Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress

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Summary

As the 78 million baby boomers approach retirement, many are concerned they will not have sufficient savings to sustain their standard of living in retirement. Few, however, may be focused on another risk to their retirement security—the potential cost of financing often expensive long-term care (LTC) services. LTC services include help with a either a functional or cognitive impairment and generally include assistance with activities such as bathing, eating, and dressing. For the majority of older Americans, the cost of obtaining paid help for these services may far exceed their financial resources in the future.

Private long-term care insurance (LTCI) is available to provide some financial protection for persons against the risk of the potentially high cost of LTC. Yet, only 7% of LTC spending was paid by LTCI in 2007. This low rate of financing reflects relatively low demand for LTCI over the past few decades. Moreover, most policy owners have not yet reached the age where they may need services.

A number of factors have adversely affected the demand for LTCI. The cost and complexity of LTCI policies have been cited as major deterrents to purchasing LTCI. In addition, increased concerns have arisen about the adequacy of consumer protections for LTCI as a result of inconsistencies in LTCI laws and regulations across the states. More recently, adverse publicity about potential problems with claims denials and heightened concerns about the future solvency of LTCI insurers in the current economic environment have further dampened demand.

The private LTCI market has undergone significant changes in the past three decades. For example, the employer-sponsored market has grown as a share of total LTCI sales and the overall market has become more concentrated in terms of the number of companies selling the product. Further, policies have become more comprehensive in terms of services covered and inflation protection, but this has also increased LTCI premiums. Finally, a number of newer product lines have been introduced that combine LTCI with other retirement and life-insurance products.

The 111th Congress has introduced a number of legislative proposals aimed at increasing participation in the voluntary LTCI market. These include proposals to

- increase tax incentives to lower the after-tax cost of policies;
- improve consumer protections to boost consumer confidence in the product;
- provide a publicly administered long-term care insurance product; and
- expand consumer education.

In addition, the recently enacted Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) establishes a publicly administered voluntary LTCI program entitled the Community Living Assistance Services and Supports (CLASS) program. PPACA creates a new Title XXXII of the Public Health Service Act (PHSA) titled Community Living Assistance Services and Supports.

This report discusses the role of LTCI in financing LTC costs and current trends in the LTCI industry; factors affecting the demand for LTCI, including cost and complexity of the product and adequacy of consumer protections; and key features of legislative proposals in the 111th Congress to address these issues.

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Introduction

As the 78 million baby boomers approach retirement, many are concerned they will not have sufficient savings to sustain their standard of living in retirement. Few, however, may have focused on another risk to their retirement security—the potential cost of financing often expensive long-term care services. The cost of long-term care (LTC) services for the majority of older Americans may far exceed their financial resources in the future. Although private long-term care insurance (LTCI) is available to provide some financial protection for persons against the risk of the potentially high cost of LTC, less than 10% of individuals aged 50 and older own a policy.[1]

This report discusses

- the role of LTCI in financing LTC costs and current trends in the LTCI industry;
- factors affecting the demand for LTCI, including cost and complexity of the product and adequacy of consumer protections; and
- key features of legislative proposals in the 111th Congress to improve affordability and participation, strengthen consumer protections, and expand consumer education.

Private Long-Term Care Insurance

Services provided by a LTCI policy may include a broad range of services and supports to help people with a limited capacity for self-care due to a physical, cognitive (such as Alzheimer's disease), or mental disability or condition.[2] Health and long-term care services are different. Health care services typically treat specific acute and chronic medical conditions in a medical setting by a medical profession. Long-term care services, on the other hand, include a wide range of health and health-related support services provided on an informal or formal basis to people who have functional disabilities or cognitive impairments over an extended period of time with the goal of maximizing their independence.[3] Unlike medical treatments, long-term care services and supports primarily assist individuals in their day-to-day activities. These "activities of daily living" (ADLs) include bathing, dressing, eating, toileting, and transferring (from a bed to a chair or vice-versa). Generally, LTCI policyholders are eligible to begin to receive benefits if they have at least two of the ADL limitations.

LTCI policies may be sold to an individual directly or to a group as part of an employer-sponsored policy. The premiums charged for LTCI vary by age of purchase, with higher premiums charged to those purchasing at older ages. This age differential reflects the higher risk

[1] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, "Long-Term Care Financing: Policy Options for the Future," Georgetown University, June 2007.

[2] See CRS Report RL33919, *Long-Term Care: Consumers, Providers, Payers, and Programs, Long-Term Care: Consumers, Providers, Payers, and Programs,* by Carol O'Shaughnessy, Julie Stone, Thomas Gabe and Laura Shrestha.

[3] Connie J. Evashwick, "The Continuum of Long-Term Care: An Integrated Systems Approach," 2004.

of needing LTC services at advanced ages. One study has estimated that over two-thirds of individuals who turn 65 years old will require LTC services at some point before they die.[4]

Current Financing of LTC Services

Although private LTCI is available to finance LTC costs, only 7% of LTC spending was paid by LTCI in 2007.[5] The majority of LTC spending (49%) is financed by the Medicaid program, which is funded jointly by the federal government and states.[6] Medicaid is not available to everyone. To be eligible, individuals must meet certain functional criteria as well as state-specified income and asset thresholds.[7] Medicare (which currently provides health care to older Americans) financed 22% of long-term care spending, but these funds were predominantly for post-acute care for short-stays in a skilled nursing home following hospitalization or for skilled home health care.

Individuals who seek paid LTC services but do not qualify for public funding or do not have private LTCI must pay for these services directly out-of-pocket. In 2007, about 18% of LTC spending was paid out-of-pocket.[8] The magnitude of out-of-pocket costs will depend on the setting, intensity (including the skill level of the provider), and the duration of long-term care services. For example, the setting of care can include care provided in one's own home, in a community-residential care setting such as an assisted living facility, or in an institutional setting such as a nursing home. For those receiving care at home, the cost will vary depending on the skill level of the paid caregiver. In 2009, the cost of personal unskilled care at home (such as bathing, dressing, and transferring) was $19 an hour, whereas skilled care from a visiting nurse was $46 an hour.[9] In addition, the annual cost of care will also vary by intensity and duration of care. Studies have found that individuals use on average about 17 hours a week of informal care, which would result in an annual cost of about $16,800 a year in 2009. Assisted living facilities that provide hands-on personal care for those who are not able to live by themselves (but do not yet require constant care provided by a nursing home) cost on average $33,900 annually in 2009. Nursing home care, on the other hand, generally costs more in that it provides LTC assistance 24 hours a day and includes the cost of room and board. In 2009, the annual cost of a nursing home stay was $66,886 for a semi-private room and $74,208 for a private room.[10] These estimates are national averages and can vary widely by geographic region.

[4] P. Kemper, H.L. Komisar, and L. Alecxih, "Long-Term Care Over An Uncertain Future: What Can Future Retirees Expect?" Inquiry 42, winter 2005-2006.

