulators and the National Association of Insurance Commissioners (NAIC).²

The Task Force consists of representatives from Treasury's Office of Economic Policy (including the Assistant Secretary for Economic Policy, who chairs the Task Force); other Treasury offices (Tax Policy, Consumer Policy, and the Federal Insurance Office (FIO)); the U.S. Department of Health and Human Services (HHS); the Centers for Medicare & Medicaid Services (CMS); the U.S. Department of Labor (DOL); and the Office of Management and Budget.

Since its inception in 2018, the Task Force has identified and analyzed proposed reforms to the regulation of LTCI and consulted with a range of stakeholders. The Task Force concludes that LTCI can play a role in providing financial protection against LTC risks and helping individuals plan their financial future. To that end, this report describes the work conducted by the Task Force and presents its recommendations to improve the regulation of LTCI in the United States. In making these recommendations, the Task Force does not intend to either promote or discourage LTCI over other solutions to the challenges of financing LTC. Implementation of the recommendations will remove barriers to innovation and increase regulatory efficiency and alignment, potentially making LTCI more affordable and accessible while allowing the market to continue shaping the evolution of this product line.

¹ U.S. Department of the Treasury, *A Financial System That Creates Economic Opportunities: Asset Management and Insurance* (Treasury, October 2017), 163 [hereinafter *Insurance Report*], available at: https://www.treasury.gov/press-center/press-releases/Documents/A-Financial-System-That-Creates-Economic-Opportunities-Asset_Management-Insurance.pdf.

² Treasury, *Insurance Report*, 144. The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, District of Columbia, and five U.S. territories.

Scope and Objectives of the Task Force

The Task Force determined that its primary objectives were to analyze, evaluate, and make recommendations concerning:

- The LTC federal policy options presented to federal agencies and Congress by the NAIC in April 2017 (NAIC 2017 List);³
- Other potential new federal policies, or modifications of existing policies, to complement state-based regulation of LTCI; and
- The manner and degree to which current laws and regulations appropriately recognize and respond to newer product designs and features in the LTCI market.

In conducting its work, the Task Force focused on federal laws and regulations relating to the private insurance market. The Task Force also examined certain state laws and regulations, primarily those referenced in federal laws.

The Task Force substantially completed its analysis and recommendations prior to the onset of the COVID-19 pandemic. The pandemic is likely to affect the provision of LTC and the market for LTCI, but the full effects will continue to emerge over time.⁴ For these reasons, this report does not seek to assess the potential impacts of COVID-19 on LTC or LTCI.

Long-Term Care Insurance in the United States

The terms “long-term care” (LTC) and “long-term services and supports” (LTSS) cover a range of services provided to people with long-term physical or cognitive limitations. The private insurance industry typically uses LTC as a shorthand term, while academic and public policy literature, as well as some governmental publications, typically use LTSS. With some exceptions, this report generally adopts LTC.⁵

Most LTC is not medical care, but rather assistance with the basic personal tasks of everyday life, such as bathing, dressing, using the toilet, transferring (to or from bed or a chair), caring for

³ National Association of Insurance Commissioners, *Long-Term Care Innovation (B) Subgroup: Federal Policy Options to Present to Congress* (Kansas City: NAIC, April 2017), 2, available at: https://www.naic.org/documents/cmte_e_res_mech_wg_related_federal_policy_issues.pdf.

⁴ Treasury will continue to monitor the effects of COVID-19 on insurance products and markets, including LTCI. COVID-19 disproportionately affects older adults and individuals with chronic illnesses or other high-risk health conditions, making the LTC population (particularly those in nursing homes or assisted living facilities) more vulnerable to the virus than the general population. Relevant factors with respect to the pricing of LTCI include mortality, policy lapses, the incidence of claims, utilization of benefits, and changes in interest rates. See Andrew Dalton et al., “Pandemic Risk on LTC Insurance Reserves,” Milliman, April 2020, available at: <https://us.milliman.com/en/insight/pandemic-risk-on-ltc-insurance-reserves>.

⁵ The Role of Insurance in Long-Term Care and the Alternative Financing Approaches sections generally adopt LTSS.

incontinence, and eating.⁶ Approximately half of Americans turning age 65 today will need some type of LTC in their lives. The older a person is, the more likely it is that he or she will need LTC at some point. The Congressional Budget Office (CBO) has projected that U.S. spending on LTC for the elderly (age 65 and above) will increase from 1% of gross domestic product in 2010 to 3% in 2050.

Based on data from the National Health Expenditure Accounts (NHEA), the Medicaid program was the largest payer of LTSS expenses in 2018 (total payments of \$159.1 billion), followed by out-of-pocket spending by individuals (\$55.0 billion). By contrast, based on industry data, private LTCI paid \$10.3 billion in claims in 2018.

Private insurers began offering LTCI in the 1970s in response to demand for financial protection against the risk of having to enter a nursing home. Sales of new policies peaked in the early 2000s, but have since declined as numerous insurers decided to exit the market due to the poor financial performance of the product line. The market remains in flux, with sales of traditional, standalone LTCI continuing to drop while “combination” insurance products have become more popular with consumers.⁷ The role of the private insurance market in addressing the growing need for LTC will largely depend on the four main subject areas examined in this report: innovation in product design and delivery; the efficiency and effectiveness of regulation; education and awareness with respect to LTC needs and planning; and federal income tax treatment of LTCI.

Review of the Process for this Report

For this report, the Task Force consulted with a wide range of stakeholders, including consumer and other advocacy groups, trade groups, insurance companies and insurance product distributors, actuaries, academics, legal experts, state insurance regulators, the NAIC, and other stakeholders with relevant knowledge. See *Appendix A* for a list of organizations and individuals providing input to the Task Force. The Task Force also reviewed data, research, and publications from both public and private sector sources.

On July 25, 2019, the Task Force held a public meeting at Treasury to obtain additional input for this report. Topics discussed at the meeting included the social need for LTC; the individual private LTCI market; employer, group, and worksite LTCI products; state regulation of LTCI; the federal government and LTCI; and federal-state partnerships and other financing approaches.

⁶ “Long-Term Care – The Basics – What is Long-Term Care?” LongTermCare.gov, U.S. Department of Health and Human Services, last modified October 2017, available at: <https://longtermcare.acl.gov/the-basics/what-is-long-term-care.html>.

⁷ In this report, “traditional” or “stand-alone” LTCI refers to policies that provide only LTCI coverage, as distinguished from “combination” policies or other product designs that combine LTCI with other coverages, such as life insurance or an annuity.

Through a posting on Treasury’s website and an announcement at the public meeting, the Task Force offered the public an opportunity to provide written comments. The Task Force received comments from a total of 16 consumers and consumer advocacy groups, actuarial organizations, and industry experts and consultants.⁸ This report addresses several recommendations from the comments, and incorporates certain data and other information provided by commenters.

Summary of Analysis and Recommendations

The Task Force organized its analysis and recommendations into four subject areas:

- **Innovation and Product Development** – product development and other innovation in the private market, including policies that combine LTCI with other types of insurance products or product features offering alternatives to traditional, stand-alone LTCI.
- **Regulatory Efficiency and Alignment** – improvements in regulatory efficiency and alignment with respect to LTCI, including inflation protection requirements, harmony between federal and state laws and regulations, and cross-state subsidization and other issues relating to state regulatory review and approval of premium increases.
- **Financial Literacy and Education** – the appropriate federal role in financial literacy and education relating to LTC needs and LTCI.
- **Tax Incentives** – current tax law treatment of LTCI and proposals to provide additional tax incentives for the purchase and use of LTCI.

Although public programs providing LTC benefits were not in scope for specific recommendations, the Task Force also reviewed several proposed public insurance options as described in the Alternative Financing Approaches section of this report.

Appendix B presents the analysis and recommendations of the Task Force and identifies the policymakers and other stakeholders the Task Force considers well positioned to implement each recommendation. Following publication of this report, Treasury will continue to monitor implementation of the recommendations.

Innovation and Product Development

In response to the decline in the market for traditional LTCI, insurers have introduced alternative product designs and new features to both increase the consumer appeal of LTCI and improve the financial returns on LTCI for insurers. These designs and features include combination products, limited LTCI, group products, and incidental benefits.

Innovation and product development have the potential to significantly strengthen the private LTCI market and better address the LTC needs of consumers. Accordingly, the Task Force

⁸ See “Public Comments Received by the Task Force,” U.S. Department of the Treasury, August 2019, available at: <https://home.treasury.gov/system/files/226/Public-Comments-Received-by-the-Task-Force.pdf>.

recommends that federal and state policymakers foster a regulatory environment that encourages flexibility, experimentation, and innovation in product design to improve consumer choice and access to benefits, while appropriately protecting the rights of consumers and the solvency of insurers.

Combination Products

Insurers have introduced a variety of products that combine LTCI with different types of insurance, primarily life insurance and annuities. These combination products offer potential advantages to consumers and insurance distributors, but also present challenges for these groups due to their complexity and the wide range of combinations available. Although claims experience on these relatively new products is limited, companies report that the incidence of claims and other actuarial results to date have been positive.

Policymakers could benefit from analysis of the impact of combination products on the market for LTCI risk protection. The Task Force recommends that actuaries, academics, and other stakeholders explore such an analysis, with coordination by FIO.

Limited LTCI Products

Compared to traditional LTCI, “short” or “limited” LTCI policies (i.e., policies that pay benefits for less than 12 months) generally have lower benefits, but also typically have no deductible or waiting period, as well as less stringent underwriting and lower premiums. Because limited LTCI emerged later than traditional LTCI, regulation of this market is less mature than the traditional market. In late 2018, the NAIC adopted a model act and model regulation for this product. However, the states generally have not yet adopted either model.

The Task Force recommends that federal policymakers work with their state counterparts and with private sector stakeholders to evaluate and monitor the market for limited LTCI, including potential impacts on the risk pool for longer-term products and on Medicaid. The Task Force further recommends that state legislators and insurance regulators take steps to better streamline and standardize the regulation of this market.

Group Products

The Task Force considered two policy proposals for LTCI group products that were included under the NAIC 2017 List, both involving the fiduciary provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The first proposal is to create a safe harbor to remove potential exposure to ERISA fiduciary liability as a factor in employers’ decisions not to offer LTCI to employees. The second proposal is to permit 401(k) and individual retirement account (IRA) participants to purchase LTCI within their accounts. The objective of both proposals is to promote a more viable group LTCI market by increasing employee participation, resulting in a larger and more favorable risk pool for insurers and, potentially, lower premiums.

Based on stakeholder input and an assessment of the market and legal landscapes for the employer market, the Task Force does not recommend either option because it is uncertain whether either proposal would have a meaningful impact on participation levels.

Incidental Benefits

Under most LTCI policies, the insured is not eligible to submit a claim for benefits until he or she becomes “chronically ill” as defined under state insurance laws and the Internal Revenue Code (Code). Some stakeholders proposed that Congress should amend the Code to permit payment of incidental benefits (such as home assessments to identify safety hazards, home modifications, or caregiver training for family members) from a LTCI policy prior to the onset of chronic illness, without causing the policy to forfeit its tax-qualified status.

Supporting the ability of those needing LTC to remain in their homes could benefit both consumers and insurers. Accordingly, the Task Force encourages industry, federal policymakers, and other experts, in consultation with consumer representatives, to identify and assess research-based evidence of cost-effective interventions. If cost-effective incidental benefits are identified, Congress could consider amending the Code to permit payment of those benefits under a tax-qualified LTCI contract prior to the insured becoming chronically ill, subject to a monetary cap and other conditions set by regulation.

Regulatory Efficiency and Alignment

The Task Force considered various recommendations to improve the efficiency and effectiveness of regulation of LTCI at the federal and state levels, including federal policies identified in the NAIC 2017 List.

Inflation Protection Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Because LTCI policies often remain in force for many years, purchasers of LTCI face a significant risk that inflation will erode the value of their benefits over time. Under current state laws and regulations, insurers must offer policyholders the right to purchase a policy feature that increases benefits at an annual compounded rate not less than 5%. In 2006, when it codified requirements for tax-qualified LTCI as part of HIPAA, Congress incorporated the 5% compound standard through reference to the 1993 version of the NAIC Long-Term Care Insurance Model Regulation (LTCI Model Regulation).⁹

The NAIC and Congress based the 5% compound inflation standard on inflation rates that prevailed in the 1980s and 1990s. Since then, particularly following the financial crisis, this standard has become a costly feature that increases premiums to levels most consumers will not

⁹ HIPAA amended the Code to add Section 7702B, which sets forth the requirements for a “qualified long-term care insurance contract.” See 26 U.S.C. § 7702B(a)(1).

accept. The Task Force concludes that inflation protection requirements under HIPAA and state insurance laws should be revised to increase the efficiency and effectiveness of regulation.

To both address outdated inflation protection requirements and provide flexibility to adapt inflation protection to evolving economic conditions, the Task Force recommends that Congress amend the Code to authorize Treasury to set inflation protections for tax-qualified LTCI.

Inflation Protection Under the DRA

In the early 1990s, four states (California, Connecticut, Indiana, and New York) implemented a federal-state program known as “Partnerships for Long-Term Care” (Partnership program). As part of the Deficit Reduction Act of 2005 (the DRA), Congress extended the Partnership program nationwide, subject to specified conditions including inflation protection and other consumer protections.¹⁰ The states have adopted widely varying inflation protection requirements for LTCI policies under the Partnership program, resulting in a regulatory patchwork with uneven consumer protections and additional complexity that makes it more difficult to write LTCI. Additionally, high inflation protection mandates in some states may raise the costs and reduce the attractiveness of Partnership policies.

The Task Force recommends that state policymakers—legislators, state Medicaid directors, insurance commissioners, and the NAIC—improve regulatory efficiency and effectiveness by harmonizing and streamlining inflation protection requirements under the Partnership program. Alternatively, Congress should consider delegating to HHS the authority to set Partnership program inflation protection requirements.

Other Consumer Protections

Apart from inflation protection, both HIPAA and the DRA mandate compliance with certain consumer protections contained in the NAIC Long-Term Care Insurance Model Act (LTCI Model Act) and the LTCI Model Regulation. However, the DRA defines “model regulation” and “model Act” by reference to the NAIC models adopted as of October 2000, while HIPAA defines these terms by reference to the January 1993 versions. This cross-referencing in two federal statutes of two outdated and conflicting versions of NAIC models creates confusion and adds complexity to conducting LTCI business.

The Task Force recommends that Congress consider options to address this regulatory inefficiency. For example, as one option, Congress could consider giving Treasury the authority, in consultation with HHS, to set consumer protection standards using one version of the LTCI Model Act and LTCI Model Regulation for purposes of both tax qualification under HIPAA and Partnership eligibility under the DRA, with flexibility to update the standards periodically (e.g., every 10 years).

¹⁰ See 42 U.S.C. § 1396p.

Review and Approval of Rate Increases

The authority of state insurance regulators to review and approve proposed rate increases for LTCI before the insurer implements those changes is a critical factor in the LTCI marketplace. Due to the non-uniform nature of the state-by-state rate increase process, policyholders in states where regulators have approved rate increases may subsidize the cost of premiums for policyholders in other states where regulators have either approved limited increases or rejected rate increases in their entirety.

In 2019, the NAIC identified the regulation of LTCI as the organization's top priority. The Task Force recommends that the NAIC and the states maintain their focus on LTCI and continue working together in 2020 to develop a consistent national approach to regulatory reviews of LTCI rate increase requests. The Task Force also recommends that FIO continue to monitor and report on this issue.

Financial Literacy and Education

The NAIC 2017 List included a federal education program around retirement security and the importance of planning for potential LTC needs. In 2019, Treasury released a report (Financial Literacy Report), laying out an appropriate federal role for financial education based on a literature review and consultations with experts and stakeholders inside and outside of the government.¹¹ In the Financial Literacy Report, Treasury recommended that the primary federal role in this area should be to empower financial education providers, as opposed to attempting to reach every American household directly.

The Task Force recommends that Treasury, HHS, DOL, and other agencies, working through the Financial Literacy Education Commission (FLEC), assess federal education resources on LTC needs and planning, and modify, update, and supplement these resources as needed.

Tax Incentives

The NAIC 2017 List included consideration of more generous tax incentives for the purchase of LTCI. Multiple stakeholders encouraged the Task Force to consider a range of amendments to tax laws or regulations aimed at increasing the take-up of private LTCI. The Task Force analyzed several potential new tax incentives and other potential tax reforms.

In its analysis, the Task Force took into account that the Code already provides favorable income tax treatment to LTCI. The Task Force concludes that the proposed incentives, in general, would reduce tax revenues and primarily benefit higher-income taxpayers, and may not be fully effective in targeting lower and middle-income individuals who need financial protection against LTC risks. Finally, the proposals would increase the complexity of the Code and could, in some

¹¹ U.S. Department of the Treasury, *Federal Financial Literacy Reform: Coordinating and Improving Financial Literacy Efforts* (Treasury, July 2019) [hereinafter *Financial Literacy Report*], available at: <https://home.treasury.gov/system/files/136/FFLRCoordinatingImprovingFinancialLiteracyEfforts.pdf>.

cases, be difficult to implement, monitor, and enforce. For these reasons, the Task Force does not recommend adoption of any of the proposed additional tax incentives, with the exception of the proposal to eliminate the additional tax on early withdrawal of funds from an IRA, 401(k), or 403(b) account that are used to pay LTCI premiums.

Alternative Financing Approaches

Experts and policymakers have proposed a range of alternative approaches to the financing of LTC, including public programs administered by the federal and state governments. Most of these approaches have focused on either front-end insurance (providing limited coverage for short, initial durations) or back-end or catastrophic insurance (coverage for longer durations beyond a specified level of need or cost). The Task Force does not recommend pursuing any particular alternative financing approach at this time. Policymakers and stakeholders should continue to develop, monitor, and analyze LTC and LTCI reform proposals—including those discussed in this report—to better understand the advantages and disadvantages of specific options, tradeoffs, program costs, and distributional impacts.

The Role of Insurance in Long-Term Care

As the elderly population continues to grow in both size and as a percentage of the overall population, the need for LTSS becomes increasingly important for social welfare. This section discusses the prevalence of need, projected future demand, and financing of LTSS, including the roles of public programs and the private LTCI market. The section concludes with an overview of supply and demand factors impeding the private market.

Prevalence of Need for LTSS

The terms “long-term care” or “long-term services and supports” encompass a wide variety of services provided to individuals with long-term physical or cognitive limitations who need help with certain daily activities. These activities include “activities of daily living” (ADLs) and “instrumental activities of daily living” (IADLs).

HIPAA defines ADLs as six basic activities:¹²

- Eating
- Toileting
- Transferring
- Bathing
- Dressing
- Continence

The IADLs include activities necessary for independent life such as paying bills and managing money, medication management, meal preparation, shopping, and using the telephone.

LTSS, therefore, include services such as direct physical assistance with ADLs, meal provision, housekeeping services, and transportation services, as well as medical services. These services and supports can be provided in individuals’ homes or in institutional settings such as assisted living facilities or nursing homes. Individuals’ needs for LTSS vary widely, ranging from round-the-clock assistance with all six ADLs to assistance with one or two IADLs.

