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The Last Hope: How Starting Over Could Save Private Long-Term Care Insurance

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INTRODUCTION

The broken model for financing long-term care services and supports (LTSS) burdens public programs and individuals. A flawed private long-term care (LTC) insurance market is limited, fails to mitigate financial burdens, and creates an unsustainable reliance on state Medicaid programs. Public insurance solutions alone are not feasible given increasing needs for LTSS, limitations of state budgets, benefit and qualifying criteria restrictions under Medicaid, and current policy proposals to reduce Medicaid funding. Despite these inherent problems, proposed solutions to finance LTSS have prioritized public and social insurance models while largely underestimating the role of private market tools. A viable solution requires a balanced approach that integrates a thriving private LTC insurance market while improving public options. This article proposes amending state legislation to initiate a remodeling of LTC insurance products to support a thriving private LTC insurance market capable of mitigating LTSS financial burdens.

LTSS assist individuals with functional impairments that interfere with daily activities due to illness or disability.[1] Among the twelve million individuals whom rely on LTSS, 6.7 million are over sixty-five years old.[2] Policy makers and scholars have long recognized that an aging society will dramatically increase the burden on LTSS systems.[3]

1. LONG-TERM CARE COMM'N, A COMPREHENSIVE APPROACH TO LONG-TERM SERVICES AND SUPPORTS (2013).

2. *Id* at 3.

3. *Id.*

In 2013, the Commission on Long-term Care made an unequivocal call to action:

"Now is the time to put these new approaches and efforts in place if the coming generations of Americans are to have access to the array of LTSS needed . . . the need is great. The time to act is now."[4]

Financing LTSS has been an elusive challenge that permeates solutions to improve access to and quality of LTSS. No prior proposed solutions to this challenge have systematically examined LTC insurance as a mechanism to resolve LTSS financing challenges. The current LTC insurance market model is plagued with high premiums, low purchase rates, high rates of medical denials, and low profitability for insurers. Yet, these are symptoms of deeper issues that stem from state regulation of LTC insurance and are the root cause of market challenges. This article will systematically address three questions:

1) What is currently causing the private LTC insurance market to fail?

2) What is the mechanism for fixing these causes and implementing change?

3) What are the points of intervention that could spur a thriving LTC insurance market?

This article argues that current state legislation has led to unproductive underwriting practices, overly restrictive LTC insurance policy benefits and external incentives, and restricted profitability to create a sustainable market. As the mechanism for resolving market failures, this article proposes using the National Association of Insurance Commissioners (NAIC) Long-term Care Insurance Model Act and Regulation as catalysts to trigger broad adoption of amendments of key state legislation. This proposal capitalizes on the NAIC's prior success to inform state law using model acts. The proposal targets three points of intervention: underwriting standards that impede access to LTC insurance policies; poorly designed benefit restrictions and external incentives that fail to motivate LTC insurance purchase by key populations; and failing to establish protective mechanisms to support LTC insurers. Addressing these failures through state legislation will increase purchase rates, leading to lower premiums, and create a thriving LTC insurance market – thus saving the LTC insurance market from its "death spiral."

This article provides an initial background to the current structure of LTSS, insurance, and regulation in Section II. Section III details the flaws in the current LTC insurance market, primarily focusing on the

4. *Id* at 6.

cause and effect of poor purchase rates and market failure. Section IV will provide an overview of solutions to LTSS financing that were previously proposed. Section V will outline a proposal to amend model law to spur market reform as a last hope to saving private LTC insurance and financing LTSS.

I. LONG-TERM CARE SERVICES AND SUPPORTS, INSURANCE, AND REGULATION

A. Long-term Care Services and Supports

Long-term care services and supports (LTSS) are non-medical services to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[5] ADLs include bathing, dressing, eating, transferring, and walking.[6] Comparatively, IADLs include meal preparation, money management, house cleaning, medication management, and transportation.[7] LTSS include assistance at a range of levels depending on the individual's needs, including part-time at home care, adult day care, and skilled nursing facilities.[8]

Approximately twelve million Americans rely on paid LTSS.[9] On average, sixty-nine percent of LTSS users will use some type of LTSS for a period of three years.[10] Among individuals who rely on LTSS, seven million individuals (sixty percent) are older than sixty-five years old.[11] The estimated number of older adults with severe LTSS needs is expected to "increase by 140 percent between 2015 and 2055,"[12] in part due to the aging "baby boomer" generation. Increased needs for LTSS are matched by an increase in age related illnesses, including

5. *Glossary*, LONG TERM CARE, U.S. DEP'T HEALTH & HUM. SERV., https://longtermcare.acl.gov/the-basics/glossary.html (last updated Oct. 10, 2017).