[5] CRS estimates based on National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-2007. Data on hospital-based home health and nursing home spending by Medicare and Medicaid, including section 1915(c) Home and Community Based Services (HCBS) waivers spending provided to CRS by the Centers for Medicare & Medicaid Services for 2006, Office of the Actuary, National Health Statistics Group.

[6] Ibid.

[7] The income and asset criteria vary by state. See CRS Report RL33593, *Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery*, by Julie Stone.

[8] See footnote 5.

[9] Genworth Financial 2009 Cost of Care Survey, April 2009.

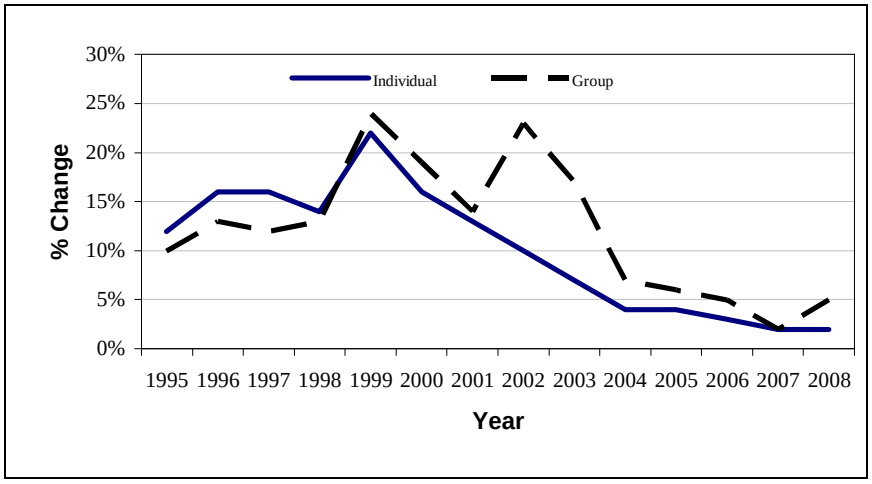
[10] Ibid.

LTC Insurance Industry Trends

The private LTC insurance market has undergone significant changes in the past three decades. The employer-sponsored market has grown as a share of total LTCI sales and the overall market has become more concentrated in terms of the number of companies selling the product. Further, a number of newer product lines have been introduced that combine LTCI with other retirement and life-insurance products. The following discussion provides greater details on these trends.

There are currently about 6 million to 7 million policies active (often called "in-force").[11] The growth in the number of LTCI policies in both the individual and group markets increased at double-digit rates from 1995 to 2002 before slowing in more recent years (see **Figure 1**). The composition of the market has also changed as employer-sponsored LTCI has grown as a share of the total LTCI market. In 2007, employer-sponsored LTCI represented one-third of all active policies, compared with less than 3% in the mid-1990s. Employer-sponsored LTCI is distinct from employer-sponsored health insurance in that employers typically do not contribute to LTCI premiums. Rather employer-sponsored LTCI provides the advantage of a larger risk pool and generally lower premiums than if LTCI is purchased in the individual market. Among employer-sponsored LTCI, the federal government is one of the largest employers offering group LTCI.

Figure 1. Percentage Change in Active LTCI Policies, 1995-2008



Source: LIMRA International Inc.

Over the past decade, the number of companies selling LTCI has declined significantly. Between 1987 and 2002, more than 100 companies were selling LTCI. A downturn in sales beginning in 2003 prompted many insurers to exit the market or merge with other firms.[12] As a result, by 2006, there were only 45 LTC insurers, with 10 of them representing nearly 80% of new sales.[13] The consolidation of the LTCI industry reflects several factors, including high administrative expenses

[11] Estimates by Marc Cohen reported in Testimony before the U.S. House Committee on Energy and Commerce Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term?* July 24, 2008.

[12] U.S. Government Accountability Office, "Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions," March 2006.

[13] C. Pfau and S. Pummer, "Ninth Annual Individual Long-Term Care Insurance Survey," *Broker World Magazine*, July 2007.

for policies relative to premiums, lower than expected terminations (i.e., lapse rates) that increased the number of people likely to submit claims, low interest rates that reduced the expected return on investments, and new government regulations limiting direct marketing by telephone.[14]

A number of legislative changes have enabled insurers to begin to develop hybrid products that combine LTCI with either an annuity or a life insurance product. The Pension Protection Act of 2006 simplified tax rules regarding combination products (effective in 2010) and added a tax provision specifying that proceeds from an annuity can be used tax-free to purchase an LTCI policy.[15] LTCI policies can also be combined with a life insurance policy through an accelerated death benefit rider. Circumstances that trigger these accelerated benefits include diagnosis of a terminal illness or a medical condition that would drastically shorten the policyholder's life span, the need for LTC, or permanent confinement to a nursing home. Also, under the American Homeownership and Economic Opportunity Act of 2000, proceeds from a reverse mortgage can be used to purchase an LTCI policy.[16]

Factors Affecting the Demand for Private LTCI

After 15 years of strong growth, demand for private LTCI has slowed considerably since 2004.[17] To date, less than 10% of the population aged 50 and older owns an LTCI policy.[18] The weakening of this market has occurred despite enhanced tax incentives (especially at the state level), increased emphasis on consumer protections, and the enactment of a private LTCI program for federal employees.

The factors affecting the demand for LTCI can be viewed by comparing two key cohorts: those under the age of 65 and those aged 65 and older. For those under the age of 65, annual LTCI premiums are generally lower.[19] However, this cohort also faces competing demands of raising families and saving for retirement. Many do not fully understand their future risks or coverage options for long-term care services. According to survey data, some incorrectly assume that the Medicare program (which currently provides health care to older Americans) will also pay for their long-term care needs. A recent survey by AARP found that only 1 in 5 respondents between the ages of 45 and 64 knew that Medicare does not cover an extended stay in a nursing home.[20]

[14] U.S. Government Accountability Office, "Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions," March 2006.

[15] See CRS Report R40008, *Converting Retirement Savings into Income: Annuities and Periodic Withdrawals*, by Janemarie Mulvey and Patrick Purcell.

[16] See CRS Report RL33843, *Reverse Mortgages: Background and Issues*, by Bruce E. Foote.

[17] J. Douglas and K. Fisherkeller, "U.S. Individual Long-Term Care Insurance: 2008 Supplement," LIMRA, 2009.

[18] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, "Long-Term Care Financing: Policy Options for the Future," Georgetown University, June 2007.

[19] Once the policy is purchased, premiums cannot increase with age, but they can increase for other reasons.

[20] AARP, "The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006," December 2006.

Although Medicare does cover up to 100 days of care in a skilled nursing facility,[21] and limited home health care,[22] it does not cover longer stays in a nursing home or personal home care.