Table 1 provides summary statistics on the prevalence of difficulty with at least one IADL, the prevalence of needing assistance with two or more ADLs, and the use of home health care in approximately the previous two years among individuals age 60 and above in the Health and Retirement Study (HRS) during 2016.¹³ The prevalence of difficulty with IADLs and the need

¹² 26 U.S.C. § 7702B(c)(2)(B).

¹³ The HRS is conducted every two years and follows individuals over time, with new respondents added each round to replace deceased respondents. Questions about medical utilization focus mainly on utilization since the previous

for assistance with ADLs rise sharply in both sexes above age 75. The share using home health care in the previous two years rises in parallel with the need for assistance with daily activities. Women above age 85 have the highest need for LTSS; around half in this group report having difficulty with at least one IADL, and nearly a quarter need assistance with two or more ADLs. A lower share (17%) used home health care in the past two years.

Table 1: Prevalence of Serious Disability and Use of Long-Term Services and Supports Among Those Age 60 and Over

	<i>Share Having Difficulty with at Least One IADL (%)</i>	<i>Share Needing Help with Two or More of Five ADLs (%)</i>	<i>Share with Home Health Care Use in Past Two Years (%)</i>
<i>Whole Sample</i>	16	5	3
<i>Female</i>			
60-69	11	3	0
70-84	18	5	3
85+	50	24	17
<i>Male</i>			
60-69	9	2	1
70-84	15	3	2
85+	39	16	10

Notes: The sample consists of respondents in the 2016 HRS age 60+. The sample size is 13,153. All means are weighted using sample weights for the 2016 wave. For purposes of the HRS, IADLs include preparing hot meals, shopping for groceries, using the telephone, managing medications, and managing money. ADLs include dressing, bathing, eating, transferring into or out of a bed or chair, and using the toilet.

Table 2 shows statistics on nursing home use and estimated spending on stays in excess of 90 days in the previous two years among HRS respondents age 60 and over.¹⁴ The table focuses on stays longer than 90 days to illustrate exposure to financial risk for stays not covered by insurance (private LTCI plans generally have an exclusion period of 90 days). As Table 2 shows, spending on nursing homes is estimated to be only about \$2,900 on average over two years across those age 60 and over. However, this average figure encompasses a wide range of

interview (approximately two years earlier) for continuing respondents and in the last two years for new respondents. For more information about the HRS, see “The Health and Retirement Study – About,” available at: <https://hrs.isr.umich.edu/about>.

¹⁴ Because the HRS tracks only the total number of nights in a nursing home in the past two years, not whether any particular stay is longer than 90 days, the table may slightly overstate the risk of long-term stays. The HRS assumes \$225 in spending for one night in a nursing home based on the average cost according to HHS. See “LongTermCare.gov – Costs of Care,” available at: <https://longtermcare.acl.gov/costs-how-to-pay/costs-of-care.html>.

spending. Among these individuals, the risk of having a long nursing home stay is low, but the average cost of a long-term stay is approximately \$112,000.

Table 2: Spending on Stays of More Than 90 Nights in a Nursing Home

	<i>Mean Number of Nights in a Nursing Home in Excess of 90 Nights in the past Two Years</i>	<i>Estimated Mean Spending on Stays of More Than 90 Nights Across Whole Sample (\$)</i>	<i>Share with More Than 90 Nights in a Nursing Home in past Two Years (%)</i>	<i>Mean Spending for Those with More Than 90 Nights (\$)</i>
<i>Whole Sample</i>	13	2,898	2.6	111,744
<i>Female</i>				
60-69	2	407	0.3	136,629
70-84	11	2,545	2.7	94,150
85+	105	23,651	18.8	125,957
<i>Male</i>				
60-69	3	636	0.7	91,578
70-84	9	1,916	1.8	108,315
85+	51	11,584	11.4	102,047

Notes: The sample consists of respondents in the 2016 HRS age 60+. The sample size is 13,153. All means are weighted using sample weights for the 2016 wave. Returning respondents were asked about nursing home utilization since their previous interview approximately two years earlier; new respondents were asked about utilization in the past two years.

Projections of Demand for LTSS

The share of the U.S. population who are elderly is expected to rise steadily throughout most of the twenty-first century. In their 2019 report, the trustees for Social Security project that the ratio of the number of people age 65 and over to the number of people age 15 through 64 (the aged-dependency ratio) will rise from 0.268 in 2018 to 0.425 in 2075, an increase of nearly 60%.¹⁵

Accordingly, the demand for LTSS is projected to rise in upcoming years. The CBO projected in 2013 that spending for LTSS for the elderly (age 65 and above) will rise from 1.3% of gross domestic product in 2010 to 3% in 2050, if age- and sex-specific rates of impairment are held

¹⁵ Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Insurance Trust Fund, *The 2019 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (Board of Trustees, April 2019), available at: <https://www.ssa.gov/OACT/TR/2019/tr2019.pdf>.

constant over time and the increase is due solely to the aging of the population.¹⁶ If increased obesity results in higher age-specific impairment rates, spending for LTSS for the elderly will rise to 3.3% of gross domestic product in 2050, according to the CBO. These estimates do not include the value of informal care. The CBO also projected that the share of nonelderly adults engaged in caregiving, either formally or informally, will increase from around 5% in 2010 to 10% in 2050, if impairment rates are held constant, and to 11% under the more pessimistic scenario of increasing impairment rates.

Dementia, LTSS, and LTCI

Dementia is a general term for impairment in a person's ability to remember, think, or make decisions that interferes with performing everyday activities. Alzheimer's disease is the most common type of dementia. According to the Centers for Disease Control and Prevention (CDC), 5.8 million Americans have Alzheimer's, and the number of individuals with dementia is expected to triple over the next 40 years. Deaths from Alzheimer's in the United States increased by 145% from 2000 to 2017, making Alzheimer's the sixth leading cause of death (and the third leading cause when combined with other types of dementia). Part of the increase may be due to a greater emphasis on reporting dementia and Alzheimer's disease as a cause of death. In any case, the burdens of dementia fall heavily on families and other caregivers—more than 16 million Americans provide unpaid care for people with Alzheimer's or other dementias.¹⁷

The CDC estimates that in 2016, the percentage of LTSS users diagnosed with Alzheimer's disease or other dementias was 41.9% for residential care community residents, 44.5% for hospice patients, and 47.8% for nursing home residents.¹⁸ Because a diagnosis of severe cognitive impairment triggers coverage under most LTCI policies, many LTCI claims (roughly half, according to some industry sources), are filed by policyholders with Alzheimer's or other dementias. Therefore, dementia already accounts for a large portion of LTCI claim payments.

While there is evidence that the prevalence of dementia is declining in the United States,¹⁹ population aging is likely to increase demand for LTSS in the future, which may in turn increase

¹⁶ Congressional Budget Office, *Rising Demand for Long-Term Services and Supports for Elderly People* (CBO, June 2013), available at: <https://www.cbo.gov/publication/44363>.

¹⁷ See "Promoting Health for Older Adults," Centers for Disease Control and Prevention, last modified September 2019, available at: <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/promoting-health-for-older-adults.htm>; "What Is Dementia?" Centers for Disease Control and Prevention, last modified April 2019, available at: <https://www.cdc.gov/aging/dementia/index.html>; Alzheimer's Association, *2019 Alzheimer's Disease Facts and Figures* (Chicago: Alzheimer's Association, 2019), 24-25, available at: <https://www.alz.org/media/Documents/alzheimers-facts-and-figures-2019-r.pdf>; Ellen A. Kramarow and Betzaida Tejada-Vera, "Dementia Mortality in the United States, 2000-2017," *National Vital Statistics Reports* 68, no. 2 (March 2019), available at: https://brainhealthinstitute.rutgers.edu/wp-content/uploads/2019/03/Dementia-Report_March-2019.pdf; "Alzheimer's Disease and Healthy Aging," Centers for Disease Control and Prevention, last modified September 2019, available at: <https://www.cdc.gov/aging/aginginfo/alzheimers.htm>.

¹⁸ "National Center for Health Statistics: Alzheimer's Disease," Centers for Disease Control and Prevention, last modified March 2016, available at: <https://www.cdc.gov/nchs/fastats/alzheimers.htm>.

¹⁹ Kenneth M. Langa et al., "A Comparison of the Prevalence of Dementia in the United States in 2000 and 2012," *JAMA Intern Med.* 177, no. 1 (January 2017): 51-58, available at: <https://www.ncbi.nlm.nih.gov/pubmed/27893041>.

demand for financial protection against LTSS risks. In addition, higher than expected claims, together with other factors, have led many insurers to set aside more assets to cover future liability and to increase premiums on both in-force and newly issued policies. Notwithstanding these challenges, the social need for protection against the costs of LTSS for dementia is also a major opportunity for insurers to develop new products and services to improve the quality of life of a large and growing segment of the U.S. population.

Financing of LTSS

Payment Sources

Public financing of LTSS in the United States is provided largely through the Medicaid program. To be eligible to receive LTSS through Medicaid, individuals generally must be 65 or over (or found to be disabled by the Social Security Administration (SSA)), and must meet tests designed to limit benefits to individuals with very low income and wealth. Because Medicaid is partly financed by the states, eligibility and benefits vary, but rules follow broad federal guidelines. Formulas for determining Medicaid eligibility are complex; in general, single individuals with more than \$2,000 in assets, other than their home and car, are not eligible.²⁰ All states must cover nursing home care through Medicaid, and nearly all offer some level of home- and community-based care through waivers provided by CMS.²¹

Based on data from the NHEA, Medicaid was the largest payer of LTSS expenses in 2018 (total payments of \$159.1 billion), followed by out-of-pocket spending (\$55.0 billion).²² By contrast, an industry association estimates that private LTCI paid \$10.3 billion in claims in 2018.²³

²⁰ Married couples with both spouses applying for nursing home coverage are allowed \$3,000 in countable assets to qualify for Medicaid. However, if only one spouse applies, the non-applicant is permitted to transfer a specified amount of assets (from \$25,728 to \$128,640 in 2020) to the non-applicant spouse. See “2020 SSI and Spousal Impoverishment Standards,” CMS, available at: https://www.medicaid.gov/sites/default/files/2020-01/ssi-and-spousal-impoverishment-standards_0.pdf. In addition, the value of the applicant’s primary home does not count against the asset limit.

²¹ Section 915(c) of the Social Security Act, 42 U.S.C. §1396n, establishes standards for these waivers.

²² Amounts provided by CMS Office of the Actuary. For information about the NHEA, see “National Health Expenditure Data: Historical,” CMS, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>. Although the NHEA tracks Medicare spending, that program only covers home health and skilled nursing care for a relatively short period (100 days) following an acute episode such as surgery. Out-of-pocket expenses are likely understated in the NHEA because it does not include payments to independent home health care providers. One study using the National Long-Term Care Survey suggests that nearly half of LTSS (as measured by hours of care) are paid for out of pocket. John Ermisch and Alexander L. Janus, “Who pays for home care? A study of nationally representative data on disabled older Americans,” *BMC Health Services Research* 15, no. 301 (July 2015), available at: <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-0978-x>.

²³ “Long-Term Care Insurance Industry Paid \$10.3 Billion in Claims in 2018,” American Association for Long-Term Care Insurance, last modified January 2019, available at: <https://www.aaltci.org/news/long-term-care-insurance-association-news/long-term-care-insurance-industry-paid-10-3-billion-in-claims-in-2018>.

The Value of Informal Care

Notably, statistics on LTSS spending omit the value of informal (and unpaid) care. Estimates of the value of this care range widely depending on the value attributed to the unpaid hours from caregivers. A 2013 study estimated that the total value of informal care for those age 65 and over in 2011 was \$234 billion, while a 2015 study estimated that value to be \$522 billion for the same year.²⁴ The difference between the two analyses rested largely on whether to value the caregivers' hours at the wage of a home health aide or at the actual or imputed wage of the caregiver, which gives a higher value for their time in most cases.

A later study, in 2018, noted that the method used by the 2013 and 2015 analyses to estimate the value of informal care does not take into account the effects on caregivers from future foregone wages from leaving employment, the value of foregone leisure time, or intrinsic benefits to caregivers from caregiving.²⁵ Using methods designed to account for these other costs and benefits, the 2018 study found that the value of informal care in 2011 was \$277 billion. In all three of these studies, the estimated total value of informal care in 2011 exceeded formal spending on LTSS for the elderly (age 65 and above) in that year, which the CBO estimated to be \$192 billion.

Private LTCI

Since the 1970s, private insurers have offered LTCI to protect against the financial risk of high LTSS expenditures. Unlike short-term medical insurance or publicly-funded Medicaid, the structure of LTCI relies on the pre-funding of benefits. Typically, purchasers buy LTCI at relatively younger ages, in their 50s or 60s, and then hold the insurance while paying premiums for a lengthy period, often over twenty years.

The private market for traditional individual LTCI is in steep decline. After rising from 380,000 in 1990 to a peak of 754,000 in 2002, the number of individual LTCI policies sold declined to 129,000 by 2014.²⁶ As shown in Figure 1, based on sales reports from the LIMRA organization,²⁷ this downward trend accelerated over the five-year period from 2014 to 2018, as

²⁴ CBO, *Rising Demand*, 2; Amalavoyal V. Chari et al., "The Opportunity Costs of Informal Elder-Care in the United States: New Estimates from the American Time Use Survey," *Health Services Research* 50, no. 3 (June 2015): 871-882, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450934/>.

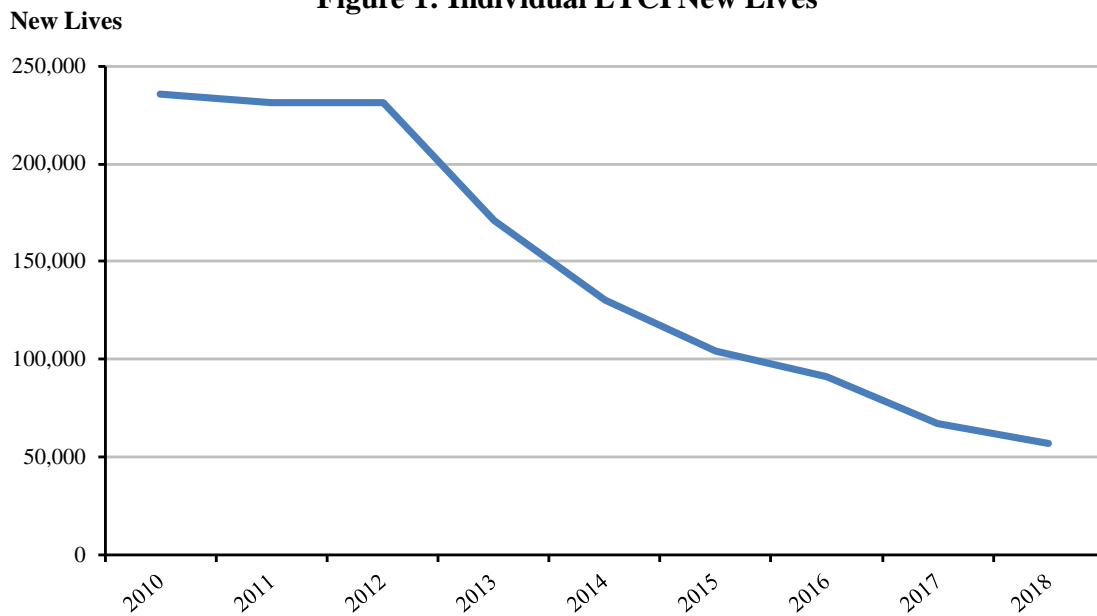
²⁵ Norma B. Coe, Eric B. Larson, and Meghan M. Skira, "A Comprehensive Measure of the Costs of Caring for a Parent: Differences According to Functional Status," *Journal of the American Geriatrics Society* 66, no. 10 (September 2018): 2003-2008, available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.15552>.

²⁶ Marc A. Cohen, "The State of the Long-Term Care Insurance Market," in *The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations*, ed. by Eric C. Nordman (Kansas City: NAIC and the Center for Insurance Policy and Research, May 2016), 7-29, available at: https://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf.

²⁷ LIMRA is a worldwide research, consulting, and professional development trade association focused on the life insurance industry. It is a recognized source for product data and other metrics in the U.S. life insurance, annuity, and LTCI markets.

the industry sold only 67,000 individual policies in 2017 and 57,000 in 2018.²⁸ In addition, as shown in Figure 2, individual new annualized premiums fell to record lows, below \$200 million, in 2017 and 2018. Meanwhile, Figure 3 shows that the level of combined premiums paid by in-force policyholders has increased only modestly in recent years. Lower sales have occurred even as the share of the population in the age group most likely to purchase private LTCI, those age 60 to 69, rose from 9.5% in 2010 to 11.4% in 2018, based on Census population estimates.

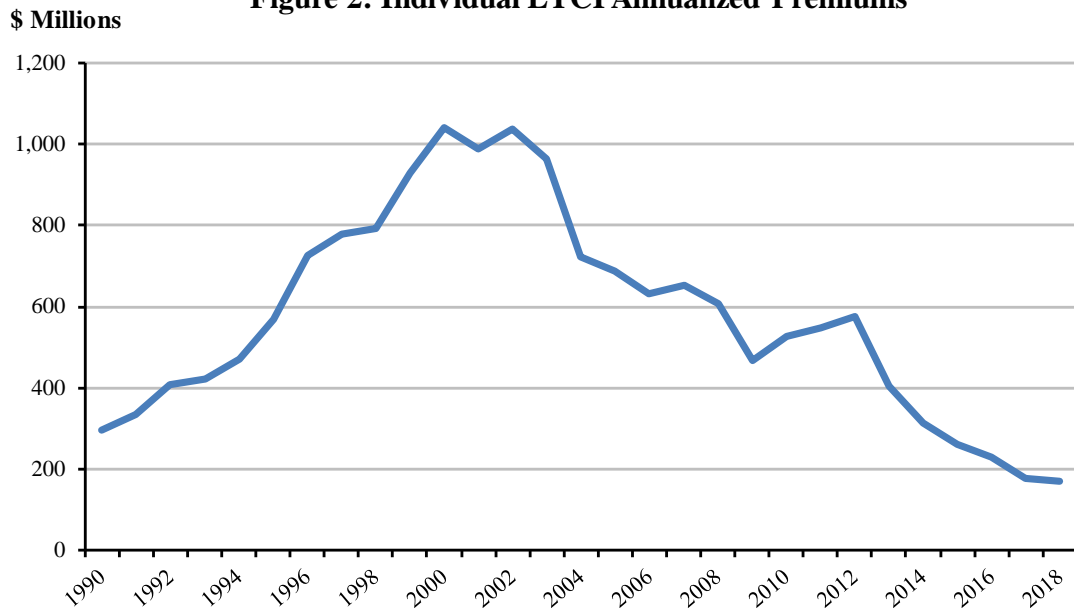
Figure 1: Individual LTCI New Lives



Source: LIMRA.