6. *Id.*

7. *Id.*

8. *See e.g.* James D. Holt, *Navigating Long-Term Care*, 3 GERONTOLOGY & GERIATRIC MED. 1, 1-4 (2017).

9. Vivian Nguyen, *Long-Term Support and Services*, AARP (Mar. 2017), https://www.aarp.org/content/dam/aarp/ppi/201701/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf.

10. AM. ACAD. OF ACTUARIES, ESSENTIAL ELEMENTS: LONG-TERM FINANCING (2014).

11. *Summary of Commission's Findings,* CAPITAL RETENTION, https://capitalretention.com/commissionsfindings/ (last visited Nov. 18, 2018).

12. Melissa M. Favreault et al., *Financing Long-term Services and Supports: Option Reflect Trade-Offs for Older Americans and Federal Spending*, 34 HEALTH AFFAIRS 2181, 2181 (2015).

Alzheimer's disease and dementias.[13] Age associated illnesses, such arthritis, heart conditions, and diabetes, are the primary causes for physical functional impairment associated with LTSS use in adults over sixty-five.[14] Among those turning sixty-five, seventy percent will need LTSS within their lifetime and twenty percent will need LTSS for more than five years.[15] While eighty-two percent of elderly receive LTSS in the community,[16] advancing age increases the likelihood that an individual will receive care within an institutional setting.[17]

Since 2011, nearly 10,000 baby boomers turn sixty-five every day.[18] Baby boomers' health and social histories are unique from preceding generations. Baby boomers' self-reported health assessments show lower scores than previous generations.[19] Socially, baby boomers are more likely to value individualism, have higher incomes, are less likely to be married, and have fewer children but more siblings.[20] While two out of three baby boomers report that they expect to need LTSS, nearly one-third do not have plans for how to pay for services.[21]

The cost of LTSS varies according to the individual's functional needs, service preferences, care setting, and geographic locations. The average cost of a private room in a skilled nursing facility is approximately $92,000 per year, compared to $44,000 per year for an assisted living facility.[22] Institutional care makes up sixty-two percent of LTSS costs, the remaining costs are those provided in the community (e.g., at home nursing care), which average $20 per hour ($800 for a

13. LONG-TERM CARE COMMISSION, *supra* note 1; ALZHEIMER'S ASS'N, ALZHEIMER'S FACTS AND FIGURES REPORT (2017).

14. LONG-TERM CARE COMMISSION, *supra* note 1.

15. AM. ACAD. OF ACTUARIES, supra note 10.

16. CONG. BUDGET OFF., RISKING DEMAND FOR LONG-TERM SERVICES AND SUPPORTS FOR ELDERLY PEOPLE, at 20 (2013).

17. Approximately 13% of elderly over the age of 85 receive LTSS in institutional settings, compare to less than 2% of adults between 65-74 years old. *See id.* at 21.

18. Julie Robison et al., *Long-Term Supports and Services Planning for the Future: Implications from a Statewide Survey of Baby Boomers and Older Adults*, 54 GERONTOLOGIST 297, 299 (2014).

19. *Id.*

20. *Id.* at 299.

21. *Id.* at 304-305.

22. Wendy Fox-Grage, *Medicaid: A Last Resort for People Needing Long-Term Services and Supports*, AARP PUB. POL'Y INST. (Mar. 2017), https://www.aarp.org/ppi/info-2017/medicaid-a-last-resort-for-people-needing-long-term-services-and-supports.html.

forty hour work week).[23] On average, individuals who require LTSS do not have a sufficient income to cover the costs of LTSS for themselves or a loved one.[24] Nursing home care costs are equivalent to 225% of the median income for individuals over sixty-five years old.[25]

Total LTSS costs in the United States were $219.9 billion in 2012, approximately 9.3% of all personal health care spending.[26] LTSS prices are expected to increase; between 2002 and 2012 price increases ranged between 1.6% (home health aide) to 5.1% (assisted living) a year.[27] A majority of these costs are covered by Medicaid (sixty-two percent).[28] Among private sources, out-of-pocket spending (seventeen percent) is most common;[29] LTC insurers pay for twelve percent of LTSS expenses.[30]