By the time individuals reach the age of 65 or so and have not sufficiently planned for their long-term care needs, the cost and complexity of the policies become a major barrier to purchase. In addition, increased concerns have arisen about the adequacy of consumer protections for LTCI as a result of inconsistencies in LTCI laws and regulations across the states. More recently, adverse publicity about potential problems with claims denials by LTC insurers and heightened concerns about the future solvency of LTCI insurers in the current economic environment have further dampened demand. The following section discusses these issues in greater detail.

Cost and Complexity of Long-Term Care Insurance

The cost of LTCI has been cited as a major deterrent to purchasing the product. Over 80% of potential buyers of LTCI who choose not to purchase a policy cite cost as a "very important" or "important" reason for their decision.[23] Over the past decade, LTCI premiums have increased significantly above the overall rate of inflation. As shown in **Table 1**, between 1995 and 2005, average age-adjusted premiums have increased 59% (above the overall rate of inflation) for individuals ages 55 to 64 and by 32% for those ages 65 to 69. One reason annual premiums have risen is because claims data used to price policies have improved. In addition, higher annual premiums reflect more comprehensive benefit packages (including inflation protection) being offered. Between 2000 and 2005, the more comprehensive policies raised premiums an average of 30%.[24]

Table 1. Average Annual Age-Specific LTCI Premiums, By Purchase Year

(in 2005 dollars)

Age	1995	2000	2005	% Change 1995 to 2005
55 to 64	$1,177	$1,376	$1,877	59%
65 to 69	$1,507	$1,686	$2,003	33%
70 to 74	$1,957	$2,074	$2,341	20%

Source: CRS estimates using CPI-U to adjust nominal premiums reported in America's Health Insurance Plans, "Who Buys Long-Term Care Insurance?" April 2007.

[21] Medicare covers up to 100 days of post-hospital care for skilled nursing or rehabilitative services on a daily basis (after a three-day hospital stay). There is no beneficiary cost-sharing for the first 20 days. Days 21-100 are subject to daily coinsurance charges ($133.50 in 2009).

[22] Medicare covers visits by personnel from a participating home health agency for beneficiaries who (1) are confined to home, (2) need skilled nursing care on an intermittent basis, or (3) need physical or occupational therapy or speech language therapy. The services must be provided under a plan of care established by a physician and the plan must be reviewed by the physician at least every 60 days.

[23] Marc Cohen, *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005,* LifePlans and America's Health Insurance Plans, 2007.

[24] Ibid.

Although more comprehensive policies have raised annual premiums, they have also increased the complexity of the purchase decision. According to America's Health Insurance Plans (AHIP), 40% of those who did not buy an LTCI policy when given the opportunity stated that the policy options were "too confusing." Potential buyers must evaluate the many different possible combinations of product features available.

Potential policyholders must decide

- the type of coverage,
- the dollar amount of coverage and annual inflation adjustments,
- the length or duration of coverage, and
- the waiting period (which is often referred to as the elimination period).

The Type of Coverage

Individuals must choose the type of services to be covered by a LTCI policy. Services covered under an LTCI policy may include care in a variety of settings, such as nursing homes or assisted living facilities, or the individual's own home through home health services. Policies may cover respite care for caregivers, homemaker and chore services and medical equipment, among others. Policies purchased in 2005 tend to be more comprehensive in terms of services covered and are most likely to cover both nursing home and home care services. According to AHIP, 90% of policies purchased in 2005 covered both nursing home and home care as compared with 61% of policies purchased in 1995 (see **Table 2**).[25]

Dollar Amount of Coverage and Annual Inflation Adjustments

Another factor affecting the cost and complexity of a policy is how much coverage should be purchased in terms of a daily benefit amount and whether to purchase inflation protection. The dollar amount of the daily benefit is often initially chosen based on the current cost of services. But the decision about how much this daily benefit should be adjusted over time to reflect inflation is a more complicated one.

Inflation adjustments (often called inflation protection) are important because a LTCI policy is often purchased 20 to 30 years before services are needed. Thus, a policy purchased today that pays a $150 a day benefit may not be sufficient given growth in the price of future LTC services. To ensure that policies cover an adequate amount of services, most companies now offer inflation protection and most public awareness campaigns have urged individuals to purchase inflation protection. As a result of these efforts, policies purchased in 2005 are more likely to include inflation protection (see **Table 2**) as compared with those purchased in 1995. Two questions for potential LTCI policyholders are what type and how much inflation protection to purchase?

[25] Marc Cohen, *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005,* LifePlans and America's Health Insurance Plans, 2007.

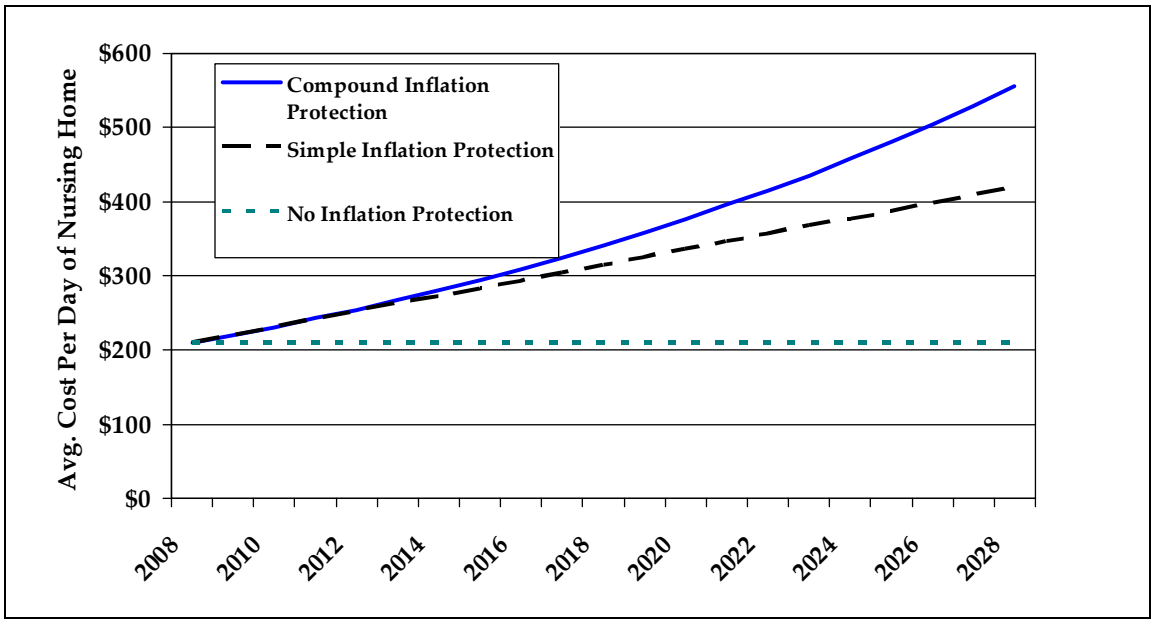
Table 2. Characteristics of LTCI Policies Purchased Since 1995

Policy Characteristics	1995	2000	2005
Policy Type (% With)			
—Nursing Home Care Only	33%	14%	3%
—Nursing Home & Home Care	61%	77%	90%
—Home Care Only	6%	9%	7%
Daily Benefit Amounts (Nominal $)			
—Nursing Home Care	$85	$109	$142
—Home Care	$78	$106	$135
% With Inflation Protection	33%	41%	76%
—Simple	14%	17%	23%
—Compound	15%	22%	49%
—Indexed to CPI	4%	2%	4%
Elimination Period for Nursing Home Benefit	46 days	47 days	81 days

Source: America's Health Insurance Plans, "Who Buys LTCI: A 15-Year Study of Buyers and Non-Buyers," Washington, DC, April 2007.