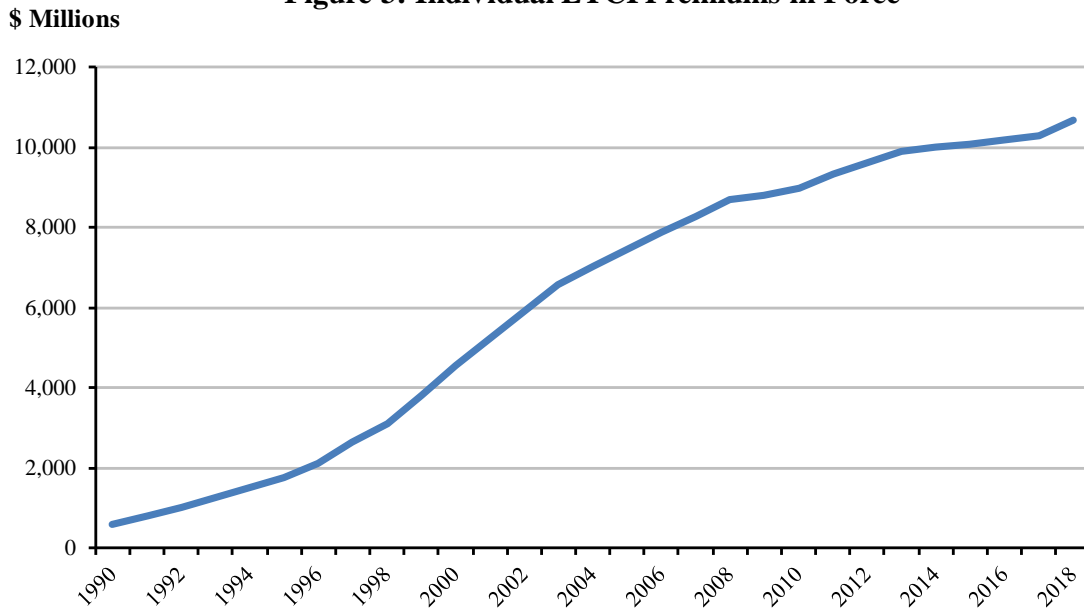
²⁸ The market for employer-sponsored group LTCI has fallen even more precipitously, with annual new lives insured reaching 140,000 in 2012 before declining to 22,000 by 2015. Currently, only one carrier continues to offer employer-sponsored group LTCI. This discussion does not include LTCI products offered to employees through employers at the worksite.

Figure 2: Individual LTCI Annualized Premiums



Source: LIMRA.

Figure 3: Individual LTCI Premiums in Force



Source: LIMRA.

Table 3 shows ownership rates of private LTCI in the 2016 HRS for respondents age 60 and above, by gender, marital status, age, and wealth quintile. Overall, 11.4% of those age 60 and over own a private LTCI policy. Men own policies at a slightly higher rate than women, and married people are more likely to own a policy than are unmarried individuals. Ownership rates

rise by wealth quintile, with around one-fifth of the top quintile having bought policies compared to only 6-7% of the bottom two quintiles. Ownership rates also rise with age, up to age 85.

Additionally, Table 3 updates a 2011 study that reported the same statistics for respondents in the 2008 HRS.²⁹ Compared with 2008, overall ownership rates declined slightly by 2016, from 13.8% in 2008 to 11.4%. The declines from 2008 to 2016 were driven by those age 60 to 69, the group most likely to purchase new LTCI; ownership rates among those age 70 and over rose between 2008 and 2016. This finding is consistent with reports from the industry, as shown in Figures 1-3, that sales are in sharp decline and the number of in-force policies has plateaued.

In summary, older individuals are exposed to financial risk from the consequences of serious disability. This exposure may be increasing over time, as sales of new policies decline and the age 60 to 69 cohort appear to be less likely to purchase LTCI than previous cohorts. The eligibility requirements for Medicaid and the limited and declining purchasing of private LTCI imply that a large proportion of LTC costs are paid for out-of-pocket by individuals not covered by Medicaid.

Table 3: Private Long-Term Care Insurance Ownership Rates Among the Elderly						
	<i>Percentage by Wealth Quintile</i>					
	<i>Whole Sample</i>	<i>Top</i>	<i>Fourth</i>	<i>Third</i>	<i>Second</i>	<i>Bottom</i>
<i>Whole Sample</i>	11.4	21.8	12.7	9.8	6.5	6.1
<i>By Gender</i>						
Men	12.0	23.6	13.4	10.8	6.6	6.7
Women	10.8	20.0	12.0	8.7	6.5	5.3
<i>By Marital Status</i>						
Married	12.7	21.8	12.8	9.3	7.3	6.1
Single	9.5	22.0	12.6	10.6	5.7	6.1
<i>By Age Cohort</i>						
60-64	9.9	18.4	11.6	7.4	5.5	5.4
65-69	13.3	22.9	13.2	10.3	8.1	8.0
70-74	15.1	27.5	12.9	14.5	8.3	5.6
75-79	17.2	29.2	20.9	16.4	7.4	6.4
80-84	18.9	31.3	17.5	18.6	12.3	12.4
85+	16.0	30.2	21.3	10.1	9.0	8.3
Notes: The sample consists of respondents in the 2016 HRS age 60+. The sample size is 13,271. All means are weighted using sample weights for the 2016 wave. Wealth is defined as total non-housing wealth.						

²⁹ Jeffrey R. Brown and Amy Finkelstein, “Insuring Long-Term Care in the United States,” *Journal of Economic Perspectives* 25, no. 4 (Fall 2011): 119-42, available at: <https://www.aeaweb.org/articles?id=10.1257/jep.25.4.119>.

Factors Impeding the Market for Private LTCI

The utilization statistics in Table 2 show that individuals over age 60 face a risk of having to stay a greater number of nights in nursing homes, thereby incurring significant expenses.

Furthermore, nursing homes represent only a part of spending on LTSS; as Table 1 shows, a small but significant share of individuals also use paid home health care or require assistance with two or more ADLs.

Standard economic models suggest that in the presence of potentially severe financial risk, individuals should be willing to pay to insure themselves against that risk. However, private LTCI appears to be underutilized relative to the potential demand and relative to the market for short-term medical insurance. Factors impeding the development of the market can largely be divided into the supply side and the demand side.

Supply-Side Factors

- **Asymmetric information and adverse selection.** Like other insurers, LTC insurers face the challenge of managing their risk pool when individuals purchasing insurance know more about their own risks than the insurer. This asymmetry of information between seller and buyer likely leads to buyers purchasing insurance only when they believe the benefits they will receive outweigh the premiums they will pay. This tilts the market towards buyers with higher average costs, driving up premiums and further limiting the pool of potential buyers.
 - **Underwriting.** LTC insurers manage adverse selection with medical underwriting, i.e., the practice of assessing applicants for policies for medical issues likely to result in future use of LTSS. A 2016 study found that between 2000 and 2009, underwriting standards tightened and the share of applications rejected for failing underwriting rose.³⁰ Another 2016 study found that 20-25% of applicants for private LTCI are ultimately rejected on medical grounds.³¹ More recent data suggests that firms may be starting to relax underwriting standards by reducing requirements for medical testing in the past few years.³²
- **Moral hazard.** Beneficiaries of insurance incur a lower cost for services covered by insurance and, as a result, may use those services more than they would if they did not have insurance--a phenomenon is known as "moral hazard." A 2019 study found evidence of significant moral hazard in the use of home care (and, potentially, nursing

³⁰ LifePlans, Inc., "Tolerating Risk: A Look at LTC Underwriting Strategies," *Behind the Data*, January 2011.

³¹ Portia Y. Cornell et al., "Medical Underwriting in Long-Term Care Insurance: Market Conditions Limit Options for Higher-Risk Consumers," *Health Affairs* 35, no. 8 (August 2016): 1494-1503, available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1133>.

³² Chris Giese, Allen Schmitz, and Claude Thau, "2019 Milliman Long-Term Care Insurance Survey," *Broker World Magazine*, July 2019, available at: <https://brokerworldmag.com/2019-milliman-long-term-care-insurance-survey/>.

homes) among owners of private LTCI.³³ Another study, which surveyed private LTCI claimants, found that the majority reported they would have used less paid care if they had not had insurance.³⁴ Insurers must take moral hazard into account when pricing plans, which may raise premiums above what some purchasers are willing to pay.

The issues of adverse selection and moral hazard are common to all insurance markets and not unique to private LTCI. Other insurance markets, however, have features that address adverse selection, such as a mandate for the purchase of insurance or a subsidy, both of which have the effect of improving the risk pool. For example, automobile owners in all states are required to purchase liability insurance, and employers usually subsidize health insurance they offer to employees.

In addition, management of these supply-side factors can impose significant administrative costs on private LTCI, resulting in low comprehensiveness (share of LTSS spending paid for by private LTCI) and high “loads,” which is a measure of the difference between the expected present discounted value (EPDV) of future benefits received and the EPDV of future premiums paid over the life of the policy.

Demand-Side Factors

- **Use of substitutes for private LTCI**
 - **Medicaid.** As discussed above, Medicaid covers LTSS for individuals with very low income and assets. Therefore, Medicaid pays for some services that would be covered by private LTCI, which reduces the incentive to purchase private LTCI. According to studies conducted by the same authors in 2008 and 2011, for the lower 60% of the wealth distribution, it is rational not to purchase actuarially fair private LTCI because of the availability of Medicaid.³⁵ For example, for a 65-year-old woman at the median of the wealth distribution, 75% of the EPDV of the benefits of a private LTCI policy would be paid for by Medicaid in the absence of the policy, significantly reducing the policy’s net financial benefit. Other papers have maintained that, in practice, the effect of Medicaid may not be as pronounced. A 2018 paper modeled the effects on private LTCI purchase, savings, and nursing home

³³ R. Tamara Konetzka et al., “Moral Hazard and Long-Term Care Insurance,” *The Geneva Papers on Risk and Insurance: Issues and Practice* 44, no. 2 (April 2019): 231-251, available at: <https://link.springer.com/article/10.1057%2Fs41288-018-00119-1>.

³⁴ Marc A. Cohen, Jessica S. Miller, and Xiaomei Shi, “Following an Admissions Cohort: Care Management, Claim Experience and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a 16 Month Period,” *Office of the Assistant Secretary for Planning and Evaluation*, May 2007, available at: <https://aspe.hhs.gov/system/files/pdf/75086/16moclm.pdf>.

³⁵ Jeffrey Brown and Amy Finkelstein, “[The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market](#),” *American Economic Review* 98, no. 3 (June 2008): 1083-1102, available at: <https://www.aeaweb.org/articles?id=10.1257/aer.98.3.1083>; Brown and Finkelstein, “Insuring Long-Term Care,” 119-42.

entry by single elderly women if Medicaid is assumed to be unavailable. The study found that the main effects were increased savings and reduced nursing home entry, with only a small increase in private LTCI purchase.³⁶

- **Unpaid care.** As discussed earlier in this section of the report, the aggregate value of unpaid care is likely higher than the value of paid care. A 2015 study found that the presence of LTCI coverage leads to reduced reliance on informal care, fewer children residing with parents, and a greater likelihood that children will be in the formal labor force.³⁷ These results suggest that the ability to receive informal care from family results in lower demand for private LTCI. Similarly, a 2012 survey found that respondents who reported receiving care from family were less likely to buy private LTCI.³⁸
- **Bequest motives.** Some sellers of private LTCI present the preservation of assets for heirs as a reason to purchase the product. A 2018 study, however, suggested that a desire to leave assets to heirs can suppress demand for private insurance because these motives reduce the negative consequences of postponing consumption in order to save.³⁹
- **Lack of information and awareness.** Two surveys, one published in 2012 and the other in 2015, have studied individuals' awareness of LTC needs and financing.⁴⁰ In general, respondents exhibited low knowledge of LTC costs, ways to finance those costs, and private LTCI. For example, the 2015 survey found that only 20% of respondents correctly estimated the average cost of a month in a nursing home and only 25% correctly identified Medicaid as the government program that pays the most for LTSS. In the 2012 survey, 72% of respondents reported they knew only "a little" about private LTCI, while 29% believed incorrectly that Medicare covered LTSS.
- **Lack of trust in insurers.** The same surveys assessed respondents' level of trust in LTC insurers as low. In the 2015 survey, 32% of respondents agreed with the statement "I do not trust private insurers." In the 2012 survey, 46% of respondents agreed with the statement "I am concerned that an insurance company might deny reasonable claims for

³⁶ Geena Kim, "Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment," *Journal of Human Capital* 12, no. 3 (Fall 2018): 431-474, available at: <https://doi.org/10.1086/698134>.

³⁷ Norma B. Coe, Gopi Shah Goda, and Courtney Harold Van Houtven, "Family Spillovers of Long-Term Care Insurance," *National Bureau of Economic Research*, Working Paper no. w21483 (August 2015), available at: <https://www.nber.org/papers/w21483>.

³⁸ Jeffrey R. Brown, Gopi Shah Goda, and Kathleen McGarry, "Long-Term Care Insurance Demand Limited by Beliefs about Needs, Concerns about Insurers, and Care Available from Family," *Health Affairs* 31, no. 6 (June 2012): 1294-1302, available at: <https://doi.org/10.1377/hlthaff.2011.1307>.

³⁹ Lee M. Lockwood, "Incidental Bequests and the Choice to Self-Insure Late-Life Risks," *American Economic Review* 108, no. 9 (September 2018): 2513-50, available at: <https://www.aeaweb.org/articles?id=10.1257/aer.20141651>.

⁴⁰ Brown, Goda, and McGarry, "Long-Term Care Insurance Demand," 1294-1302; "Findings from the Survey of Long-Term Care Awareness and Planning," Office of the Assistant Secretary for Planning and Evaluation, July 2015, available at: <https://aspe.hhs.gov/system/files/pdf/110366/SLTCAPrb.pdf>.

long-term care,” while 58% of respondents expressed concern that their premiums would increase. In addition, policyholders in recent years have experienced a number of unexpected premium rate increases, and this history is likely an impediment to growing the market for private LTCI.

- **Premiums, costs and loads.** Lower demand for LTCI is likely attributable in part to the high level of premiums charged under new LTCI policies compared to older designs.⁴¹ Premiums vary widely and are based on multiple factors, including the insured’s age, gender, and health, the period of coverage selected, the elimination period, and the premium for optional riders. The administrative costs and high loads of private LTCI also play a role in limiting demand.⁴² For additional information on LTCI pricing, see the “Premium Increases on LTCI” box in the Regulatory Efficiency and Alignment section of this report.

⁴¹ A recent report estimates that in 2019 the average individual LTCI policyholder paid \$3,036 during the first year of coverage, 2% more than in 2018. LIMRA, *U.S. Individual Long-Term Care Insurance (Annual Review 2019)*, 3.

⁴² The 2012 survey reported that, in response to open-ended questions, the most common reason cited for not purchasing private LTCI was the cost. The authors noted, however, that this answer does not distinguish among potential inhibitors such as lack of actuarial fairness, administrative costs, and affordability of premiums.

Innovation and Product Development

In response to the decline of LTCI in the traditional market, insurers have introduced alternative product designs and new features to both increase the consumer appeal of LTCI and improve financial returns on this product line for insurers. In addition, insurers and industry experts have researched and proposed new designs and features that have not been introduced in the market for several reasons, including regulatory considerations and uncertain demand from consumers and insurance distributors. This section of the report describes several innovations that have generated activity and attracted attention from insurers, consumers, regulators, and other stakeholders.

Recommendation: Overall, the Task Force believes that innovation and product development have the potential to significantly strengthen the private LTCI market and better address the LTC needs of consumers.⁴³ Accordingly, the Task Force recommends that federal and state policymakers and regulators foster a regulatory environment that encourages flexibility, experimentation, and innovation in product design to improve consumer choice and access to benefits, while appropriately protecting the rights of consumers and the solvency of insurers.

Combination Products

Insurers have introduced a variety of products that combine LTCI with other types of insurance. One popular “combination” or “hybrid” product combines a life insurance policy with a rider that accelerates payment of the death benefit for qualifying “chronic illness” (as defined under federal tax law) needs.⁴⁴ Another common design features a life insurance policy that accelerates the death benefit for qualifying LTC needs. These accelerated chronic illness or accelerated LTC riders limit the payout to 100% of the death benefit amount. Insurers also offer life insurance policies with extension of benefits riders that allow payouts higher than the death benefit.⁴⁵ Finally, some insurers offer deferred annuity contracts with LTC riders that also allow payouts exceeding the death benefit.

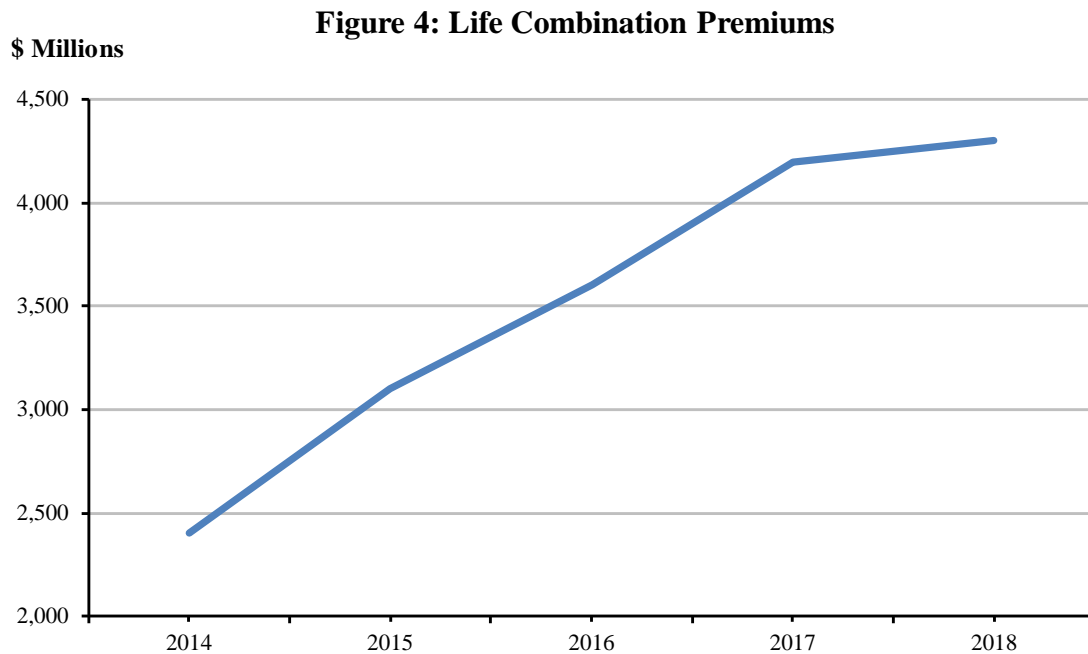
Figures 4-6 present data for combination products during the five years from 2014 to 2018. Life combination products generated \$4.3 billion in premiums in 2018, which is 2% lower than in

⁴³ The NAIC has studied and commented on the important role of innovation in LTC financing. For example, a 2016 study by the NAIC’s research arm aimed to stimulate debate to support innovation and the future development of LTC. See National Association of Insurance Commissioners and the Center for Insurance and Policy Research, *The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations*, ed. by Eric C. Nordman (Kansas City: NAIC and the Center for Insurance Policy and Research), May 2016, available at: https://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf. As another example, the NAIC 2017 List was produced by the NAIC’s Long Term Care Innovations (B) Subgroup.

⁴⁴ Chronic illness riders may have triggers identical to traditional LTCI (i.e., severe cognitive impairment or inability to perform two ADLs), but they are regulated differently for federal tax law and state law purposes, and cannot be marketed as LTCI.