In terms of the type of inflation protection, companies offer both simple and compound inflation adjustments. Although both methods increase the daily benefit by a fixed percentage, they vary on which year the percentage is applied. Simple inflation adjustments increase annually based on a fixed percentage of the daily benefit amount calculated from the *first year the policy is purchased*, so annual adjustments are a fixed dollar amount. Whereas compound inflation adjustments increase the daily benefit amount annually based on a fixed percentage calculated from each *previous year's* daily benefit amount (see **Figure 2**), so the annual adjustments of the daily benefit amount increase over time.

Figure 2. Illustration of Compound vs. Simple Inflation Adjustments



Source: CRS Estimates. Daily benefit amounts in 2008 derived from Genworth Financial 2008 Cost of Care Survey, April 2008.

Notes: Inflation adjustments assume 5% annual rate of growth.

Once the policyholder chooses the type of inflation protection, he or she then must decide how much inflation-protection to purchase annually. In making this decision, one approach would be to rely on historical data. For example, since 2000, the price of nursing home care increased at an annual average rate of 4.3%. However, it is unknown whether these trends will continue in the future. Potential policyholders must decide whether they should choose inflation protection based on historical trends or choose a higher or lower rate based on expectations about the future. This decision raises both the complexity and the cost of the policy. An AHIP analysis found that the existence of inflation protection increased premiums by about 25% between 2000 and 2005.[26]

Duration of the Benefit

The length of coverage (in years) of a LTCI policy is called the *duration of the benefit*. Deciding how much coverage to purchase further complicates the decision process. LTCI policies can cover two to five years of services and some policies can provide lifetime benefits. Although potential policyholders want to purchase a policy that may sufficiently cover future risks, most do not know what that risk may be because it varies widely across the older population. For example, researchers have estimated that, of those who turned 65 years old in 2005, approximately one-third will not require any LTC services over their remaining lifetime. At the same time, one in five will require LTC services for more than five years.[27] The longer the duration of coverage, the higher the premiums.

[26] Marc Cohen, *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005*, LifePlans and America's Health Insurance Plans, 2007.

[27] Kemper et al., "Long Term Care Over An Uncertain Future: What Can Current Retirees Expect," *Inquiry*, winter 2005-2006.

Elimination Period

LTCI policies often have a waiting or elimination period that is the length of time between the onset of qualifying impairments and commencement of payment for LTC services. The elimination period is selected by the policyholder when he or she purchases the policy. This elimination period is conceptually similar to a deductible in a health care plan—the longer the elimination period the lower the cost of the policy, all other things equal. Policies purchased in 2005 tend to have a longer waiting ("elimination") period, as compared with 15 years earlier (see **Table 2**). Unlike other policy design features, a longer elimination period has reduced premiums. Recent estimates show that the trend toward longer elimination periods in policies purchased between 2000 and 2005 has reduced premiums by 6%.[28]

Adequacy of Consumer Protections For LTCI Policyholders

In addition to the cost and complexity of products, there has been a growing concern that many LTCI policies do not have sufficient consumer protections. These consumer protections are important given that an LTCI policy is often purchased 20 years or longer before the actual benefit is used. This long time horizon introduces a great deal of uncertainty regarding the nature of future benefits, long-run affordability of premiums for purchasers, and the financial stability of insurers. Many of the laws and regulations that have been established by federal and state governments attempt to address these issues. However, each state has its own set of laws and regulations and there is wide variation across states.

State Oversight

State governments have primary jurisdiction for regulating the LTCI market. To do this, states have established laws and regulations for LTCI carriers and the products they sell and play an active role in verifying carriers' and products' compliance with these requirements. To help guide states in their LTCI oversight efforts, the National Association of Insurance Commissioners (NAIC) has developed a number of "Model Laws" and "Model Regulations" which provide recommended guidelines for state regulators to adopt. These Model Laws and Model Regulations are updated periodically by the state insurance commissioners. Because each state ultimately establishes its own LTCI laws and regulations, state oversight requirements are not consistent across states, leaving gaps in consumer protections. According to the NAIC, 47 states and the District of Columbia based their LTCI regulations on the NAIC Model, 2 based their regulations partially on the model, and 2 did not follow the NAIC Model. But even for states that have adopted the NAIC Model, there is variability in which version was adopted. According to the NAIC, as of November 2008, 24 states have adopted key features of the 2006 NAIC Model language.[29]

[28] Marc Cohen, *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005*, LifePlans and America's Health Insurance Plans, 2007.

[29] NAIC's Compendium of State Laws on Insurance Topics, Long-Term Care Insurance Act Provisions, November 2008.

Federal Oversight

Since 1996, the federal government has attempted to standardize these regulations at a national level for certain LTCI products. Federal law has included provisions for federal tax benefits and minimum consumer protection standards for purchasers of "tax-qualified" LTCI policies as authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191).[30] HIPAA tax-qualified products must conform to most of the provisions in the 1993 NAIC Model Law and Regulations. These products are also required to offer inflation protection.

In addition, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171)[31] amended federal law to establish the Medicaid LTCI Partnership program, a public-private partnership between Medicaid and the private LTCI market. Under Medicaid's LTCI Partnership program, states with approved plan amendments[32] may extend Medicaid coverage, including LTC benefits, to certain persons who have purchased LTCI partnership policies without requiring them to meet the same means-testing requirements applicable to other groups of Medicaid eligibles.[33] During the eligibility determination for Medicaid, these states may disregard assets equal to the amount paid out in benefits under the Partnership policy. However, to be eligible for Medicaid, individuals would still have to meet the general residency, functional, and income criteria under their state program.

DRA also includes minimum consumer protection requirements for the LTCI plans sold under the Partnership program as specified in the 2000 NAIC Model Provisions (see **Table 3**). In contrast to the HIPAA voluntary 5% compound inflation-protection requirement, the DRA provisions include a mandatory inflation-protection provision for certain age groups. DRA, however, does not specify the amount of inflation-protection that is required and instead leaves this decision up to the individual states.

Table 3. Summary of Consumer Protections for LTCI Specified By Different Versions of the NAIC Model Provisions

	1993 NAIC Model Provisions	2000 NAIC Model Provisions	2006 NAIC Model Provisions	2009 NAIC Draft Model Provisions[a]
Revised Pricing and Eligibility for LTC Insurance	Yes	Yes	Yes	Yes
Strengthened Suitability and Rate Stability Provisions	No	Yes	Yes	Yes
Imposed Stricter Criteria for Training and Certification of Insurance Agents	No	No	Yes	Yes
Independent Review of Benefit Trigger Denials and Standardized Claims Definitions	No	No	No	Yes

[30] These provisions for tax-qualification are also specified in the Internal Revenue Code (IRC) Section 7702(B)).

[31] These provisions are also specified in the Social Security Act Title XIX Section 1917(b)(5)(42 U.S.C. 1396p(b)(5)).

[32] Section 1902(r)(2) of the Social Security Act.

[33] See CRS Report RL32610, *Medicaid's Long-Term Care Insurance Partnership Program*, by Julie Stone.

	1993 NAIC Model Provisions	2000 NAIC Model Provisions	2006 NAIC Model Provisions	2009 NAIC Draft Model Provisions[a]
Current Federal Law Requirements	Health Insurance Portability and Accountability Act (P.L. 104-191)	Deficit Reduction Act of 2005 (P.L. 109-171)[b]	None	None

Source: Congressional Research Service.

Notes: The term NAIC Model Provisions include both the Model Regulations and the Model Act promulgated by the NAIC.

a. These consumer protections are currently being reviewed by the NAIC and have not formally been adopted yet.

b. The LTCI Partnership consumer protections described in the Deficit Reduction Act of 2005 did not include the rate stability language in the NAIC 2000 Model Act.

However, federal laws standardizing LTCI regulations have become outdated and do not include all of the relevant provisions of a specific NAIC Model Provision. For example, neither the HIPAA tax-qualified policies or the Medicaid LTCI Partnership policies include the rate stability provisions in the NAIC 2000 Model Act. These federal laws also do not address recent concerns about the misrepresentation of LTCI by unqualified sales agents or inappropriate denial of claims. The following section provides more detail about each of these issues.

Premium Instability

Generally, premiums for LTCI are lower when policies are purchased at younger ages. Yet, younger purchasers will also be paying premiums over a longer period of time and long-run stability of premiums is important to ensure their affordability in the future. Although insurers are prohibited from increasing an individual's premium based on a change in the policyholder's circumstances (i.e., increased age or onset of disability), insurers, however, are still able to request permission from a state insurance commissioner to increase premiums for a class of insured.[34] This premium increase can be necessitated by inadequate medical underwriting, premiums that were initially set too low, or insufficient growth in reserves to cover future claims.[35] Thus, premium or rate stability depends largely on the ability of insurers to adequately predict future claims.

Data on the extent of premium increases is not widely available. However, the limited data available for individual states have shown that one-time premium increases, when they do occur, have often been in the 10% to 20% range.[36] For example, a field notice for a major LTC insurer announced an 18% increase in 2008 on their two oldest policies. The one-time premium increases were for policies that were issued over 15 years ago when claims underwriting was not as comprehensive.

[34] A class of insured is generally defined as all individuals of the same age with the same policy form in the same state and with the same coverage.

[35] R. Desonia, "The Promise and Reality of Long-Term Care Insurance," National Health Policy Forum. 2004.

[36] Ibid.

Most recently, the Office of Personnel Management (OPM) has signed a new contract that includes a new benefit option with increased home health care reimbursements, new benefit periods, and higher daily benefit amounts. As a result of the new contract, OPM announced that premium rates for current enrollees who had purchased automatic compound inflation protection may experience rate increases of between 5% and 25%. Current enrollees who do experience premium increases will be provided the opportunity to keep their current premiums substantially the same by making changes to their benefit package.[37]

To reduce the likelihood of future premium increases on current policyholders, the NAIC revised its model regulation in 2000 to require companies to provide actuarial information to certify the adequacy of all proposed rates and to show that the vast majority of premium increases are devoted to paying claims. In addition, when premiums are increased, 85% of the increased portion of the premium must be available to cover claims. In addition, the NAIC Model Act requires reimbursement of unnecessary rate increases to policyholders. Policyholders are also provided the option to escape the effect of rising rate spirals by being guaranteed the right to switch to another lower premium policy. Finally, the 2000 NAIC Model Act authorizes the commissioner to ban from the market place for five years companies that persist in filing inadequate initial premiums. As of November 2008, 36 of the 51 states and the District of Columbia have adopted some provisions addressing premium rate increase, but not all of the 36 comply fully with the NAIC rate stability standards.[38]

Inappropriate Sales Practices

Following the 1993 NAIC Model Act, there had been a concern that some private sector insurers and agents were inappropriately selling products to persons with low income and assets who may otherwise be eligible for public assistance under Medicaid. In other words, these LTCI policies would not be *suitable* for certain individuals given their circumstances. There was also a concern that individuals may not fully understand the future value of the benefits they purchase. To address these issues, the 2000 NAIC Model required insurers to develop and use suitability standards, and to train agents with respect to the standards. Both insurers and agents must ascertain an applicant's ability to pay and their goals and needs through the use of a personal worksheet. There are a number of disclosure requirements related to suitability, including the requirement that the agent and insurer must distribute to the potential policyholder a brochure on the "Things to Know Before You Buy." Since then, the 2006 NAIC Model added provisions concerning training of insurance agents to address concerns about suitability. The 2006 Model Act also includes a new section on producer (insurance agent) training, which requires producers to complete a one-time eight-hour training course before selling LTCI. According to the NAIC, as of November 2008, 27 states have some form of agent's licensing requirements in their state legislation, but not all of them comply fully with the 2006 NAIC Model Act language.[39]

[37] Office of Personnel Management, "OPM Awards New Long Term Care Insurance Contract," press release, May 1, 2009.

[38] NAIC's Compendium of State Laws on Insurance Topics, Long-Term Care Insurance Act Provisions, February 2009.

[39] Ibid.

Inappropriate Denial of Claims

Over the past year, there has been some anecdotal evidence that some LTCI policyholders are having difficulty in accessing their benefits once a claim is filed.[40] Recent actions by the NAIC against a large LTC insurer have heightened these concerns. National level data from the NAIC have also shown that the number of complaints regarding LTCI has increased between 2004 and 2006.[41] According to a recent survey of LTC insurers by the NAIC, the number of overall complaints regarding LTCI relative to policies in-force have doubled since 2004 from 5.0 complaints per 10,000 policies in-force to 10.6 complaints per 10,000 policies in-force in 2006. Relative to the actual number of claims, the complaint ratio has nearly tripled (from 11.3 per 10,000 claims received to 27.0 per 10,000 claims received).