⁴⁵ Stakeholders indicated that some EOB riders pay up to two or three times higher than the death benefit amount.

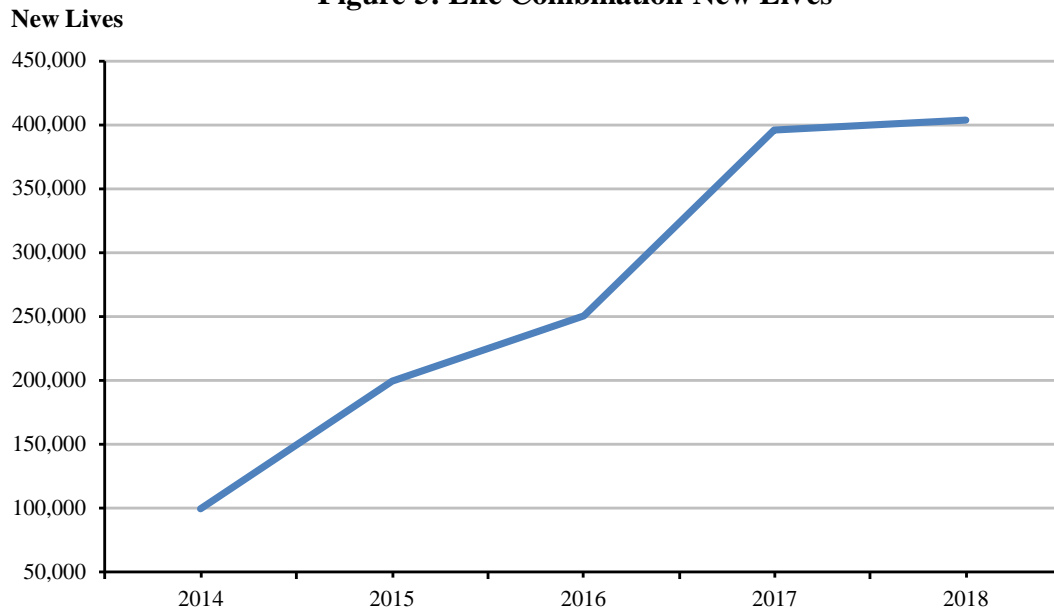
2017 but almost 80% higher than \$2.4 billion in premiums in 2014. New policy counts increased 2% year-over-year in 2018, with over 400,000 policies sold, a fourfold increase compared to the number of new policies sold in 2014. Measured by new lives insured, life combination products constituted more than 87% of the market for individual LTCI solutions in 2018.⁴⁶ Annuity combination sales reached \$575 million in 2018, 4.5% higher than the prior year, while the number of contracts sold grew from 4,940 to 5,130, or 4%.



Source: LIMRA.

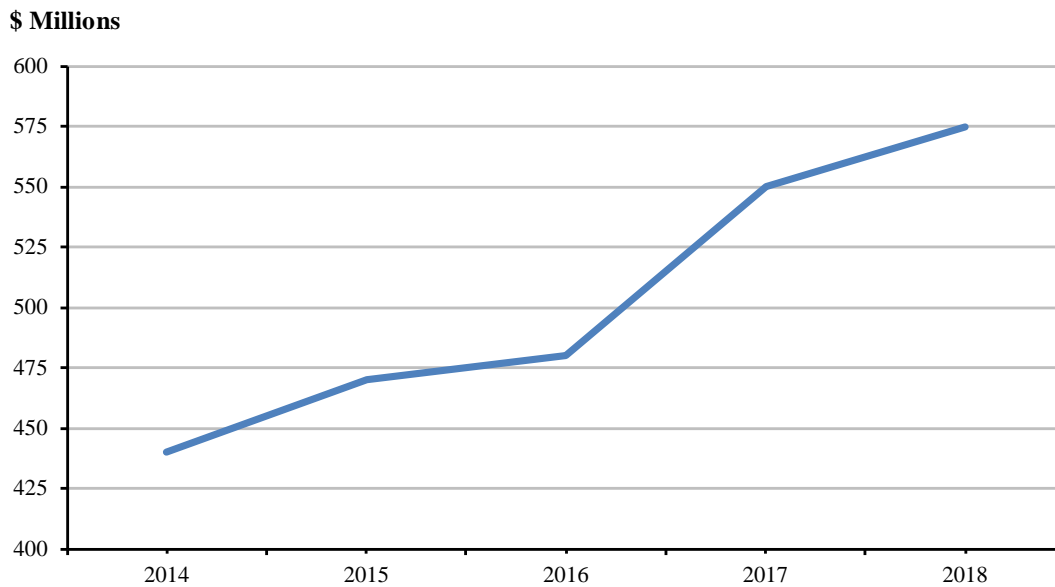
⁴⁶ Source: LIMRA.

Figure 5: Life Combination New Lives



Source: LIMRA.

Figure 6 : Annuity Combination Premiums



Source: LIMRA.

Combination products offer potential advantages from the consumer perspective, particularly for those consumers who are deterred by the “use or lose” aspect of stand-alone LTCI policies. The underlying life insurance policy builds cash value and provides a death benefit even if the policyholder does not make a claim for LTCI expenses. The ability to combine different coverages into a single policy, with one purchasing decision instead of two or more, appeals to

some consumers. In addition, consumers may perceive that premiums for stand-alone LTCI, or for both a life insurance policy and a stand-alone LTCI policy, are too expensive and that a combination product is more affordable.⁴⁷

On the other hand, navigating the market for combination products can be challenging for both consumers and distributors. Because these products differ from each other in their basic designs (accelerated benefits, extension of benefits, and either a life insurance or an annuity chassis), pricing, and features, selecting an appropriate solution to an individual's particular needs can be highly complex. For this reason, the quality of consumer information and education, the clarity of marketing materials, and the training of insurance producers are important attributes in the market.

From the insurers' perspective, combination products are less risky than LTC stand-alone products.⁴⁸ According to a 2017 survey of 11 insurers in the LTCI market, the incidence of claims and other actuarial results with respect to combination products have been positive for insurers.⁴⁹ Given their consumer appeal, lower risk profile, and favorable actuarial experience, combination products are likely to continue growing in variety and volume (although cost may limit their upside potential).⁵⁰

Recommendation: Policymakers could benefit from analysis of the impact of combination products on the market for LTC risk protection. To the extent that combination products are attracting purchasers who would otherwise buy stand-alone products, they are not necessarily expanding overall LTCI coverage. However, if combination products are attracting consumers who would not otherwise buy LTC protection, on balance they likely are increasing coverage. The Task Force recommends that actuaries, academics, and other stakeholders explore such an analysis, with coordination by FIO.

⁴⁷ Comparative pricing between combination products and stand-alone LTCI is not straightforward because the products provide different coverages with different features and payment structures. For a comparison of premiums and benefits under life combination products, annuity combination products, and stand-alone LTCI at issue ages 50 and 65, see Carl Friedrich et al., "Unlocking Potential – New Combination Long-Term Care Insurance Solutions Show Promise," *Contingencies Magazine*, May/June 2019, Figures 2 and 3, available at: <http://contingencies.org/unlocking-potential-new-combination-long-term-care-insurance-solutions-show-promise/>.

⁴⁸ See "Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long Term-Care Insurance," Milliman, March 2012, available at: <https://www.soa.org/globalassets/assets/files/research/projects/research-2012-03-quant-nat-hedge-report.pdf>.

⁴⁹ Friedrich et al, "Unlocking Potential."

⁵⁰ Earlier versions of life combination products were largely funded by single premiums, requiring large up-front payments compared to a recurring premium design. A 2018 LIMRA market overview found that in 2017, the average single premium for a life combination product with an extension of benefits rider was \$91,000, well beyond the price range of the middle market (households with annual income of \$35,000 to \$99,999). However, the overview noted that newer recurring premium policies offer more affordable premiums, and that life combination products with chronic illness or LTC acceleration riders can be less expensive.

Other New Product Designs

“Morphing” Policies

Innovation and experimentation in the LTCI market extend beyond combination products. The NAIC 2017 List included allowing products that begin as life insurance (or other type of coverage, such as disability or chronic illness) and later automatically convert (“morph”) into LTCI at a pre-determined date, such as after the policyholder reaches a certain age. In addition, the Society of Actuaries (SOA) has developed a product concept it refers to as “LifeStage Protection,” an insurance policy that starts as term life insurance during prime income-earning years and switches to LTCI in later years.⁵¹

The Task Force is not aware of any insurers that have developed and launched a morphing product such as LifeStage Protection. The level of potential demand from consumers and insurance distributors is uncertain, and it is possible that insurers are hesitant to incur the expense of fully developing this type of product due to uncertainty regarding its regulatory treatment under state law.⁵² At the same time, state regulators may be reluctant to define precisely how they would treat the product if they do not have access to product specifications or a policy form.⁵³

Limited LTCI

“Short” or “limited” LTCI policies have attracted attention from some insurers and consumers as a lower-cost alternative to traditional products. This interest is reflected in the NAIC 2017 List, which includes the option of “allowing shorter maximum benefit plans (<1 year) to be tax qualified to incent market expansion through lower-price, shorter duration policies.” Unlike traditional LTCI, which must provide coverage for a period of not less than 12 consecutive months, limited LTCI typically stops providing coverage after one year from the commencement of benefit payments.⁵⁴

⁵¹ “Society of Actuaries Drives Innovation in the Long-Term Care Market; Conceptualizes New, Low-Risk Products That Could Help Ease Industry Challenges,” Society of Actuaries, July 2018, available at: <https://www.soa.org/globalassets/assets/files/resources/research-report/2018/ltc-market-fact-sheet.pdf>; see also Treasury, “Public Comments,” Society of Actuaries.

⁵² State law uncertainty derives from the absence of product specifications and policy forms tailored to this new product concept. At the federal level, the Task Force did not identify any federal income tax barriers to the morphing product concept.

⁵³ Several states have demonstrated openness to considering innovative product designs. For example, the state of Minnesota has been directly involved in developing LifeStage Protection and has stated that “there appear to be pathways available to overcome potential regulatory hurdles.” See “LifeStage Protection Product Final Report,” Minnesota Department of Human Services, December 2018, available at: <https://mn.gov/dhs/assets/LifeStage-protection-product%E2%80%93373463.pdf>.

⁵⁴ Under the NAIC’s LTCI Model Act, a policy does not meet the definition of “long-term care insurance” unless it provides coverage for not less than 12 consecutive months for each person covered. National Association of Insurance Commissioners, *Long-Term Care Insurance Model Act* (Kansas City: NAIC, Quarter 1 2017), Section 4.A, available at: <https://www.naic.org/store/free/MDL-640.pdf?10>.

Although metrics for this market are not widely published, one insurance association estimates that:

- Almost half (49%) of traditional LTCI claims last one year or less;
- The typical limited LTCI policy provides coverage for one year or less;
- The majority of limited policies have no deductible or elimination period, while about 94% of traditional policies feature a 90-day waiting period before benefits can be paid;
- Most applications for limited policies have seven to ten health questions with no additional underwriting requirements;
- The typical buyer of limited LTCI is between the ages of 65 and 74 and has a net worth of less than \$500,000;
- A typical premium at age 65 is \$105 monthly; and
- Typical benefit amounts are \$100, \$150, or \$200 per day.⁵⁵

Based on these estimates, limited LTCI may be an alternative to traditional policies for individuals who cannot afford the higher premiums charged for traditional products. However, consumer representatives note that limited LTCI policies may not pay for coverage outside of nursing homes, such as assisted living or home care, and likely do not provide adequate protection against a catastrophic LTCI event.⁵⁶ In addition, some insurers and insurance regulators have expressed concerns that the labels “short long-term care” or “limited long-term care” are counter-intuitive and inherently confusing for consumers, and that policies with shorter benefit periods are susceptible to misunderstanding and inappropriate marketing practices.⁵⁷

In late 2018, the NAIC adopted the Limited Long-Term Care Insurance Model Act and the Limited Long-Term Insurance Model Regulation.⁵⁸ In general, these models track those for traditional LTCI, with adjustments to reflect a benefit period of less than twelve months. In particular, the models contain substantially the same consumer protections as their traditional

⁵⁵ “National Advisory Center for Short-Term Care Information,” American Association for Long-Term Care Insurance, last accessed February 2020, available at: <https://www.aaltci.org/short-term-care-insurance/>.

⁵⁶ Ellen Stark, “Long-Term-Care Insurance Gets a Makeover,” *Consumer Reports*, August 2017, available at: <https://www.consumerreports.org/long-term-care-insurance/long-term-care-insurance-gets-a-makeover/>; Eleanor Laise, “Short-Term-Care Insurance Policies on the Rise,” *Kiplinger*, October 2015, available at: <https://www.kiplinger.com/article/insurance/T027-C000-S004-short-term-care-insurance-policies-on-the-rise.html>.

⁵⁷ Allison Bell, “Short-Term Care Insurance Faces a Name Fight,” *ThinkAdvisor*, May 2018, available at: <https://www.thinkadvisor.com/2018/05/30/short-term-care-insurance-faces-a-name-fight/?kw=%27Short-Term%20Care%20Insurance%27%20Faces%20a%20Name%20Fight&et=editorial&bu=TA&cn=20180530&src=EMC-Email&pt=LifeHealthNewsFlash>.

⁵⁸ National Association of Insurance Commissioners, *Limited Long-Term Care Insurance Model Act* (Kansas City: NAIC, Quarter 4 2018), available at: <https://www.naic.org/store/free/MDL-642.pdf>; National Association of Insurance Commissioners, *Limited Long-Term Care Insurance Model Regulation* (Kansas City: NAIC, Quarter 4 2018), available at: <https://www.naic.org/store/free/MDL-643.pdf>.

counterparts, except that insurers must offer inflation protection at a 3% annual compound rate instead of a 5% annual compound rate. However, the states generally have not yet adopted either model.⁵⁹

Recommendation: The Task Force recommends that federal policymakers work with their state counterparts and with private sector stakeholders to evaluate and monitor the market for limited LTCI, including potential impacts on the risk pool for longer-term products and on Medicaid. The Task Force further recommends that state legislators and insurance regulators take steps to better streamline and standardize the regulation of this market.

Group Products

The Task Force considered two policy proposals for LTCI group products that were included under the NAIC 2017 List, both involving the fiduciary provisions of ERISA. ERISA safeguards the participants and beneficiaries of employee benefit plans by imposing standards of care and loyalty on plan fiduciaries, and by holding fiduciaries accountable when they breach those obligations. ERISA does not require any employer to establish a plan, but does require those who establish plans to meet certain standards.

One policy proposal is to create a safe harbor to remove potential exposure to ERISA fiduciary liability as a factor in employers' decisions not to offer LTCI to employees, including offering it on an automatic enrollment or "opt-out" basis. A second policy proposal is to permit 401(k) and IRA participants to purchase LTCI within their accounts ("Retirement Plus"). The objective of both proposals is to promote a more viable group LTCI market by increasing employee participation, resulting in a larger and more favorable risk pool for insurers and, potentially, lower premiums.

Recommendation: Based on stakeholder input and an assessment of the market and legal landscapes, the Task Force questions whether either proposal would have a meaningful impact on participation levels. Accordingly, the Task Force does not recommend either proposal.

In general, while automatic enrollment has increased employees' participation in 401(k) plans,⁶⁰ the effect may not be the same with respect to LTCI. Low take-up rates for LTCI appear to stem at least in part from low demand for these products, as reflected in some stakeholders' comments to the Task Force. Currently, employees generally must affirmatively enroll or "opt-in" to LTCI and shoulder the entire premium cost without favorable tax treatment. According to the U.S.

⁵⁹ Utah adopted the Limited Long-Term Insurance Model Act in April 2020. Utah Code Ann. §§ 31A-22-2001-2006.

⁶⁰ See Brigitte C. Madrian and Dennis F. Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," *The Quarterly Journal of Economics* 116, no. 4 (November 2001): 1149-1187, available at: https://www.ssc.wisc.edu/~scholz/Teaching_742/Madrian_Shea.pdf.

Bureau of Labor Statistics, 17% of civilian employees had access to LTCI in 2019.⁶¹ Employee take-up rates are typically between 5% and 7% based on a report from the NAIC and the Center for Insurance Policy and Research in 2016.⁶²

Without higher demand for LTCI on the part of employees, the Task Force does not expect employers to choose to provide LTCI as part of their compensation package. The Task Force considers it unlikely that employers would default a percentage of their workers' payroll towards contributions for LTCI premiums, regardless of a fiduciary safe harbor. Similarly, with respect to the purchase of LTCI as a 401(k) plan "investment" option, the Task Force questions whether employers or workers would be willing to increase their contributions to the plan to fund LTCI premiums or replace current contributions to retirement savings with LTCI premium payments.

In addition to considerations of employee demand, 401(k) plans and LTCI impose different obligations on plan sponsors, as discussed below.

Fiduciary Safe Harbor

The NAIC 2017 List suggests "addressing concerns that may prevent an employer from providing LTCI on an opt-out basis by providing a safe harbor to limit the employer's fiduciary liability."⁶³ The Task Force recognizes both employers' concerns and the power of automatic enrollment to promote participation in many contexts, but generally considers it unlikely that this proposal would promote a significant increase in demand for LTCI.

As an initial matter, the proposal is premised on the possibility that potential exposure to ERISA fiduciary liability may be a significant factor in employers' decisions not to offer LTCI, especially with respect to opt-out arrangements where the employee is not making an affirmative choice to participate. Similar concerns about long-term fiduciary liability exposure for selection of the insurance provider have been cited as an obstacle to employers offering annuities in 401(k) plans, but efforts to address the issue in that context to date have not had a significant effect on availability or use of annuity options in 401(k) plans.⁶⁴

⁶¹ "Table 41. "Health-related Benefits: Access, Civilian Workers, March 2019," Bureau of Labor Statistics, available at: <https://www.bls.gov/ncs/ebs/benefits/2019/ownership/civilian/table41a.pdf>.

⁶² NAIC and CIPR, *State of Long-Term Care Insurance*, 10.

⁶³ The NAIC 2017 list additionally proposes expanding "catch-up" contributions to retirement plans and allowing LTCI purchases through a cafeteria plan. These are primarily tax-related rather than ERISA-related proposals, and as such are addressed in the Tax Incentives section of this report.

⁶⁴ In 2008, DOL issued a rule that provides plan fiduciaries with the steps they should take when selecting annuities in such cases. In 2015, DOL publicly emphasized that, under this rule, a fiduciary decision is evaluated based on the information available at the time the decision was made, and not on subsequent events (e.g., an insurer's subsequent failure, which was not foreseeable at the time of the decision). See 29 CFR § 2550.404a-4; "Field Assistance Bulletin No. 2015-02," Employee Benefits Security Administration, July 13, 2015, available at: <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2015-02>. This rule and guidance, however, are generally perceived to have stopped short of fulfilling employers' wishes for bright-line safe harbor criteria. Congress responded to these concerns in the *Setting Every Community Up for Retirement and*

In circumstances where workplace LTCI is not covered by ERISA, a fiduciary safe harbor would be of no consequence. ERISA includes a statutory enumeration of classes of benefits it covers, including retirement, medical benefits, and benefits in the event of sickness or disability, but does not explicitly include LTCI benefits.⁶⁵ Therefore, whether LTCI constitutes an ERISA-covered benefit depends, in part, on whether particular LTCI benefits fall within the scope of one of the listed classes of benefits. Further, the statutory definition covers enumerated benefits only when they are offered as part of a covered “employee benefit plan,” which requires a certain level of involvement by the employer. A DOL regulation provides conditions under which voluntary arrangements funded entirely with employee contributions are not treated as ERISA-covered employee benefit plans.⁶⁶

Potential conflicts with state wage payment laws pose a challenge to mandating auto-enrollment. DOL has taken the position that ERISA generally preempts state laws that limit, prohibit, or regulate an employer’s adoption of automatic enrollment arrangements in connection with an ERISA-covered plan, or from making related deductions from employee wages for contributions to such a plan.⁶⁷

Finally, the success of an existing statutory safe harbor for 401(k) default investments may not provide evidence for the likely success of a safe harbor for LTCI.⁶⁸ As described below, there are three important differences between this 401(k) precedent and a potential safe harbor for LTCI.