One of the key areas for complaints is the denial of claims. Although the number of claims denials has increased, the increase is not as large when adjusted by the number of claims submitted. The total percentage of claims denied for all policies increased since 2004 from 3.2% to 3.9% in 2006. The percentage of claims denied for comprehensive policies increased from 4.1% to 4.9% over the same period. This data reflects activity from 2004 to 2006 and does not provide any information on more recent years.

Denial of claims can occur for a number of reasons. For example, a number of issues within the reimbursement process could lead to a delay in payment. The first relates to the eligibility for payments from the insurer. The policyholder (or his/her guardian) must notify the insurer and document that the policy has been "triggered." For example, for non-cognitive impairments this means the policyholder meets the requirement of needing assistance with two or more activities of daily living (ADLs).[42] Documentation can include a written statement from the policyholder's physician verifying this information or the insurer may require him or her to meet with an assigned care manager to assess eligibility. Thus, a claim can be denied if the insurer does not receive supporting documentation regarding eligibility for payment in a timely manner.

Another reason for denying a claim is that the policyholder has not yet reached the end of the policy's elimination period. Between 2004 and 2006, denied claims for home care because the elimination period had not been met increased 16.3%, for comprehensive policies they increased 37.5%. Finally, denied claims for nursing home benefits where the elimination period had not been met increased 17.7% over the same period.[43]

Although anecdotal evidence raised concerns among policymakers that some insurers are further delaying claims on purpose,[44] national level data from the NAIC do not validate these concerns. According to the NAIC, since 2004, there has been a 37.9% increase in claims paid within 60 days and a 38.9% decrease in claims paid after 60 days. According to the NAIC, denial of payments beyond 60 days was not a major issue between 2004 and 2006.[45] Other survey data support the fact that relatively few claims are denied. According to a Lifeplans Survey of 1,500

[40] U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term?*, hearing, July 24, 2008.

[41] National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

[42] ADLs include eating, bathing, dressing, toileting, transferring, or walking across the room.

[43] National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

[44] Charles Duhigg, "Aged, Frail and Denied Care by Their Insurers," *New York Times*, March 26, 2007.

[45] National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

policyholders over a 2½-year period, 96% of claims were approved and 4% were denied. Those who conducted the survey suggest this indicates an industry-wide initial claims denial rate of 4%. The same survey reported that the vast majority (93%) of denied claims had a decision rendered within a two-month period and the remaining 7% within another two months.[46]

Although problems in the delay of claims processing are not evident in the NAIC data collected between 2004 and 2006, there is evidence that the problem may be isolated for policies issued by one large insurer. The recent settlement against Conseco, Inc. highlights the use of improper processing practices by the company. In May 2008, state insurance regulators and the NAIC brought a regulatory settlement against Conseco, Inc. for mishandling of LTCI claims. Specifically, claims were not handled in a timely manner and claims files were not documented or maintained. The Conseco investigation found that the primary problem in most cases was a delay in payment of the claim, rather than a denial.

Given these concerns the NAIC has developed draft revisions to the NAIC Model Act that provide for external independent review of benefit trigger denials. This draft is being worked on by a subgroup of the NAIC Senior Issues Task Force. As of May 2009, the subgroup is close to having a final draft. A separate subgroup has been formed to work on revisions of the model regulation to provide for standardized claims definitions. This subgroup plans to begin working on a draft as soon as the independent review subgroup completes its work.[47]

Solvency of LTC Insurers

Given the current economic downturn, concerns about the long-run solvency of LTC insurers may adversely affect the demand for the product. Amidst this uncertainty, potential LTCI policyholders may decide to wait until the economic situation improves before contemplating a purchase of LTCI. In addition, there are concerns about the guarantee of benefits for current policyholders.

The insurance industry does provide a number of safeguards to protect LTCI policyholders from an insolvent insurer. The current system of protection for LTCI policyholders is called insurance guaranty funds. This interdependent system is a cooperative effort among regulators and insurers in the states where the insolvent insurer operated. It is administered state-by-state and funded by assessments on insurers.[48] When an insurer's financial condition deteriorates to the point where it may have trouble meeting its obligations, it is placed into receivership. In effect, the company and its policies are taken over by the insurance commissioner of the state where the insurer is domiciled. In the absence of bankruptcy, the commissioner may need to establish a plan to ensure policyholders receive coverage or benefits. For example, the insurance commissioner may allow other insurers to purchase parts of the troubled insurer's business. If, however, the company is liquidated, a state guaranty association may need to assume or reinsure policies of the failed insurer.

State law requires insurers to become members of the guaranty associations in each state in which they are licensed to do business. For health and long-term care insurance, the average coverage is

[46] Testimony of M. Cohen, president, LifePlans, Inc., before the U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term*?, hearings, July 24, 2008.

[47] Based on conversations with NAIC staff on April 21, 2009.

[48] For more information on these funds, see CRS Report RL32175, *Insurance Guaranty Funds*, by Baird Webel.

about $100,000. One concern about guaranty funds is that the amount of coverage per policy may not be sufficient to insure future potential losses due to insolvency. This does raise the possibility that the guaranty funds would have to raise premium rates and potentially reduce benefits for current policyholders in the future if even a few insurers become insolvent.

Key Features of Legislative Proposals in the 111th Congress

LTCI legislative proposals in the 111th Congress are aimed at lowering the cost of policies and improving consumer protections to increase participation in the LTCI market. If participation rates increase, many believe the overall costs of policies may be further reduced because the available risk-pool would be larger. Specifically, one of the key premises of insurance is to spread risk across as large a population as possible. Adverse selection occurs when individuals who expect to have a higher risk of LTC in the future (e.g., family history of Alzheimer's) are more likely to purchase a policy than those who do not. In a voluntary program, low participation may limit an insurer's ability to spread risk adequately resulting in adverse selection. When adverse selection is present in a voluntary system, insurers must charge higher premiums to cover the higher risk of the insured group. Thus, the greater the participation among the general population, the lower the effects of adverse selection.

A number of legislative proposals to increase demand for private LTC policies have been introduced or discussed in the 111th Congress. These include proposals to

- increase tax incentives to lower the after-tax cost of policies,
- improve consumer protections and increase consumer confidence in the product,
- provide a voluntary publicly-administered long-term care insurance product, and
- expand consumer education.

Expand Tax Incentives to Improve Affordability of LTCI

LTCI premiums currently do not have as generous tax incentives as health insurance. A number of legislative proposals introduced in the 111th Congress would expand the tax treatment of annual LTCI premiums. This section will first discuss the current tax treatment of LTCI and then detail the individual proposals and their implications for after-tax LTCI premiums.

Current Tax Treatment of LTCI Premiums

Under current law, there are some tax advantages provided to some aspects of private LTCI. Benefits from a "qualified" LTCI policy are excluded from the gross income of the taxpayer (i.e., they are exempt from taxation).[49] The exclusion for insurance benefits paid on a per diem or other periodic basis is limited to the greater of (1) $280 a day (in 2009) or (2) the cost of LTC services. Premiums for LTCI are allowed as itemized deductions to the extent they and other unreimbursed

[49] Health Insurance Portability and Accountability Act, P.L. 104-191 and Section 7702B(b) of the Internal Revenue Code.

medical expenses exceed 7.5% of adjusted gross income (AGI).[50] LTCI premiums, however, are subject to age-adjusted limits. In 2009, these limits range annually from $320 for persons aged 40 or younger to $3,980 for persons over the age of 70. In addition, under current law, employer contributions toward the cost of tax-qualified LTCI policies are excluded from the gross income of the employee. Self-employed individuals are allowed to include LTCI premiums in calculating their deductions for health insurance expenses. Only amounts not exceeding the age-adjusted limits can be deducted or excluded from taxable income.

In addition, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) authorized Health Savings Accounts (HSAs), which allow individuals to pay for LTCI premiums on a tax-advantaged basis. Individuals are eligible to establish and contribute to an HSA if they have a qualifying high deductible health plan (HDHP). Individuals enrolled in Medicare are excluded. Withdrawals from HSAs are exempt from federal income taxes if used for purchase of LTCI.[51]

A number of legislative changes to the tax code have enabled insurers to develop hybrid products that combine LTCI with either an annuity or a life insurance product. The Pension Protection Act (PPA) of 2006 simplified tax rules regarding combination products (effective in 2010) and added a tax provision specifying that proceeds from an annuity can be used tax-free to purchase a tax-qualified LTCI policy (under Section 7702B(b) of the Internal Revenue Code (IRC)).[52] PPA also allows individuals to use the cash surrender value of a life insurance policy as payment for a tax-qualified LTCI policy and exclude these payments from taxable income. Finally, PPA revised Section 1035 of the IRC to allow for tax-free exchanges of certain insurance contracts. Under this provision, no gain or loss is recognized on the exchange of a life insurance contract, an endowment contract, an annuity contract for a qualified LTCI contract or the exchange of one qualified LTCI contract for another.

Legislative Proposals To Expand Tax Incentives For LTCI

Legislative proposals in the 111th Congress include a number of additional tax incentives for LTCI. Their intent is to improve the affordability of LTCI policies by reducing the after-tax cost of policies and increasing the demand for LTCI. To do this, LTC insurance premiums would be included in one or more of the following options:

- an employer-sponsored cafeteria or flexible spending account plan, which would exclude them from gross income;
- as an "above-the-line" tax deduction to arrive at AGI; or
- as a credit against tax liability ("tax credit").

Table 4 summarizes the advantages and disadvantages of each option.

[50] See Section 213(d) of the Internal Revenue Code.

[51] CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2010*, by Janemarie Mulvey.

[52] See CRS Report R40008, *Converting Retirement Savings into Income: Annuities and Periodic Withdrawals*, by Janemarie Mulvey and Patrick Purcell.

Table 4. Advantages and Disadvantages to Taxpayers of Alternative Tax Incentives for LTC Insurance Premiums

Tax Treatment of LTC Insurance Premiums	Advantages	Disadvantages
Cafeteria Plan or Flexible Spending Account	Not limited to taxpayers who itemize. Reduces AGI for purposes of other tax provisions. Lowers wage base for Social Security and Medicare taxes on wages.	The employer must offer a cafeteria or flexible spending plan.
Above-the-Line Deduction	Not limited to taxpayers who itemize. Reduces AGI for purposes of other tax provisions.	Required to pay Social Security and Medicare payroll taxes on income used to fund premiums.
Tax Credit	Reduces regular tax liability by amount of credit.	Non-refundable tax credit. If tax liability is less than the credit amount then taxpayer would not benefit from full credit.

Source: Congressional Research Service.

Note: One proposal not included here (H.R. 1413, Representative Joseph) allows a below-the-line deduction from gross income for retirees for LTCI premiums.

Include Annual LTCI Premiums in Cafeteria and Flexible Spending Accounts

Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain benefits. Under this option, LTCI would be an eligible benefit within the plan and the employee would not be taxed on the value of the benefit. This arrangement reduces both income and employment taxes (i.e., Social Security and Medicare payroll taxes). Under some of the current legislative proposals, LTCI could also be an eligible expense in a flexible spending account (FSA). FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. Reimbursements through an FSA are also exempt from income and employment taxes.[53] Including LTCI in a cafeteria plan or FSA would also reduce adjusted gross income for purposes of other tax provisions. Cafeteria plans and FSAs only benefit individuals whose employer has established such plans. Retired workers are not likely to have coverage. For an individual filer with $55,000 in gross income and in the 25% tax bracket, this option would reduce the effective cost of the premiums by 32.65% (this includes a reduction in employment taxes of 7.65% as well).[54] Examples of legislative proposals in the 111th Congress to include LTCI premiums as part of FSAs or cafeteria plan are H.R. 897, H.R. 1721, S. 697, and S. 702.

[53] See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

[54] Example assumes a 50-year old individual who is a single tax filer with no dependents, earns $55,000 a year and is in the 25% tax bracket.

Above-the-Line Deduction

Under this option, LTCI premiums would be deducted from a taxpayer's gross income. An above-the-line deduction also reduces adjusted gross income for other tax provisions. The key difference from a cafeteria plan is that the provision is available to everyone and not limited to those employers who offer a plan. In addition, under this option, LTCI premiums (even if deducted from gross income) would still be subject to employment taxes if the individual were employed. For an individual filer with $55,000 in income and in the 25% tax bracket, this option would reduce after-tax LTCI premiums by 25%. Examples of legislative proposals in the 111th Congress that would include LTCI premiums as an above-the-line deduction are S. 697, H.R. 897, H.R. 1192, H.R. 1263, H.R. 1721, and H.R. 1891.

A Tax Credit

A tax credit is applied directly against a taxpayer's tax liability. The key distinction in a tax credit is whether it is refundable or nonrefundable. A fully refundable tax credit is paid to the taxpayer even if the amount of the credit exceeds the taxpayer's tax liability. Under a nonrefundable credit, if the tax liability is less than the credit amount of all refundable credits available, then the taxpayer would not benefit from the full credit. Under this option, after tax premiums for the individual filer with $55,000 in gross income would decline dollar for dollar by the amount of the tax credit if the individual's tax liability was equal to or exceeded the amount of all available tax credits. As of May 2009, there has been one proposal (S. 94) introduced in the 111th Congress to allow LTCI premiums to be a nonrefundable credit against one's tax liability.

Other Provisions

Although the discussion above provides a brief overview of the impact of the different options, actual tax savings will vary depending on the specific details of each of the proposals. To minimize the cost to the federal government, many of the current legislative proposals would not allow the full deduction or credit of premiums initially. Instead these proposals would

- phase-in the deduction or credit over time;
- base the percentage of LTCI premiums that is deductible or creditable on the number of years a policy is held; or
- limit the income from which a deduction can be taken, allowing only a deduction from gross income for distributions from a 401(k) or IRA.