First, the current 401(k) safe harbor for default investments is narrower than the contemplated LTCI safe harbor insofar as it addresses only the selection of the broad types of investments

Enhancement Act of 2019 (SECURE Act). Section 204 of the SECURE Act amended ERISA to provide a statutory safe harbor for complying with ERISA’s prudent person standard of care for the selection of an insurer to provide a guaranteed retirement income contract. There is no data yet available on whether this statutory version of a fiduciary safe harbor will materially affect employers’ decisions to offer annuity options in 401(k) plans or employee use of such options.

⁶⁵ See U.S. House, *H.R.2 – Employee Retirement Income Security Act* (Washington: 93rd Congress, 1974), Sections 3(1) and 3(2).

⁶⁶ These types of voluntary group and group-type insurance programs are not treated as ERISA plans if the employer merely offers such insurance for employee purchase by payroll deduction and neither endorses nor helps pay for the insurance. See 29 CFR 2510.3-1(j).

⁶⁷ While ERISA generally does not preempt state criminal laws of general application, it generally does preempt state civil laws that otherwise would interfere with automatic enrollment in ERISA-covered welfare plans. For a fuller discussion of this topic, see “Information Letter 12-4-2018,” Employee Benefits Security Administration, December 2018, available at: <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/information-letters/12-4-2018>.

⁶⁸ A 2006 federal pension law amended ERISA and the Code to add a fiduciary safe harbor and other provisions to facilitate automatic enrollment in, and automatic payroll withholding contributions to, 401(k)-type plans. U.S. House, *H.R.4 – Pension Protection Act of 2006* (Washington: 109th Congress, 2006); U.S. House, *ERISA*, Section 514(e). That law addressed two obstacles to automatic 401(k) plans: fiduciary concern about the selection of default investments and state wage payment laws. The 2006 law charged DOL with issuing a fiduciary safe harbor for qualified default investments, and preempted state wage payment laws for plans that operate within the safe harbor.

(generally, a diversified mix of stocks and bonds) available under the plan.⁶⁹ Default options are also easier for plan sponsors to implement for 401(k) plans than for LTCI. Employers who offer LTCI have to consider whether, or under what circumstances, automatic enrollment in LTCI would be appropriate for their workforce in light of variation in employees' circumstances and needs.

Second, the current 401(k) safe harbor bears less weight than its potential LTCI counterpart because 401(k) participants can more easily shift out of default investments, while LTCI participants are more constrained.

Third, as noted above, it is unclear how many of these LTCI arrangements would be covered by ERISA. For these reasons, while the 401(k) fiduciary safe harbor is generally regarded as a success in increasing participation in 401(k) plans, an LTCI safe harbor would likely be less effective.

In summary, even if Congress or DOL could craft an appropriate fiduciary safe harbor, there remains substantial doubt regarding whether it would materially expand the demand for LTCI. Demand is low in the marketplace and it is unclear whether concern for fiduciary liability is an important driver in employers' decisions on LTCI. The lack of employer and employee demand, as reflected in some stakeholders' comments to the Task Force, also would likely continue to discourage employers from deciding to auto-enroll employees (and direct a portion of their pay) into LTCI.⁷⁰

Retirement Plus

The SOA, in its comment letter to the Task Force, references its "Retirement Plus" proposal.⁷¹ The proposal would make LTCI available as an option within a 401(k) or IRA, with premiums deducted directly from the account balance. However, the Task Force notes that adding LTCI as a 401(k) "investment" option would likely require changes to current law.

ERISA generally classifies plans as providing either retirement or welfare benefits, and includes separate provisions tailored for each. ERISA's fiduciary provisions applicable to 401(k) accounts generally speak to the "investment" of "assets" in the account. If ERISA were amended to facilitate LTCI within a 401(k) plan, employers still might be reluctant to offer this feature, fearing fiduciary liability.

⁶⁹ The current 401(k) safe harbor does not address the evaluation of insurers' claims-paying capability, the amount of premiums, or the appropriateness of alternative insurance policy provisions.

⁷⁰ For example, some stakeholders expressed that employers are disinclined to offer LTCI benefits because they face more pressing issues, such as compliance with health care laws. Stakeholders further cited wariness of financial products stemming from the 2007-2009 recession as a factor in the low demand for LTCI.

⁷¹ Treasury, "Public Comments," Society of Actuaries.

Incidental Benefits

Under most LTCI policies, the insured is not eligible to submit a claim for benefits until he or she becomes “chronically ill” as defined under state insurance laws and the Code. Policies typically define chronic illness as severe cognitive impairment or the inability to perform without substantial assistance at least two ADLs. In order for an LTCI policy to qualify for favorable tax treatment under the Code, it must condition the payment of benefits upon certification by a licensed health care practitioner that the insured is chronically ill.⁷²

Some stakeholders proposed that Congress should amend the Code to permit payment of incidental benefits from a LTCI policy prior to the onset of chronic illness, without causing the policy to forfeit its tax-qualified status. These benefits could include limited provision of evidence-based, cost-effective incidental benefits that would reduce the likelihood of someone at higher than average risk of becoming chronically ill. For example, a LTCI policy could pay for home assessments or modifications to identify and mitigate fall risks or other safety hazards to mobility- or vision-impaired individuals. In addition, incidental benefits might include caregiver training for non-professional caregivers, including family, or sharing information regarding local LTC providers to policyholders who need or anticipate needing assistance to remain in their homes. The rationale for this proposal is that permitting these types of benefits would support healthy, independent living and aging in place.

Recommendation: Supporting the ability of those potentially needing LTC to remain in their homes could benefit both consumers and insurers. Accordingly, the Task Force encourages industry, federal policymakers, and other experts, in consultation with consumer representatives, to identify and assess evidence of cost-effective interventions. Depending on the results of the analysis, Congress could consider amending the Code to permit payment of evidence-based, cost-effective incidental benefits under a tax-qualified LTCI contract prior to the insured becoming chronically ill, subject to a monetary cap and other conditions set by regulation.

⁷² 26 U.S.C. §7702B(c)(2).

Regulatory Efficiency and Alignment

The Task Force considered various recommendations to improve the efficiency and effectiveness of regulation of LTCI at the federal and state levels, including options under the NAIC 2017 List. This section discusses proposed regulatory reforms in the areas of inflation protection, other consumer protections, and the review and approval of premium increases on LTCI policies.

Inflation Protection

An LTCI policy is, by definition, a long-term financial obligation of the insurer that issues the policy.⁷³ Although the period between issuance of the policy and a claim for benefits will vary widely by policyholder, that period can exceed 20 years or more. Accordingly, consumers face a significant risk that inflation will erode the value of their benefits over time.

Recognizing this risk, the NAIC included inflation protection as a core consumer safeguard when it adopted the LTCI Model Regulation in 1988. Under the LTCI Model Regulation, insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature that increases benefit levels at an annual compounded rate not less than 5%. Insurers must also provide a graphic comparison between the benefit levels of a policy that increases benefits over a period of at least 20 years and a policy that does not increase benefits. The LTCI Model Regulation further requires insurers to include inflation protection in the policy unless the policyholder rejects it in writing.⁷⁴

Inflation protection is also required under two federal statutes addressing LTCI: HIPAA and the DRA. These statutes address two different subjects—tax qualification under HIPAA, and a federal-state partnership program under the DRA—and their inflation protections operate differently. The Task Force concludes that the efficiency and effectiveness of both statutes can be improved, as detailed below.

Inflation Protection for Tax-Qualified LTCI Policies Under HIPAA

As part of enacting HIPAA in 1996, Congress amended the Code to add Section 7702B, which sets requirements that an LTCI policy must meet in order to be “qualified” LTCI for purposes of the itemized expense deduction and certain other Code purposes. Among these requirements is compliance with consumer protections contained in specified sections of the 1993 versions of the

⁷³ Under the LTCI Model Act, a “long-term care insurance” policy must provide coverage for not less than 12 consecutive months for each person covered. NAIC, *LTCI Model Act*, Section 4.A. However, according to the American Association for Long-Term Care Insurance, the average time elapsed between purchase of a LTCI policy and eligibility for benefits is 13.4 years. “Long-Term Care Insurance Facts – Data – Statistics – 2019 Report,” American Association for Long-Term Care Insurance, last modified October 2019, Figure 13, available at: <https://www.aaltci.org/long-term-care-insurance/learning-center/lcfacts-2019.php#2019claims2>.

⁷⁴ National Association of Insurance Commissioners, *Long-Term Care Insurance Model Regulation* (Kansas City: NAIC, Quarter 1 2017), Section 13, available at: <https://www.naic.org/store/free/MDL-641.pdf>.

LTCI Model Act and LTCI Model Regulation, including the provision in the LTCI Model Regulation requiring insurers to offer 5% annual compound inflation (ACI) protection.⁷⁵ Accordingly, although HIPAA does not directly impose a requirement to offer ACI protection, it accomplishes the same result by reference to the LTCI Model Regulation.

Because almost all currently sold LTCI policies are tax-qualified under HIPAA, the requirement to offer 5% ACI protection is effectively universal.⁷⁶ For every sale, the insurer or producer must explain and graphically illustrate a benefit feature that is misaligned with actual economic conditions and that very few consumers accept.⁷⁷ The benefit is costly, potentially increasing premiums by four or five times over a policy with no inflation protection.⁷⁸ For these reasons, the Task Force concludes that inflation protection requirements under HIPAA and state insurance laws should be revised to increase the efficiency and effectiveness of regulation. At the same time, the Task Force believes that inflation continues to represent a risk to consumers and, accordingly, policymakers should revise the current 5% ACI standard rather than eliminate the offer of inflation protection.⁷⁹

Unless Congress changes the existing statutory structure, with its intertwining of HIPAA and the NAIC models, revising the inflation protection standard is dependent upon both (1) the NAIC amending the LTCI Model Regulation to set a different standard, and (2) Congressional legislation amending HIPAA to define the “model regulation” by reference to the updated model.⁸⁰ Finally, even if Congress and the NAIC did so, the revised standard would itself likely become outdated and uncorrelated with economic conditions.

Recommendation: To both address the outdated inflation requirement and to provide flexibility to adapt inflation protection to evolving economic conditions, the Task Force recommends that Congress amend the Code to authorize Treasury to set inflation protections for tax-qualified

⁷⁵ For purposes of these consumer protections, the Code defines the LTCI Model Regulation and LTCI Model Act as “the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the [NAIC] (as adopted as of January 1993).” 26 U.S.C. § 7702B(g)(2)(B)(i).

⁷⁶ Giese, Schmitz, and Thau, “Milliman Survey,” 17.

⁷⁷ Over time, and particularly in the prevailing interest rate environment following the financial crisis, this 5% standard has become an anachronism, with inflation in recent years running significantly lower than 20 years ago when the NAIC and (by reference) Congress set the ACI at 5%. See Treasury, “Public Comments,” American Academy of Actuaries. Consumers have reacted to this change by increasingly rejecting the initial offer of 5% ACI because of the higher premium costs associated with this level of protection. According to one survey, in 2018 only 2% of LTCI sales included 5% ACI protection, compared to 56% in 2003 and more than 47% each year from 2006 to 2008. Giese, Schmitz, and Thau, “Milliman Survey,” 11-13.

⁷⁸ Treasury, “Public Comments,” American Academy of Actuaries.

⁷⁹ Some stakeholders suggested that inflation in the cost of LTSS might be a more appropriate HIPAA benchmark than a fixed percentage or the rate of inflation in the general economy. For estimates of increases in the cost of various categories of LTSS from 2018 to 2019, see “Genworth Cost of Care Survey 2019: Summary and Methodology,” Genworth Financial, Inc., last modified October 2019, available at: <https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf>.

⁸⁰ In addition, even if the NAIC and Congress took these two steps, state insurance laws and regulations would continue to require the 5% ACI offer until the states conformed those laws and regulations to the revised model.

LTCI. With this authority, Treasury and Congress could coordinate with the NAIC and the states to implement changes in inflation protection through the regulatory process without the necessity of additional Congressional legislation.

Inflation Protection for the Partnership Program Under the DRA

In the early 1990s, four states—California, Connecticut, Indiana, and New York—implemented the Partnership program. The program aims to lower federal LTC costs by encouraging individuals who might otherwise “spend down” their assets (in order to qualify for Medicaid) to rely instead on a LTCI policy. For every dollar of coverage paid by a Partnership policy, the policyholder may disregard one dollar of the asset amount necessary to become eligible for Medicaid LTC benefits.⁸¹

The DRA opened the Partnership program to all states, subject to specified conditions including inflation protection and other consumer protections.⁸² The DRA inflation protection rules differ from those under HIPAA in three significant ways: (1) under the DRA, inflation protection must be not only offered, but also included in the policy; (2) the DRA links inflation protection to three age tiers;⁸³ and (3) the DRA does not specify the amount of inflation protection required, leaving that issue to the states.

Based on Treasury staff research, states that have adopted the Partnership program vary widely in their inflation protection requirements.⁸⁴ This lack of uniformity has created a regulatory patchwork with uneven consumer protection standards and additional complexity that makes it more difficult to write LTCI. Additionally, high inflation protection requirements may raise costs and reduce the attractiveness of Partnership policies. For example, insurers sell almost no Partnership policies in California, a populous state that requires 5% inflation protection. Although multiple factors can affect sales volume in a given state, the effect of 5% compound inflation on pricing is significant.⁸⁵

⁸¹ See generally “Long-Term Care Partnership Expansion: A New Opportunity for States,” Center for Health Care Strategies, Inc., last modified May 2007, available at: https://www.chcs.org/media/Long-Term_Care_Partnership_Expansion.pdf; “Long Term Care Insurance Partnership Plans,” American Association for Long-Term Care Insurance, last accessed February 2020, available at: <https://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php>.

⁸² 42 U.S.C. § 1396p.

⁸³ The DRA requires the policy to provide ACI protection for individuals under age 61, “some level” of inflation protection for individuals between ages 61 and 75, and no inflation protection for individuals age 76 and over (although inflation protection may be included). 42 U.S.C. § 1396p(b)(1)(C)(iii)(IV).

⁸⁴ Four require no less than 5%; 17 require no less than 3%; six require no less than 1%; three have other formulas; and 17 do not specify a level of inflation protection. Approximately 25 states link the level of protection to either a stated percentage or changes in the Consumer Price Index. As an example of additional variations, some states specifically prohibit guaranteed purchase options as a means of meeting inflation protection requirements, others are silent, and a smaller number specifically allow guaranteed purchase options.

⁸⁵ According to one estimate, in early 2019 a typical Partnership policy for a 57-year-old couple in California costs \$15,099 per year with 5% compound protection compared to \$7,312 per year with 3% compound. Louis H.

Recommendation: The Task Force recommends that state policymakers—legislators, state Medicaid directors, insurance commissioners, and the NAIC—improve regulatory efficiency and effectiveness by harmonizing and streamlining inflation protection requirements under the Partnership program. Alternatively, Congress could delegate to HHS the authority to set Partnership program inflation protection requirements under the DRA.⁸⁶

Other Consumer Protections

Apart from inflation protection, both HIPAA and the DRA mandate compliance with certain consumer protections contained in the NAIC’s LTCI Model Act and LTCI Model Regulation. However, the DRA defines “model regulation” and “model Act” by reference to the NAIC models adopted as of October 2000, while HIPAA does so by reference to the January 1993 versions. This federal cross-referencing in two separate statutes of two outdated and conflicting versions of NAIC models creates confusion and adds complexity to writing LTCI business.

Recommendation: The Task Force recommends that Congress consider options to address this regulatory inefficiency. For example, as one option, Congress could empower Treasury, in consultation with HHS, to set consumer protection standards using one version of the LTCI Model Act and LTCI Model Regulation for purposes of both tax qualification under HIPAA and Partnership eligibility under the DRA, with flexibility to update the standards periodically (e.g., every 10 years). Under this approach, Treasury and HHS could coordinate with the NAIC and the states to maintain consistency between federal and state laws with respect to consumer protection, without the necessity of additional federal legislation.

Review and Approval of Rate Increases

In most states, the chief insurance regulator has the authority to approve fully, approve in part, or reject premium rate increases proposed by an insurer. The regulator may also condition its approval on actions or commitments by the insurer, such as agreeing to withhold requests for future rate increases for a specified number of years. The authority of state regulators to review and approve proposed rate increases before the insurer implements those changes is a critical factor in the LTCI marketplace.

Historically, some state insurance regulators have been more receptive than others to proposed rate increases. Policyholders in states where regulators have approved rate increases may

Brownstone, “The California Partnership for Long-Term Care Revives,” *Broker World Magazine*, February 2019, available at: <https://brokerworldmag.com/the-california-partnership-for-long-term-care-revives/>. In September 2016, California enacted Senate Bill 1384. This bill requires insurers to offer both 5% compound inflation and at least one lower cost option. See California Welfare and Institutions Code § 22005.1(b)(3). To date, the California Department of Health Care Services has not issued guidance or regulations identifying a lower cost option.

⁸⁶ The DRA already allows the Secretary of HHS to incorporate revisions to consumer protections under the LTCI Model Act and LTCI Model Regulation into Partnership requirements. See 42 U.S.C. § 1396p(b)(5)(C).

subsidize premiums in other states where regulators have limited or rejected rate increases.⁸⁷ Insurers' uncertainty concerning regulatory treatment of requested rate increases limits their ability to remain active in the LTCI market. In addition, the inability to obtain timely and consistent approvals of actuarially justified rate increases may threaten the financial stability of in-force blocks of LTCI policies and, in some cases, an insurer itself.⁸⁸

Premium Rate Increases for LTCI

Insurers set rates, or premiums, for their products based on actuarial assumptions about risk, future policyholder behavior, and future economic conditions. The accuracy of these assumptions is particularly important for products such as LTCI that remain in force for long periods. Primary determinants of pricing for LTCI include morbidity (how many policyholders need LTC, and for how long), lapse (how many policyholders voluntarily drop their coverage), and interest rates (which determine the amount of income earned by insurers on assets supporting their liabilities). Since 2000, all of these factors have gone in an unfavorable direction for insurers: morbidity is somewhat worse than expected; voluntary lapse rates are lower than for other insurance products; and interest rates are significantly lower than levels assumed in pricing.⁸⁹

As the profitability of in-force LTCI policies has eroded over the past two decades, many insurers have increased premiums on those policies, in some cases by a cumulative 100% or more. Although regulators often require insurers to phase in these increases over a specified timeframe, such as three years, the impact on affordability for policyholders can be severe. In addition, repeated rate increases generate both adverse publicity for insurers and distrust among consumers and insurance producers, lowering demand for LTCI.