Improve Consumer Protections for LTCI

As the market for LTCI expands, there is a growing concern that current regulations may not be sufficient to protect consumers from potential abuses in claims administration and processing and future rate stability. To address these issues, a few legislative proposals to expand tax incentives for LTCI require that these tax-qualified policies meet specific NAIC Model Regulations and Laws. These proposals are similar in that they would strengthen and create greater uniformity in consumer protections from tax-qualified plans. They vary with respect to which version of the NAIC Model Act is specified. (See **Table 3** for a summary of different versions of the NAIC Model Act with respect to consumer protections.) Examples of legislative proposals in the 111th Congress to improve consumer protections for LTCI include the following:

- H.R. 1192 would require tax-qualified policies to meet the 2000 NAIC Model Act.
- S. 702 would require tax-qualified policies to meet the 2006 NAIC Model Act.
- H.R. 897 would require tax-qualified policies to meet the 2008 NAIC Model Act (which is essentially the 2006 language with some technical corrections).
- S. 1636 would require the NAIC to develop a model disclosure form to assist consumers in purchasing LTCI.

In addition to the above proposals, a more comprehensive approach toward strengthening consumer protections was introduced through S. 1177, the Confidence in Long-Term Care Insurance Act of 2009. The legislation would apply current consumer protections for LTCI Partnership Policies to tax-qualified plans. In addition, the proposed legislation would formalize a process by which consumer protections in both tax-qualified and partnership policies could be updated in an expedited manner as new NAIC Model language is released.

S. 1177 would also direct the Secretary of Health and Human Services (HHS) to request the NAIC to conduct a biennial review of national and state-specific LTCI markets. These market reviews would be required to include data on the size and scope of the LTCI market, as well as data on complaints, cancellations, and premium rate increases. The NAIC would also be directed to develop consistent definitions for model disclosures and for marketing of LTCI policies. The Confidence in LTCI Act of 2009 would also require several reports to Congress, including

- a report with the results of the biennial market review;
- biennial reports on the impact of Medicaid LTCI Partnerships; and
- a report regarding the need for minimum annual inflation-protection.

Expand Consumer Education

The "Own Your Future" Long-Term Care Awareness Campaign is a joint federal-state initiative to increase awareness among the American public about the importance of planning for future LTC needs. The Own Your Future Campaign is a collaboration of the Centers for Medicare & Medicaid Services (see http://www.cms.hhs.gov), the Office of the Assistant Secretary for Planning & Evaluation (see http://www.aspe.hhs.gov), and the Administration on Aging (see http://www.aoa.gov), and it has support from the National Governors Association (see http://www.nga.org). The program was started in January 2005. The project's core activities are state-based direct mail campaigns supported by each participating state's governor, and targeted to households with members between the ages of 45 to 70. Campaign materials include a Long-Term Care Planning Kit and state specific information and resources in both print and on the internet. As of January 2009, 23 states have participated in the Own Your Future Campaign.

The response from consumers to the first two phases of the Own Your Future Campaign exceeded expectations, both in terms of consumer interest and in initiating LTC planning actions. Research following a five-state phase of the campaign indicated that individuals who received the planning kit were twice as likely to take some type of LTC planning action as compared to those who did not receive the kit. Based on these successes, Congress provided additional support for LTC education initiatives by establishing the National Clearinghouse for Long-Term Care Information

under the Deficit Reduction Act of 2005. Under Section 6021(d) of the act, Congress appropriated $15 million in funding for the National Clearinghouse over five years (2006 to 2010).

In the 111th Congress, there are two legislative proposal that would expand funding for the National Clearinghouse for Long-Term Care Information. H.R. 519 would appropriate annually $10 million for FY2010 to FY2012. S. 1177 would expand the National Clearinghouse for Long-Term Care Information to include an internet directory called "LTC Insurance Compare" that will provide tools to assist consumers in evaluating LTCI policies. S. 1177 includes $5 million annually in funding of LTCI Compare from 2011 to 2013.

LTCI in the Context of Health Care Reform

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148, as amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010, or HCERA), which establishes a publicly administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program.[55]

The publicly administered LTCI program is intended to address many of the concerns in the private LTCI market. Once established around 2013, employed individuals aged 18 and older could voluntarily enroll in the program. CLASS enrollment would not be subject to underwriting, except for age, so coverage would be available to all persons who enroll, regardless of pre-existing conditions. Employers can choose to participate in the CLASS program. In doing so, they must automatically enroll eligible employees. Employees would then have the opportunity to "opt-out" if they do not want to participate. The Secretary of HHS is required to develop an alternative enrollment process for self-employed individuals, those with more than one employer, and those who have an employer that does not elect to participate.

Premiums for the CLASS program are to be determined by the Secretary based on 75-year actuarial estimates of expected future use and expenditures. After a five-year vesting period, eligibility for benefits from the CLASS program is based on the existence of a functional or cognitive impairment that lasts for at least 90 days and that is certified by a licensed health care practitioner. Benefits to eligible recipients include a cash benefit of at least $50 a day, which varies based on the degree of the beneficiary's functional or cognitive impairment. Other benefits include advocacy services, and advice and assistance counseling on accessing and coordinating LTC services. PPACA also includes premium subsidies for workers with incomes below the federal poverty level and full-time students aged 18 to 21 who currently are working.

Table 5 shows premium estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS). CBO estimates that the average monthly premium in 2011 will be $123 (with premiums for new enrollees increasing for inflation in later years). These estimated premiums were calculated to be adequate for the program to remain solvent for 75 years, taking into account the interest income that would be generated on unspent balances in the program's Trust Fund.

[55] CRS Report R40842, *Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey and Kirsten J. Colello.

As shown in **Table 5**, CMS estimates that the initial average premium would be about $240 per month.[56] Premium estimates from CMS are higher than CBO's, largely reflecting assumptions about increased adverse selection. CMS states that "in general, a voluntary, unsubsidized, and non-underwritten insurance program such as CLASS faces a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases."[57] According to CMS, the problem of adverse selection would be intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees.

Table 5. Estimates of Average Monthly Premiums Under CLASS Program

CBO Estimate	$123 per month
CMS Estimate	$240 per month

Source: CMS estimates available in Memorandum from the Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as amended*. April 22, 2010. CBO estimates available in Memorandum to Senator Reid, dated March 11, 2010, at http://www.cbo.gov.

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[56] Memorandum from the Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as amended*, April 22, 2010.

[57] An analysis of the potential adverse selection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. This memorandum entitled "Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program" was issued on July 22, 2009, and based on the CLASS provisions in S. 1679, The Affordable Health Choices Act, which is similar to the CLASS provisions in PPACA.