The financial performance of in-force LTCI policies remains a key issue for the insurance industry, investors, regulators, and policyholders. LTCI carriers continue to increase their reserves (funds set aside to pay future claims), update their actuarial assumptions, and disclose their reserving methodologies in more detail. One rating agency estimates that most insurers will

⁸⁷ See, e.g., Jason Wobelen, "Regulator Rejects LTC Rate Hike, Says Request Biased against Utah Policyholders," *S&P Global Market Intelligence*, November 2019, available at: <https://platform.marketintelligence.spglobal.com/web/client?auth=inherit&ignoreIDMContext=1#news/article?id=55482328&KeyProductLinkType=2>.

⁸⁸ Insurers that focus mainly on the LTCI product line may be particularly vulnerable. For example, on February 3, 2020, the Pennsylvania Insurance Commissioner obtained a state court order placing Senior Health Insurance Company of Pennsylvania into rehabilitation. As of December 31, 2019, the company had approximately 54,000 LTCI policyholders, \$2.7 billion in liabilities, and a surplus deficit of \$466 million. See Allison Bell, "Pennsylvania Puts LTCI Issuer in Rehabilitation," *ThinkAdvisor*, February 2020, available at: <https://www.thinkadvisor.com/2020/02/06/pennsylvania-puts-ltci-issuer-in-rehabilitation/>. When an insurer is liquidated, state insurance guaranty associations pay certain covered claims and fund those payments by assessments on solvent insurers in the states of residence of the policyholders.

⁸⁹ Marc A. Cohen "The Current State of the Long-Term Care Insurance Market," presentation to the Federal Advisory Committee on Insurance, February 2018, available at: https://home.treasury.gov/system/files/311/FACIFebruary2018_UMass.pdf.

not reach their peak reserves for in-force business for another 10 to 15 years.⁹⁰ Accordingly, uncertainty about the profitability of in-force business will persist. This uncertainty, combined with negative trends in claims experience as well as ongoing questions regarding the ability of insurers to obtain regulatory approvals of rate increases, has led many insurers to exit the LTCI market, creating a drain in capital.⁹¹ Concerns over the financial solvency of insurers, and the potential impact of insolvencies on state insurance guaranty associations, are also important considerations for this market.

In 2019, the NAIC identified the regulation of LTCI as the organization's top priority, noting significant issues posed by the current LTCI environment to both consumers and the state-based system of insurance regulation. The NAIC formed an Executive Task Force charged with developing "a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization."⁹² The Executive Task Force is also charged with identifying options to provide choices for consumers regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.

The primary work stream of the Executive Task Force is a multistate review of LTCI focusing on different actuarial methodologies used by the states. In addition, the Executive Task Force has organized five other work streams to:

- explore alternatives for protecting policyholders from caps on state guaranty association coverage and potential inequities arising from the states' inconsistent approaches to premium rate increase requests;
- ensure policyholders understand their options when faced with a rate increase;
- evaluate the interaction between rate increase issues and reserving issues;
- address non-actuarial variances among the states when reviewing rate increases; and
- consider whether the task force needs additional data to support its work.

Recommendation: The Task Force recommends that the NAIC and the states maintain their focus on LTCI and work together in 2020 to develop a consistent national approach to regulatory reviews of LTCI rate increase requests. The Task Force also recommends that FIO continue to monitor and report on this issue.

⁹⁰ "Following the Trail of U.S. Insurers' Long-Term Care Assumptions," S&P Global Ratings, January 10, 2019, available at: https://www.spratings.com/documents/20184/908539/LifeINSHT_Jan2419_Article4.pdf/2f9c6736-6f26-36ae-d32e-3f2d8c265818.

⁹¹ The number of insurers offering LTCI policies has dropped from more than 100 in 2000 to only a dozen or so in 2020.

⁹² "Long-Term Care Insurance (EX) Task Force," National Association of Insurance Commissioners, last accessed February 2020, available at: https://content.naic.org/cmte_ex_ltc_i_tf.htm.

Financial Literacy and Education

Reviewing the Federal Role in Financial Education

The NAIC 2017 List included a federal education program around retirement security and the importance of planning for potential LTC needs. In July 2019, Treasury issued the Financial Literacy Report, which laid out an appropriate federal role for financial education and considered the roles of the private and non-profit sectors, and other government entities in this field.⁹³ The issuance of the Financial Literacy Report followed a literature review and extensive consultations with experts and stakeholders inside and outside of the government.

In the Financial Literacy Report, Treasury recommended that the primary federal role for financial literacy and education should be to empower financial education providers as opposed to attempting to reach every American household directly. This federal role could include developing and implementing policy, encouraging research, and other activities, such as conducting financial education programs and developing educational resources to advance best practices and standards. The Financial Literacy Report further recommended that the federal government should consider the impact of the lack of financial literacy on households and the risk to the economy from negative externalities and market failures.

The Financial Literacy Report defined high-priority areas for financial education, including retirement saving and investor education. Treasury noted the significant level and interconnection among retirement planning concerns. For example, 25% of Americans have no retirement savings, less than 40% of non-retired adults believe they are on track for a secure retirement, and many working age Americans face difficult challenges in planning for their old age.⁹⁴

The Financial Literacy Report also described current federal programs on retirement planning, including programs and information provided by DOL's Employee Benefits Security Administration (EBSA) and by SSA. EBSA provides education materials and tools, conducts outreach, and answers questions from employers and employees about all aspects of workplace retirement savings plans; and SSA conducts outreach through websites, mass media, and in-person events. Other federal agencies promote their retirement planning resources through networks of relevant organizations and through social media. However, despite the number of programs and resources available, in fiscal year 2017, retirement savings education was one of the least-funded financial education priorities in the federal government, totaling less than 1% of expenditures on financial education (\$2.2 million out of \$273 million).⁹⁵

⁹³ Treasury, *Financial Literacy Report*.

⁹⁴ Treasury, *Financial Literacy Report*, 32.

⁹⁵ Treasury, *Financial Literacy Report*, 1, 53.

From 2005 to 2010, HHS, along with 24 states and the District of Columbia, participated in the Own Your Future Awareness Campaign, which was designed to raise awareness about the risks of needing LTC and to encourage LTC financial awareness.⁹⁶ The National Clearinghouse for Long-Term Care Information website was launched in 2006 to supplement the campaign by helping Americans actively engage in planning for LTC.⁹⁷ Through this campaign, approximately 20 million households were reached and 1.5 million LTC planning guides were distributed.⁹⁸

A post-campaign survey found that people who received the planning guide were more likely to take action (as compared to those who did not), such as reviewing existing coverage, talking to an advisor about LTC needs, or buying LTCI.⁹⁹ Additionally, a 2004 survey of consumers aged 45 to 70 found that those who had heard about LTC were more likely to request additional information, especially those who received direct mail.¹⁰⁰ However, there is evidence that those who requested the guide would have been more likely to take those steps even without the prompt.¹⁰¹

Stakeholder Recommendations Relating to Education

A number of organizations have recommended education as an important way to improve awareness of LTCI and LTC planning; however, these recommendations do not provide evidence or specificity about how to implement education in ways that will have a measurable impact.

In 2019, the NAIC organized a Retirement Security Working Group, which drafted a work plan that includes researching and developing financial education curricula for each life stage from high school through retirement (financial literacy and decision-making, the time value of money, LTC, and debt and credit are subjects to be considered). Additionally, the plan includes developing an education campaign targeting employers to provide retirement plans and assist

⁹⁶ See “Empowering Consumers Through Education,” America’s Health Insurance Plans, last modified September 2018, available at: <https://www.ahip.org/empowering-consumers-through-education/>.

⁹⁷ Section 6021(d) of the DRA directed the Secretary of HHS to establish the Clearinghouse.

⁹⁸ “Final Report on the “Own Your Future” Consumer Survey,” U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, last modified November 2006, available at: <https://aspe.hhs.gov/basic-report/final-report-own-your-future-consumer-survey>.

⁹⁹ Eileen J. Tell, “The Own Your Future Long-Term Care Awareness Campaign: Implications for CLASS,” *CLASS Technical Assistance Brief Series*, Spring 2011, available at: http://www.thescanfoundation.org/sites/default/files/TSF_CLASS_TA_No_13_Own_Your_Future_FINAL.pdf.

¹⁰⁰ Tell, “Own Your Future.”

¹⁰¹ Office of the Assistant Secretary for Planning and Evaluation, “Final Report.”

employees with saving for retirement.¹⁰² While these concepts are promising, additional work will be needed to develop specifics about how to effectively attain goals through these strategies.

Insurance industry organizations favor more federally-funded education. For example, America's Health Insurance Plans and the American Council of Life Insurers recommended re-starting the Own Your Future Awareness Campaign, and the National Association of Insurance and Financial Advisors similarly pointed to the value of such a campaign.¹⁰³

In 2018, the Maryland Governor's Task Force on Long-Term Care Planning recommended methods to educate residents about LTC. The group concluded that current workers should be a key target of outreach and education, especially through employers, and young people should be introduced to LTC planning early.¹⁰⁴ Industry stakeholders similarly identified employers as a venue for effectively providing education about LTCI at the July 25, 2019 public meeting of the Task Force. However, these recommendations reflect a wide variety of strategies and are not backed by clear evidence of effectiveness or plans for implementation.

Task Force consultations with consumer advocates pointed to the challenges of LTCI education. One group noted that insurance products, including LTCI, can be complex, and emphasized the need for understandable, plain language information, and the need to train insurance and investment professionals on appropriate application of suitability standards.¹⁰⁵ Another consumer organization commented that promotion of stand-alone LTCI is not consistent with government efforts to help consumers understand lifetime insurance and retirement income needs.¹⁰⁶ Finally, a health policy group pointed to the value of personalized assistance with navigating the care delivery system at critical points, such as before or after retirement.¹⁰⁷

Best Practices for Financial Education

The Financial Literacy Report details best practices for financial education that are applicable to educating consumers about LTC planning and LTCI. These include:

- **Provide Actionable, Relevant, and Timely Information.** Delivering financial information in an actionable, relevant, and timely manner results in greater likelihood of

¹⁰² "Retirement Security Working Group," National Association of Insurance Commissioners Retirement Security (A) Working Group, last modified November 2019, available at: <https://content.naic.org/sites/default/files/inline-files/Taylor%20Retirement%20Security%20Work%20Plan%20November%202019a.pdf>.

¹⁰³ Treasury, "Public Comments," America's Health Insurance Plans, American Council of Life Insurers, and National Association of Insurance and Financial Advisors.

¹⁰⁴ Maryland Governor's Task Force on Long Term Care Planning, *Report of the Maryland Governor's Task Force on Long Term Care Planning* (Annapolis: October 2018), available at: [http://dlslibrary.state.md.us/publications/NonMd/SB696Ch212HB953Ch213\(2017\)_2018.pdf](http://dlslibrary.state.md.us/publications/NonMd/SB696Ch212HB953Ch213(2017)_2018.pdf).

¹⁰⁵ Treasury, "Public Comments," California Health Advocates.

¹⁰⁶ Treasury, "Public Comments," Center for Economic Justice.

¹⁰⁷ Treasury, "Public Comments," Healthsperien.

retention and action. This practice underscores the need for information that is clear and provides actionable steps for the consumer at appropriate times in their decision-making.

- **Build on Motivation.** Effective financial literacy and education programs capitalize on people's motivations. This may mean that financial education on LTC planning could be effectively delivered by trusted sources, such as faith-based or community organizations.¹⁰⁸
- **Make It Easy to Make Good Decisions and Follow Through.** The environment or context can make it easier for people to carry out their intentions. For example, changing the options presented, removing hassles and barriers, and adding supports can help people bridge the gap between intentions and actions. Simplifying options is often key to helping people make good choices.¹⁰⁹

Recommendations: There is a clear need for consumers to plan for retirement and later life, including consideration of LTC costs and how to finance those costs. Yet, decisions about these topics are complex, unpredictable, and often made more challenging by social and emotional hurdles to planning for possible disability. In addition, LTCI can be difficult to understand and easy to avoid. These factors likely detract from the effectiveness of financial education focused solely on LTC and LTCI. Rather, planning for LTC costs and ways to pay for them should be included as part of other financial education on planning, saving, and investing for retirement.

The Task Force recommends that Treasury, HHS, DOL, and other agencies working through the FLEC, assess federal education resources on LTC needs and planning, and modify, update, and supplement these resources as needed.¹¹⁰ As part of its efforts to improve consumers' capability in retirement planning, the FLEC should clearly integrate LTC planning into retirement education topics. These efforts should be consistent with the recommendations and best practices set forth in the Financial Literacy Report. In particular, educational programs and materials should be clear, simple, avoid jargon, and point people to concrete actions that they can take or avoid. Interagency cooperation is necessary in modifying, updating, and supplementing resources, alongside coordination with private sector entities, state government agencies, and other appropriate parties.

¹⁰⁸ Although multiple stakeholders recommend that consumers make LTC decisions in consultation with family members, a 2014 survey found that barely one-quarter of adults had a detailed discussion about LTC preferences with a partner or family member. Benjamin Allaire et al., "*Long-Term Care Awareness and Planning: What Do Americans Want?*" Office of the Assistant Secretary for Planning and Evaluation, July 30, 2015, available at: <https://aspe.hhs.gov/system/files/pdf/111341/Awareness.pdf>.

¹⁰⁹ For the full list of best practices, see Treasury, *Financial Literacy Report*, 54-58.

¹¹⁰ Congress established the FLEC under the Fair and Accurate Credit Transactions Act of 2003 for the purpose of coordinating the federal government's financial literacy efforts.

Tax Incentives

The Code currently provides favorable federal income tax treatment for LTCI. Multiple stakeholders encouraged the Task Force to consider a range of amendments to tax laws or regulations aimed at increasing the take-up of private LTCI. This section of the report begins with an overview of current tax rules regarding LTCI, and then presents an analysis of various tax proposals considered by the Task Force.

Current Tax Rules Regarding LTCI

The Code currently treats a “qualified” LTCI contract as an accident and health insurance contract and provides various tax preferences.¹¹¹ For example, the Code permits individuals to deduct premiums paid for LTCI under limited circumstances. It also permits employers to provide LTCI to their employees on a pre-tax basis. The requirements for a LTCI contract to be tax qualified and the current tax treatment of qualified LTCI are summarized below.

Requirements for Qualified LTCI Contracts

The Code defines a qualified LTCI contract as any insurance contract if the only insurance protection provided under the contract is coverage of qualified long-term care services.¹¹² A qualified LTCI contract also may not provide for a cash surrender value in excess of premiums paid under the contract or provide other money that can be paid, assigned, pledged as collateral for a loan, or borrowed.¹¹³ As discussed in more detail below, premiums paid for a qualified LTCI contract are eligible to be deducted as medical expenses, subject to specified, age-based dollar limits. In addition, amounts received under the contract generally are excludable from gross income as amounts received for personal injuries or sickness.

The Code defines qualified LTC services as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.¹¹⁴

A “chronically ill individual” means any individual who has been certified by a licensed health care practitioner as:

¹¹¹ 26 U.S.C. §7702B(a)(1).

¹¹² 26 U.S.C. §7702B(b).

¹¹³ In this regard, 26 U.S.C. §7702B(b)(2)(C) permits a refund that does not exceed the aggregate premiums paid under the contract upon: (i) the death of the insured or (ii) a complete surrender or cancellation of the LTCI contract. Any such refund must be includible in gross income to the extent that any deduction or exclusion from income was allowed with respect to the premiums paid. *See also* 26 U.S.C. §7702B(b)(1)(D) (additional requirements for qualified LTCI contracts).

¹¹⁴ 26 U.S.C. §7702B(c)(1).

- i. Being unable to perform (without substantial assistance from another individual) at least two of six ADLs (eating, toileting, transferring, bathing, dressing, and continence) for a period of at least 90 days due to a loss of functional capacity;
- ii. Having a level of disability similar (as determined under regulations) to the level of disability described in i.; or
- iii. Requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.¹¹⁵

Tax Treatment of LTCI Premium Payments by Individuals

Under current law, qualified LTCI premiums are eligible to be deducted as medical expenses only to the extent that total medical expenses, including qualified LTC expenses, exceed the threshold of adjusted gross income (AGI). Currently, the threshold is 7.5% of AGI.¹¹⁶ The annual amount of LTCI premiums that qualify as medical expenses is capped at an age-dependent amount indexed for inflation. This cap on LTCI premiums (Age-Dependent Cap) is applied before calculating whether total eligible medical expenses exceed 7.5% of AGI.¹¹⁷

Table 4: 2020 Age-Dependent Caps

<i>Age at End of Tax Year</i>	<i>Maximum LTCI Premium Deduction</i>
40 or less	\$430
41 to 50	\$810
51 to 60	\$1,630
61 to 70	\$4,350
Over 70	\$5,430

Further, an individual taxpayer may claim a medical expense deduction only if itemizing deductions on Schedule A of Form 1040. The Tax Cuts and Jobs Act almost doubled the standard deduction amount for tax years beginning after December 31, 2017.¹¹⁸ Standard deductions for 2020 are:

- \$12,400 if the taxpayer is single or uses married filing separately status,
- \$24,800 if the taxpayer is married and files a joint return with spouse, and

¹¹⁵ 26 U.S.C. §7702B(c)(2).

¹¹⁶ For tax years beginning on or after January 1, 2021, the AGI threshold for deducting medical expenses will increase to 10% unless Congress chooses to extend the 7.5% threshold. See 26 U.S.C. §213(a) and (f).

¹¹⁷ 26 U.S.C. §213(d)(10).

¹¹⁸ U.S. House, *H.R.1 – An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018* (115th Congress, December 2017).

- \$18,650 if the taxpayer is a head of household.

Thus, in order to deduct LTCI premium payments under the existing rules, a taxpayer must have a proportionally large amount of medical expenses (to meet the 7.5% of AGI threshold) and have sufficient additional itemized deductions for itemizing to be tax-advantageous. As an example, a married couple filing jointly for the 2020 tax year that earns \$100,000 in annual income may include medical expenses in itemized deductions only to the extent that they exceed \$7,500 in 2020. In addition, unless the couple's total medical expenses were in the range of 32.5% of AGI, or \$32,500, they would need additional itemizable deductions in order for itemizing to be economically advantageous. The increased standard deduction is more tax-advantageous than itemizing for many taxpayers.

For the 2017 tax year (the latest year for which data is available), approximately 10 million tax returns claimed an itemized medical deduction.¹¹⁹ It is likely that this number will decrease for the 2018 tax year, given the increase in the standard deduction. The extent to which LTCI premiums are a component of the itemized medical deduction is not known, but it may be relatively uncommon. Individuals in poor health are less likely to qualify for LTCI protection due to medical underwriting for these policies, and individuals in good health may be unlikely to incur enough out-of-pocket medical expenses to exceed the 7.5% of AGI threshold, particularly if they have employer-provided health insurance and pay their own share of health insurance premiums pre-tax.

Restrictions on Retirement Account Distributions

Distributions from qualified retirement plans (such as 401(k) and 403(b) plans and IRAs) prior to age 59½ generally are subject to an additional 10% tax on the amount of the distribution, although certain exceptions apply.¹²⁰ The exceptions include distributions to pay premiums for LTCI under two circumstances:

- i. Qualified LTCI premiums (up to the Age-Dependent Cap amount) can be paid with 401(k), 403(b), or IRA distributions with no additional early withdrawal tax to the extent that, in combination with other out-of-pocket medical expenses, they exceed the threshold for deductible medical expenses.¹²¹ It is not necessary to itemize deductions for tax return purposes to obtain this additional tax relief. However, taxpayers would still need relatively high total medical expenses to take advantage of this exception.
- ii. Qualified LTCI premiums (up to the Age-Dependent Cap amount), as well as other health insurance premiums, can be paid with IRA (but not 401(k) or 403(b)) distributions with no additional early withdrawal tax if the policyholder experiences a substantial period of

¹¹⁹ "Individual Income Tax Returns Complete Report 2017," Internal Revenue Service, 91, available at: <https://www.irs.gov/pub/irs-pdf/p1304.pdf>.

¹²⁰ 26 U.S.C. §72(t)(1).

¹²¹ 26 U.S.C. §72(t)(2)(B).

unemployment, regardless of whether the taxpayer's total medical expenses exceed the threshold for deductible medical expenses.¹²² This provision can help taxpayers keep up with LTCI premiums when the loss of a job interrupts disposable income.

In 2016, a majority of families at relevant ages held retirement accounts (IRAs, 401(k)s, and 403(b)s), including 57% of those headed by someone age 35-44, 60% age 45-54, and 59% age 55-64. Among those holding accounts, the median amounts held at these same ages were \$37,000, \$83,000, and \$120,000, respectively.¹²³ These amounts are quite low compared to projected retirement income needs. For example, at the federal employee Thrift Savings Plan annuity rate, \$120,000 at age 65 would provide a level annuity of \$7,488 each year for life.¹²⁴

Tax Treatment of LTCI Purchases in the Employment Context

The costs of employer-provided accident and health plans are excluded from employees' gross income and tax-qualified LTCI qualifies as an accident and health plan for this purpose (although the employer's deduction for premiums paid is limited to the Age-Dependent Cap).¹²⁵ Accordingly, employers can currently provide LTCI to employees tax-free. However, employers cannot currently offer LTCI as part of a cafeteria plan, which is a common vehicle for providing employees with benefits for which the employer does not incur additional costs.

Cafeteria plans (often incorporating a flexible spending arrangement (FSA), discussed below) provide employees an opportunity to substitute a portion of their taxable cash compensation with one or more qualified benefits on a pre-tax basis.¹²⁶ If an employee chooses to receive a qualified benefit under a cafeteria plan, the fact that the employee could have received cash or a taxable benefit instead will not make the qualified benefit taxable. Under current law, qualified benefits include most accident and health insurance benefits, including insurance policy purchases, adoption assistance, dependent care assistance, group term life insurance, and health savings accounts (HSA) (including the ability to use HSA funds to pay for qualified LTC services). However, cafeteria plans may not offer LTCI.¹²⁷

¹²² Generally, the relief from the additional early withdrawal tax applies if the individual receives unemployment compensation for 12 consecutive weeks under a federal or state unemployment compensation law in the current year (or received it in the preceding year) and the relief extends to distributions for up to 60 days after employment resumes. A self-employed individual may be treated as meeting this requirement if the individual would have received unemployment compensation under federal or state law but for the fact that the individual was self-employed. See 26 U.S.C. §72(t)(2)(D).

¹²³ "Survey of Consumer Finances – 2016 SCF Chartbook," Board of Governors of the Federal Reserve System, October 16, 2017, 442, available at: <https://www.federalreserve.gov/econres/files/BulletinCharts.pdf>. The Board of Governors of the Federal Reserve System conducts the Survey of Consumer Finances every three years. The Board has not yet published the 2019 survey.

¹²⁴ Calculated at the current 1.75% interest rate assumption.

¹²⁵ See 26 U.S.C. §106(a).

¹²⁶ See 26 U.S.C. §125(f)(1).

¹²⁷ See 26 U.S.C. §125(f)(2).

A Health FSA may be established under an employer's cafeteria plan, either as one of several components or as the sole component. Health FSAs are accounts funded each year with pre-tax income (i.e., income that is not subject to federal income and payroll tax) that may be used to pay for qualified medical expenses during the relevant year that are not reimbursable by health insurance or otherwise. Most common uses are to cover health insurance policy deductibles and co-pays, as well as qualified medical expenses that may not be covered by insurance, such as vision care. The annual Health FSA funding cap is indexed for inflation, and the maximum contribution for 2020 is \$2,750. A Health FSA differs from an HSA (discussed below) in that HSA balances carry over in full from year to year and can earn tax-free investment income, whereas Health FSA annual contributions are generally "use or lose," with the exception of a permissible grace period or carryover limit. An employer may either choose to allow Health FSAs a two and a half month grace period at the end of the plan year so that account holders can use their remaining Health FSA balance to pay for expenses incurred during that extended period, or choose to allow account holders to carry over an amount equal to 20 percent of the maximum salary reduction contribution for any given plan year (\$550 for the 2020 plan year). Health FSA balances do not accrue interest. Under current law, insurance premium payments, including LTCI premiums, are not eligible expenses for Health FSAs.

An HSA is a tax-advantaged medical savings account available to taxpayers who enroll in a high-deductible health plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit. Annual contributions in 2020 are limited to \$3,550 for an individual and \$7,100 for a family, with HSA holders age 55 and over being allowed to contribute an additional \$1,000 per year. Further, individuals eligible for Medicare cannot contribute to HSAs. Around 22 million people held an HSA-qualified HDHP in 2017.¹²⁸

HSAs (in combination with an HDHP) are also available to persons who are self-employed or to persons whose employer does not offer a health plan, but most often are offered in conjunction with an employer-sponsored HDHP.

Analysis of Tax Incentives Considered

Based on the NAIC 2017 List (Options 1, 2, 4, and 8) and stakeholder feedback, the Task Force considered the following additional tax incentives to encourage the purchase of LTCI:

- Allow a full federal tax deduction for LTCI premiums paid by individuals.
- Allow increased contributions to an HSA if the HSA is used to fund LTCI premiums.
- Create a new type of account modeled after HSAs (but without the requirement that the account holder have an HDHP) that could be used to fund both direct LTC expenses and LTCI premiums.

¹²⁸ "Health Savings Accounts and Consumer-Directed Health Plans Grow as Valuable Financial Planning Tools," America's Health Insurance Plans, April 2018, available at: https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18-1.pdf.

- Allow purchase of LTCI through cafeteria plans offered by employers.
- Allow purchase of LTCI through Health FSAs.
- Allow cash value beyond a return of premium under qualified LTCI contracts.
- Allow retirement plan participants to receive a distribution from 401(k)s, 403(b)s, or IRAs to purchase LTCI with no additional early withdrawal tax.

Recommendation: In its analysis of these proposed incentives, the Task Force took into account that the Code already provides favorable income tax treatment to LTCI. The Task Force recognizes that the proposed incentives could have the beneficial effect of motivating individuals to plan their financial future and help protect their retirement savings against depletion by LTCI expenses. However, the proposals would likely reduce tax revenues and the amount of the reductions could be significant. In addition, the proposals would primarily benefit higher income taxpayers with higher marginal tax rates, and may not be fully effective in targeting lower- and middle-income families who need financial protection against LTC risks. Finally, the proposals would increase the complexity of the Code and could, in some cases, be difficult to implement, monitor, and enforce. Accordingly, the Task Force does not recommend adoption of any of the proposed additional tax incentives, with the exception of the proposal to eliminate the early withdrawal tax if funds from an IRA, 401(k), or 403(b) account are used to pay LTCI premiums.

Federal Income Tax Deduction for LTCI Premiums

The Code currently allows taxpayers to deduct a limited set of expenses “above the line” from their gross income. These deductions, which reduce AGI, are available irrespective of whether a taxpayer claims the standard deduction or itemizes deductions. The permitted above the line expense deductions are mostly business expenses or other expenses incurred for the production of income, but include other categories of expenses, such as IRA contributions, HSA contributions, and student loan interest expense deductions. The Task Force considered a proposal to add LTCI premiums (with or without Age-Dependent Caps) as an above the line deduction category.

The argument in support of this proposal is that the current rules regarding LTCI premium deductions do not provide an incentive to purchase LTCI for most individual taxpayers, because (1) most taxpayers take the standard deduction rather than itemize, and (2) only medical expenses in excess of the AGI threshold (7.5%) may be deducted as an itemized deduction—a threshold not reached by most taxpayers who itemize deductions.

However, from a tax policy perspective, an above the line tax deduction is a very significant subsidy that would decrease tax revenue. Although increasing the number of U.S. persons with LTCI may be desirable, it is debatable whether LTCI premiums should have a privileged deductibility status compared to other medical expenses (which are subject to the 7.5% AGI cap) and other expense categories (such as the charitable contribution deduction) that cannot be deducted unless the taxpayer itemizes. As previously discussed, the Tax Cuts and Jobs Act

almost doubled the standard deduction for individual taxpayers. The standard deduction simplifies tax filing by not requiring taxpayers to track which of their expenses may be claimed as itemized deductions. A separate deduction for LTCI premiums would increase complexity and largely benefit higher-income taxpayers.

Increased Contributions to an HSA to Fund LTCI Premiums

The Task Force considered a proposal to allow increased contributions to an HSA if the HSA is used to fund LTCI premiums. Because HSA funds may already be used to purchase LTCI (up to the Age-Dependent Cap amounts), this proposal would increase the overall HSA contribution allowed (currently capped at \$3,550 for an individual and \$7,100 for a family, plus an additional \$1,000 for HSA holders age 55 and over) if the HSA is used to purchase LTCI. This proposal would make LTCI more affordable for persons with HSAs who are already maximizing their HSA contributions and could stimulate demand for private purchases of LTCI.

However, HSA contribution limits are already high and the tax treatment for HSAs is currently the most generous treatment for health care expenses because it is mathematically equivalent to combining tax-free build-up on earnings with an above-the-line deduction for medical care. For individuals who use their HSAs to fund medical care a few years in the future, the tax-free build-up on earnings is relatively modest. For LTC, where the build-up can occur over decades, the tax-free build-up on earnings combined with tax-free contributions and withdrawals for qualified LTCI or LTC services already provide a substantial tax subsidy.

Furthermore, this proposed change would be likely to primarily benefit persons with relatively high incomes who can afford larger HSA contributions, rather than lower- or middle-income taxpayers, since this proposal would affect only individuals who already contribute the maximum annual amount to HSAs (e.g., \$7,100 yearly for a family). In addition, the proposal would only help individuals with HSAs, which are limited to those with HDHPs.¹²⁹ Individuals eligible for Medicare, who might be more likely to take advantage of this new rule, cannot contribute to HSAs.

New Type of Account to Fund LTC Expenses and LTCI Premiums

The Task Force considered a proposal to create a new type of account modeled after HSAs, without the requirement that the account holder have a HDHP, which could be used to fund direct LTC expenses and LTCI premiums on a pre-tax basis (a LTC savings account (LTCSA)). If the HSA model were followed, distributions from an LTCSA would receive more generous tax treatment than distributions from other retirement savings accounts because a distribution from a 401(k), 403(b), or IRA is generally included in income at least in part; in addition, any deduction for medical expenses (including qualified LTC expenses) would be subject to the 7.5% AGI

¹²⁹ Approximately 22 million people held an HSA-qualified HDHP in 2017. America's Health Insurance Plans, "Health Savings Accounts," available at: https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18-1.pdf.

floor for medical expenses deductions and would not be available to taxpayers who itemize. By contrast, a distribution from the LTCSA would be tax-free, provided it was used to pay LTC premiums (up to the Age-Dependent Cap) or other LTC expenses.

This proposal could increase saving for LTC expenses generally, if the contribution limits for LTCSAs did not affect the limits for retirement savings accounts. Because the benefit would not be limited to persons with HDHPs, it could incentivize LTCI purchases by a larger number of taxpayers than the proposal to increase HSA contribution limits.

However, because the new LTCSA would be available to all taxpayers, and not just taxpayers with HDHPs, the tax revenue impact of this proposal would be correspondingly larger. Availability of the LTCSA would potentially provide a large tax subsidy that likely would benefit mainly higher income taxpayers because individuals with high marginal tax rates are most likely to take advantage of this type of account.

With respect to the use of the LTCSA to pay LTC expenses (as opposed to insurance premiums), there is not always a clear line between an LTC expense and post-retirement living expenses generally, and people cannot know in advance whether they will need LTC. It may be advantageous for most taxpayers to contribute more robustly to existing retirement accounts than to isolate a stream of savings specifically for LTC expenses when there is no guarantee that a particular taxpayer will incur expenses that clearly qualify as LTC expenses. In addition, if the LTCSA were allowed, taxpayers would have an incentive to characterize a larger amount of expenses as LTC expenses because LTCSA distributions would often receive more generous tax treatment than distributions from retirement accounts. Federal tax authorities would need to monitor appropriate use and develop rules regarding how to treat unused LTCSA balances, if a taxpayer does not need LTC.

Purchase of LTCI Under Cafeteria Plans

The Task Force considered a proposal to allow employers to add tax-qualified LTCI to the group of qualified benefits that employees may receive on a pre-tax basis under a cafeteria plan. Under this proposal, LTCI premium exclusions from income could be limited based on the current Age-Dependent Caps.

Under current law, employers can provide LTCI to employees outside of a cafeteria plan, although not very many employers do so. If employers could provide LTCI through a cafeteria plan, they might be more likely to offer it. Employees might be more likely to opt to purchase LTCI offered on a pre-tax basis under a cafeteria plan. Employers also might be able to negotiate more favorable product terms than an individual could obtain independently. Allowing the offer of LTCI on a pre-tax basis within cafeteria plans would further encourage employers to include information about LTC options in their employee benefits packages.

Like any tax incentive, this proposal would decrease tax revenue to the extent that additional employees purchased LTCI through their cafeteria plan. Higher income taxpayers may be most

likely to take advantage of this new cafeteria plan option, as they can better afford to purchase LTCI, whether on a pre- or post-tax basis.

Employers can already provide LTCI to their employees on a pre-tax basis outside of cafeteria plans. It seems unlikely that a statutory change permitting employers to offer LTCI as a pre-tax option within a cafeteria plan would also cause employers to make additional contributions to the cafeteria plan to help fund the employees' purchase. If so, the cost of the LTCI cafeteria plan offering would still come out of employee pockets (although it would be on a pre-tax basis).

Purchase of LTCI Through Health FSAs

The Task Force considered a proposal to add tax-qualified LTCI to the group of expenses that an employee can pay with Health FSA funds, subject to Age-Dependent Caps on LTCI premium payments. Allowing the funding of LTCI on a pre-tax basis through Health FSAs could encourage purchase of LTCI.

One purpose of Health FSAs is to help fund medical expenses not covered by insurance (e.g., deductibles and co-pays). The maximum annual contribution to Health FSAs is only \$2,750 (for 2020), and allowing Health FSA contributions to cover premiums would reduce amounts available to meet the types of costs that Health FSAs were intended to cover. Unless other types of insurance premiums were also eligible for payment from a Health FSA, the proposal would privilege LTCI over other types of insurance. In addition, higher income taxpayers may be most likely to take advantage of the option to use Health FSA contributions to fund LTCI because they can better afford it, even on a pre-tax basis.

Cash Value Under Qualified LTCI Contracts

Under current law, a qualified LTCI contract generally may not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. As a limited exception, a qualified LTCI contract may provide for a refund that does not exceed the aggregate premiums paid on the death of the insured, complete surrender, or cancellation of the contract. Any such refund is includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums paid. In addition, premium refunds and dividends credited while the contract is in force may be used to reduce future premiums or increase future benefits, but may not be paid out to the policyholder.

The Task Force considered a proposal to allow cash value beyond a return of premium under qualified LTCI contracts. Cash value or cash surrender value is the amount of money the insurance company is obligated to pay a policyholder or beneficiary if a life insurance or annuity contract is terminated. Policyholders also may be able to borrow against or otherwise benefit from the cash value. If the Code permitted qualified LTCI to accumulate cash value, LTCI could be more attractive because policyholders could receive a benefit (cash value withdrawal) even if they did not become chronically ill.

However, if a qualified LTCI contract were permitted to have cash surrender value beyond the limited return of premium currently allowed, it would to that extent be an investment vehicle and more closely resemble a type of life insurance contract than an accident and health insurance contract. While the Code permits earnings on life insurance and annuity contracts with cash value generally to accumulate tax-free, it generally does not permit policyholders to deduct premiums paid for life insurance or annuity contracts. Policyholders are also required to pay taxes on the investment component of distributions made under life insurance and annuity contracts (other than payment of death benefits under life insurance contracts). Congress imposed the current cash value restrictions on qualified LTCI in exchange for permitting LTCI to receive some of the more favored tax treatment provided to health insurance premium payments, including deductions for premium payments under some circumstances and tax-free treatment of policy benefits when received. Allowing qualified LTCI to have substantial cash value would give it more of a life insurance character and undermine the rationale for the tax-favored treatment currently accorded to qualified LTCI.

Receiving 401(k), 403(b), or IRA Distributions to Purchase LTCI

The Task Force considered a proposal to allow retirement plan participants to receive distributions from 401(k)s, 403(b)s, or IRAs to purchase LTCI with no additional early withdrawal tax. This could be accomplished by adding a new exception to the Code to fully exempt distributions from 401(k)s, 403(b)s, and IRAs used to purchase LTCI from the 10% additional income tax. The retirement account distributions in many cases would still be subject to regular income tax (depending on whether the taxpayer's retirement account contribution was originally made pre-tax or post-tax), but the additional early withdrawal tax would not apply. The proposal could lower an obstacle to LTCI affordability (or perceived affordability) for some individuals with retirement savings but limited disposable income.

In some cases, the proposal may provide little or no true economic advantage over using current income to pay LTCI premiums. For example, there would be no economic difference for active 401(k) or 403(b) participants who are contributing more than needed to receive the maximum employer matching contributions (and to any active IRA contributor) between taking a distribution and alternatively redirecting some contributions to LTCI premiums. On the other hand, individuals who wish to contribute just enough to their 401(k) or 403(b) plan to receive the maximum employer matching contribution, but who also have limited funds available to pay LTCI premiums, might be more likely to purchase LTCI if they had the option of receiving an early distribution of previously-contributed funds without the additional 10% early withdrawal tax.

Arguments against the proposal include the concerns that too many Americans have insufficient retirement savings, an individual who diverts funds otherwise earmarked for retirement income to LTCI could erode retirement security, and the proposed exemption would not benefit the large minority of families without retirement accounts.

Given that the Code provides exceptions to the additional 10% early withdrawal tax for the purchase of LTCI insurance in certain circumstances already (including as medical expenses above the itemized medical deduction floor regardless of whether an itemized deduction is claimed, as well as health insurance and LTCI premiums for unemployed individuals),¹³⁰ the Task Force recommends that the Code be amended to allow retirement plan participants to receive distributions from 401(k)s, 403(b)s, or IRAs to purchase LTCI with no early withdrawal tax. This change may make it easier for some individuals with retirement savings, but limited disposable income, to pay LTCI premiums, and the individuals most likely to take advantage of the early distribution option may be individuals in their mid-to-late 50s when LTCI premiums are becoming more expensive, but the individuals are not yet age-eligible to take ordinary retirement account distributions. This recommendation will likely have a minimal effect on tax revenues as taxpayers most likely to purchase long-term care insurance could avoid the penalty by reducing contributions to these accounts, reducing other consumption, or borrowing.

¹³⁰ 26 U.S.C. §72(t)(2)(B) and (D).

Alternative Financing Approaches

This section briefly reviews proposals for public insurance approaches to reform in the United States organized around the structure of the benefit and how it protects individuals from the financial risk of needing LTC. Most of these approaches focus on either front-end insurance (coverage of initial LTC costs for mostly short durations or limited scope) or back-end, or catastrophic, insurance (coverage beyond a specified level of need or cost for longer durations). Very few options provide comprehensive coverage of the entire spectrum of LTC risk. In addition, this review is limited to proposals and approaches that include detailed descriptions of major program features such as program eligibility, scope of coverage, and, most importantly, financing and cost estimates. The Task Force has not attempted to review in detail conceptual proposals and ideas that are not supported by specific financing and cost estimates.

Front-End Benefit Options

Options that address initial LTC costs are frequently referred to as front-end coverage benefits.¹³¹ These options are also typically limited in their duration of coverage. Option 9 under the NAIC 2017 List is a good example of a type of front-end benefit. Specifically, this option recommends that policymakers:

Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans. Medicare provides extensive acute care coverage but more limited post-acute coverage (home health and skilled nursing facility care). Medicare Advantage and Medigap plans fill the gaps in Medicare coverage. But most LTC services are not covered by Medicare, leaving a considerable gap in coverage for post-acute care... There has been discussion of adding either something akin to a long-term care benefit or, less extensive, new home and community-based benefits either to Medicare (which would affect supplemental carriers) or to Medicare Advantage and/or Medigap plans.

Establishing a home care benefit, a type of front-end insurance option that addresses initial needs for LTC services, has been an objective of policymakers for decades. For example, the 1993 Health Security Act included a state-run home care program for persons with disabilities that would be funded largely through federal grants. Rather than establishing a new, completely independent program, a 2016 report¹³² recommended adding a home-care benefit to Medicare or, like Option 9, including it as part of Medicare Supplement Insurance (such as Medigap) policies or Medicare Advantage (MA).

¹³¹ 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* 34, no. 12 (December 2015): 2181–91, available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1226>.

¹³² Karen Davis, Cathy Schoen, and Amber Willink, “Medicare Help At Home,” *Health Affairs*, April 2016, available at: <https://www.healthaffairs.org/doi/10.1377/hblog20160413.054429/full/>.

The home-care benefit proposal would pay for 20 hours per week of home care and other services for Medicare beneficiaries with two or more limitations in ADL or severe cognitive impairment, a benefit trigger similar to that for tax-qualified LTCI policies. Like Medicare Supplement Insurance, people turning age 65 who are eligible for Medicare would have the option to enroll in the program without medical underwriting. The home care benefit would be financed through a combination of co-insurance varying by income, beneficiary premiums, and a payroll tax. Beneficiaries would have a co-pay requirement ranging from 5% of the cost of service for low-income beneficiaries to 50% for those with income greater than 400 percent of the federal poverty level. The 2016 report estimated that a monthly premium of \$35 and a payroll tax of 0.35% paid by both employer and worker would cover the public costs of the program under specific assumptions.¹³³

One of the policy options explored by the Bipartisan Policy Center in their 2017 report is the provision of a limited home care benefit through Medigap or MA plans.¹³⁴ The basic structure of the benefit is similar to the home-care benefit proposal with some significant differences. For example, the amount of the daily benefit available to pay for services is much higher, \$100 per day, but is limited to one year. In addition, enrollees are not eligible to receive a benefit until 90 days after a documented need for LTC. Most importantly, private insurers rather than the government provide the benefit and the program is financed exclusively through premiums paid after voluntary enrollment in the program. Assuming a discount rate of 3% and a loss ratio of 85%, estimated monthly premium costs range from \$55 if all eligible beneficiaries enroll at age 65 to approximately \$200 if only 5% enroll at that age. Although the Bipartisan Policy Center does not specify the participation rate, it estimates that reducing the benefit to \$75 per day and increasing the elimination period to 180 days could result in monthly premiums of \$35 to \$40.

Washington State's Long-Term Services and Supports Trust Program

In 2019, Washington State passed a public LTCI program, the Long-Term Services and Supports Trust Program.¹³⁵ Beginning in 2025, the program will pay, per individual, up to \$36,500 of LTSS received from approved providers. The list of services that can be reimbursed is quite broad and includes services and equipment provided in the community (e.g., in-home personal care, adaptive equipment and technology, home modifications, respite for family caregivers, home delivered meals, transportation, etc.) as well as those provided in assisted living and nursing facilities. The program will be funded through a mandatory payroll tax of 0.58% on

¹³³ These estimates assume that home care services cost approximately \$20 per hour (\$15 per hour plus 33% for fringe benefits) and that 75% of those eligible for the home care benefit who are not already on Medicaid would participate each year. Benefits would, therefore, cost up to \$400 per week or \$20,800 per year.

¹³⁴ "Financing Long-Term Services and Support: Seeking Bipartisan Solutions in Politically Challenging Times," Bipartisan Policy Center, July 2017, 22-24, available at: <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Financing-Long-Term-Services-and-Supports.pdf>.

¹³⁵ Washington State Legislature, *Title 50B Long-Term Care – Chapter 50B.04 RCW: Long-Term Services and Supports Trust Program* (Olympia: 2019).

employees. Self-employed workers may opt into the program, while persons with LTCI could choose not to participate. Payroll tax withholding is scheduled to begin in 2022.

In order to be a qualified program participant, an individual must have paid the payroll tax for ten years (without interruption for five consecutive years) or three years within the last six, and worked at least 500 hours during each of those years. Once qualified, an individual is eligible to receive a benefit if he or she is 18 years or older, was not disabled before the age of 18, is a Washington State resident, and requires assistance with at least three ADLs. Because the legislation did not identify specific ADLs, eligibility criteria could be more or less restrictive than those for tax-qualified LTCI. The lack of consistency between the two sets of eligibility criteria will likely create a barrier to the development of private insurance that supplements the benefits of the new program.

In November 2019, a nonbinding advisory measure was included on the state’s general election ballot and voters voted against the idea of paying a new tax on wages to fund the program. A media representative for the Washington State Office of the Insurance Commissioner said the vote was an advisory measure that would not affect the enacted legislation.¹³⁶

Medicare Advantage

The Bipartisan Budget Act of 2018 amended Section 1852(a) of the Social Security Act to expand the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees.¹³⁷ These benefits, referred to as Special Supplemental Benefits for the Chronically Ill (SSBCI), include supplemental benefits that are not primarily health-related and may be offered non-uniformly to eligible chronically ill enrollees. The purpose of the new category of supplemental benefits is to enable MA plans to better tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill population.

As a result of these changes, beginning in 2020 many MA plans are allowed to cover certain “non-primarily health related” items or services as a supplemental benefit for certain beneficiaries. This includes adult day health care, home based palliative care, caregiver support, in-home support services, transportation, and general supports for living, food, and other expenses.¹³⁸ In general, MA organizations have broad discretion in developing items and services they may offer as SSBCI, if the item or service has a reasonable expectation of improving or maintaining the overall health or overall function of the chronically ill enrollee.

¹³⁶ Allison Bell, “Wash. State Continues Public LTCI Effort, in Spite of Ballot Measure Results,” *ThinkAdvisor*, November 2019, available at: <https://www.thinkadvisor.com/2019/11/26/wash-state-continues-public-ltci-effort-in-spite-of-ballot-measure-results/>.

¹³⁷ U.S. House, *H.R. 1892 – Bipartisan Budget Act of 2018* (115th Congress, February 2018).

¹³⁸ “Implementing Supplemental Benefits for Chronically Ill Enrollees,” Centers for Medicare & Medicaid Services, April 24, 2019, available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

Furthermore, MA organizations have broad discretion in determining what may be considered “a reasonable expectation” when choosing to offer specific items and services as SSBCI.

While the 2018 legislation provides increased flexibility to MA plans, it does not change the payment structure used to finance supplemental benefits. Medicare pays MA plans a capitated amount to provide all Medicare Part A and B benefits. Plans submit bids every year in each county of operation and each bid is compared to a payment area’s benchmark, which is the maximum amount that Medicare will pay MA plans in that area. CMS also risk adjusts the benchmark base rate payments for each enrollee to account for various demographic and health status differences. If a plan bids below the benchmark, the plan and Medicare split the difference (with the plan’s share known as the “rebate”) between the bid and the benchmark. The rebate must be used to lower out-of-pocket costs, provide supplemental benefits, or both. If a plan bids above the benchmark, enrollees pay the difference between the bid and the benchmark in the form of a monthly premium in addition to the Part B premium.¹³⁹

Back-End (Catastrophic) Options

Back-end, or catastrophic, coverage options mitigate the risk of long durations of LTC and associated high costs. This approach addresses the risk of an unlikely, but potentially very costly and financially ruinous, event. An advantage to focusing on the tail of the risk distribution is that the cost of the insurance should be lower than other more comprehensive approaches. Several advocacy and non-partisan organizations have supported, at least in principle, the development of a catastrophic coverage option, and a 2018 paper proposed and modeled a detailed catastrophic insurance option.¹⁴⁰ The latter effort is notable because it is one of the few catastrophic reform efforts to estimate the cost of the program and explore distributional impacts.

The authors of the 2018 paper maintained that a public catastrophic insurance option could provide a platform for private insurers to offer supplemental policies that in combination would provide more comprehensive coverage. Their proposed program is structured around a lifetime \$110 per day cash benefit that would be available once enrollees had a demonstrated need for services beyond a specified duration. The 2018 paper referred to this duration as an “income-

¹³⁹ “Medicare Advantage,” Kaiser Family Foundation, last modified June 2019, available at: <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>.

¹⁴⁰ See, e.g., Treasury, “Public Comments,” America’s Health Insurance Plans and American Council of Life Insurers; Bipartisan Policy Center, “Financing Long-Term Services and Support;” Treasury, “Public Comments,” California Health Advocates; Marc Cohen, Melissa Favreault, and Judith Feder, “A New Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance,” LeadingAge LTSS Center @UMass Boston, Urban Institute, and Office of the Assistant Secretary for Planning and Evaluation, last modified January 2018, available at: <https://www.urban.org/research/publication/new-public-private-partnership-catastrophic-public-and-front-end-private-ltc-insurance>; “A Consensus Framework for Long-Term Care Financing Reform,” Convergence Center for Policy Resolution, last modified February 2016, available at: <https://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf>; U.S. Senate, *Commission on Long-Term Care: Report to Congress* (September 2013), available at: <https://www.govinfo.gov/content/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>.

related waiting period” ranging from one to four years depending on an enrollee’s lifetime income.¹⁴¹ The waiting period would begin once an enrollee met the same criteria for LTC needs found in tax-qualified LTCI policies, i.e., need for assistance with two or more ADLs or severe cognitive impairment. A surcharge on the Medicare payroll tax paid by workers age 40 and older would finance the benefit. The program would be phased in over ten years and enrollees would be eligible for benefit after having paid the requisite payroll tax for 40 quarters.

Assuming an average waiting period of 2.2 years, the 2018 paper estimated that the program could be funded with a payroll tax surcharge of 1%. Approximately one-third of enrollees would eventually receive benefits, and payouts would cover 31% of all LTC costs. Compared to the current system, the new program would lead to an increase in overall LTC spending, but family out-of-pocket costs would decline by 15% and spending for Medicaid would be 25% lower, according to the authors.

Comprehensive Options

Recent LTC reform efforts have generally not focused on covering the full risk and cost of LTC services. The few full risk options have largely been conceptual and lack critical program details, such as specific financing mechanisms and cost estimates. For example, the 2013 Report to Congress of the Commission on Long-Term Care outlined a comprehensive Medicare benefit for LTSS as a model of what can be achieved through social insurance.¹⁴² Enrollees would be eligible for benefits under roughly the same criteria as those for tax-qualified private LTCI, and an increase in the Medicare payroll tax and premiums would finance the program. However, this report discussed neither the scope of benefits nor the requisite tax rates and premium amounts. In fact, the Commission did not agree on a financing mechanism for any of its proposals and thus made no formal recommendation.

Recommendation: The Task Force does not recommend pursuing any particular alternative financing approach at this time. Policymakers and stakeholders should continue to develop, monitor, and analyze LTC and LTCI reform proposals—including those discussed in this report—to better understand the advantages and disadvantages of specific options, tradeoffs, program costs, and distributional impacts.

¹⁴¹ The specific waiting period schedule is one year for enrollees with lifetime income in the lowest two income quintiles, two years if one’s lifetime income was in the third highest quintile, and three and four years if lifetime income was in the two highest quintiles.

¹⁴² U.S. Senate, *Commission on Long-Term Care*.

Appendices

Appendix A: Participants in the Engagement Process

Actuarial Organizations and Consultants	
American Academy of Actuaries	Oliver Wyman
Milliman	Society of Actuaries
Consumer Advocates	
AARP	California Health Advocates
Alzheimer's Association	Center for Economic Justice
Government-Related Entities	
National Association of Insurance Commissioners	
Industry and Trade Groups	
America's Health Insurance Plans	Lincoln National
American Council of Life Insurers	National Association of Insurance and Financial Advisors
Davis and Harmon	New York Life Insurance Company
Genworth Financial	O'Leary Marketing Associates, LLC
The Golleher Group, LLC	Transamerica Life Insurance Co.
John Hancock	
Regulators	
Alaska Department of Commerce, Community, and Economic Development Division of Insurance	Maryland Insurance Administration
Colorado Department of Regulatory Agencies Division of Insurance	Nebraska Department of Insurance
Connecticut Insurance Department	Pennsylvania Insurance Department
Think Tanks	
The LeadingAge LTSS Center @UMass Boston	Urban Institute

Appendix B: Summary of Analysis and Recommendations

Analysis/Recommendation	Implementation		
	Federal	State	Other Stakeholders
Innovation and Product Development			
Innovation and product development have the potential to significantly strengthen the private LTCI market and better address consumers' needs for LTC. The Task Force recommends that federal and state policymakers and regulators foster a regulatory environment that encourages flexibility, experimentation, and innovation in policy design to improve consumer choice and access to benefits, while appropriately protecting the rights of consumers and the solvency of insurers.	Treasury, IRS, HHS, DOL	Insurance Regulators, NAIC	
Policymakers could benefit from analysis of the impact of combination products on the market for LTC risk protection. The Task Force recommends that actuaries, academics, and other stakeholders explore such an analysis with coordination by FIO.	Treasury, FIO		Actuaries, Academics, Policy Experts
The Task Force recommends that federal policymakers work with their state counterparts and with private sector stakeholders to evaluate and monitor the market for limited LTCI, including potential impacts on the risk pool for longer-term products and on Medicaid.	Treasury, IRS, HHS, CMS	Insurance Regulators, NAIC	Industry, Consumer Groups, Policy Experts
The Task Force recommends that state legislators and insurance regulators take steps to better streamline and standardize the regulation of the limited LTCI market.		Legislators, Insurance Regulators	
The Task Force considered two policy proposals for LTCI group products, both involving the fiduciary provisions of ERISA. The Task Force does not recommend either proposal.			

Analysis/Recommendation	Implementation		
	Federal	State	Other Stakeholders
Supporting the ability of individuals who need LTC to remain in their homes could benefit both consumers and insurers. The Task Force encourages industry, federal policymakers, and other experts, in consultation with consumer representatives, to identify and assess evidence of cost-effective pre-claim interventions under LTCI policies. Depending on the results of the analysis, Congress could consider amending the Code to permit payment of evidence-based, cost-effective incidental benefits under a tax-qualified LTCI contract prior to the insured becoming chronically ill, subject to a monetary cap and other conditions set by regulation.	Congress, Treasury, IRS		Industry, Policy Experts, Consumer Groups
Regulatory Efficiency and Alignment			
Inflation protection requirements under HIPAA and state insurance laws should be revised to improve the efficiency and effectiveness of regulation. To both address outdated requirements and provide flexibility to adapt inflation protection to evolving economic conditions, the Task Force recommends that Congress amend the Code to authorize Treasury to set inflation protections for tax-qualified LTCI.	Congress, Treasury, IRS	Insurance Regulators, NAIC	
The Task Force recommends that state policymakers—legislators, Medicaid directors, insurance regulators, and the NAIC—improve regulatory efficiency and effectiveness by harmonizing and streamlining inflation protection requirements under the Partnership program. Alternatively, Congress could delegate to HHS the authority to set Partnership program inflation protection requirements.	Congress, HHS	Legislators, Medicaid Directors, Insurance Regulators, NAIC	

Analysis/Recommendation	Implementation		
	Federal	State	Other Stakeholders
HIPAA and the DRA create regulatory inefficiency by incorporating two outdated and conflicting versions of NAIC models with respect to consumer protections for LTCI. The Task Force recommends that Congress consider options to address this regulatory inefficiency. One option is to empower Treasury, in consultation with HHS, to set consumer protection standards using one version of the LTCI Model Act and Model Regulation for purposes of both tax qualification under HIPAA and Partnership eligibility under the DRA, with flexibility to update the standards periodically (e.g., every ten years).	Congress, Treasury, HHS		
The Task Force recommends that the NAIC and the states maintain their focus on LTCI and work together in 2020 to develop a consistent national approach to regulatory reviews of LTCI rate increase requests. The Task Force also recommends that FIO continue to monitor and report on this issue.	Treasury, FIO	NAIC, Insurance Regulators	Industry, Consumer Groups
Financial Literacy and Education			
The Task Force recommends that Treasury, HHS, DOL, and other agencies, working through the FLEC, assess federal education resources on LTC needs and planning, and modify, update, and supplement these resources as needed. As part of its efforts to improve consumers' capability in retirement planning, the FLEC should clearly integrate LTC planning into retirement education topics.	Treasury, HHS, DOL, FLEC		

Analysis/Recommendation	Implementation		
	Federal	State	Other Stakeholders
Tax Incentives			
The Task Force considered multiple proposals to amend federal tax laws and regulations to encourage the purchase of LTCI. The Task Force does not recommend adoption of any of the proposed additional tax incentives, with the exception of the proposal to eliminate the additional tax on early withdrawal of funds from an IRA, 401(k), or 403(b) account that are used to pay LTCI premiums.	Congress, Treasury, IRS		
Alternative Financing Approaches			
The Task Force conducted a high-level review of select public insurance approaches to financing LTC. The Task Force does not recommend pursuing any particular alternative financing approach at this time. Policymakers and other stakeholders should continue to develop, monitor, and analyze LTC and LTCI reform proposals to better understand the advantages and disadvantages of specific options, tradeoffs, program costs, and distributional impacts.	Treasury, HHS, CMS	Legislators, Medicaid Directors, Insurance Regulators	