Family members and informal (non-paid) caregivers serve a critical role in the larger LTSS system. Informal caregivers are responsible for up to fifty-five percent of LTSS provided to the elderly.[31] In 2009, the monetary value of informal care was $450 billion.[32] Informal care allows individuals to remain in their community longer and reduces direct LTSS expenses.[33] While many informal caregivers do so because they prefer to be the one providing care to a loved one, a lack of access due to high expenses associated with LTSS is also a driving factor for the high rates of informal caregivers.[34] Caregivers absorb costs and risks associated with providing care, including caregiver burden and opportunity costs (e.g., loss of employment and interruption of care for other dependents).[35] The reliance on informal caregivers is becoming

23. NAT'L HEALTH POL'Y FORUM, NATIONAL SPENDING FOR LONG-TERM SERVICES AND SUPPORTS (LTSS), 2012 (2014); PAMELA DOTY & SAMUEL SHIPLEY, DEPT. HEALTH AND HUMAN SERV. OFFICE ASSISTANT SECRETARY FOR PLAN. AND EVALUATION, LONG-TERM CARE INSURANCE 1 (2012).

24. Fox-Grage, *supra* note 22.

25. *Id.*

26. NAT'L HEALTH POL'Y FORUM, supra note 23.

27. CONG. BUDGET OFF., *supra* note 16, at 24.

28. *Id.* at 25.

29. LONG-TERM CARE COMM'N, *supra* note 1.

30. CONG. BUDGET OFF., *supra* note 16, at 28.

31. *Id.* at 31.

32. LONG-TERM CARE COMM'N, *supra* note 1, at 14.

33. Allison K. Hoffman, *The Reverberating Risk of Long-Term Care,* 15 YALE J. HEALTH POL'Y L. & ETHICS 57, 60 (2015).

34. LONG-TERM CARE COMM'N, *supra* note 1, at 4.

35. Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y L. & ETHICS 147, 153-154 (2016).

"increasingly untenable" given an aging society.[36] The aging of the baby boomer generation will dramatically influence the number of available caregivers. The number of potential informal caregivers for each older adult will decrease from seven to less than three between 2015 and 2050.[37]

B. LTSS Financing: Medicaid and LTC Insurance

Individuals and families are unlikely to have sufficient income or savings to fully cover LTSS out-of-pocket.[38] As described below, a minority of people own an LTC insurance policy.[39] The broadly accepted misperception that health insurance and Medicare cover LTSS expenses prevents individual and familial preparation.[40] This misunderstanding is highlighted in data reporting that individuals are misinformed regarding costs of LTSS and available insurers and payors that provide LTSS coverage.[41] This section will provide an introduction on LTC insurance and Medicaid as the primary payor of LTSS.

1. Private Long-term Care Insurance

LTC insurance policies emerged in the market over thirty years ago, initially as "nursing home insurance" providing benefits to offset the cost of skilled nursing facilities.[42] In the 1990s, insurers began selling comprehensive policies to cover institutional and community based care.[43] By 2015, a majority of policies offered broader benefits including home care, with less than one percent of policies only covering nursing

36. *Id.*

37. Shana Siegel & Neil T. Rimsky, *Where Do We Go From Here? Long-Term Care in the Age of the Baby Boomers*, 11 NAT'L ACAD. ELDER L. ATT'Y J. 49, 52 (2015).

38. LONG-TERM CARE COMM'N, *supra* note 1 at 6.

39. *Id.* at 3.

40. *Id.* at 13; Erica L. Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*, HENRY J. KAISER FAMILY FOUND. (Dec. 15, 2015), https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/; PAUL A. WERTSCH, COUNCIL ON MED. SERV., FINANCING OF LONG-TERM SERVICES AND SUPPORTS 1 (2018).

41. Galina Kahtutsky et al., *What Do People Know About Long Term Services and Supports?*, U.S. DEP'T. OF HEALTH & HUM. SERV. (Sept. 1, 2016), https://aspe.hhs.gov/basic-report/what-do-people-know-about-long-term-services-and-supports.

42. ERIC C. NORDMAN, THE STATE OF LONG-TERM CARE INSURANCE: THE MARKET, CHALLENGES AND FUTURE INNOVATIONS, NAT'L ASS'N INS. COMMISSIONERS 2 (2016).

43. *Id.* at 7.

home care.[44] The LTC insurance market is largely an individual private market, in comparison to health insurance which relies on group and employer policies.[45] Group policies were initially introduced into the LTC insurance market in 1987.[46] Only twenty percent of employers with more than ten employees (.5% of all employers) offer LTC insurance.[47]

LTC insurance is unique among its counterparts, adopting characteristics of health, life, and disability insurance.[48] Life insurance provides coverage for a definitive loss (death) that occurs with predictable benefits, determined by the amount selected by the policyholder.[49] Public and private health insurance cover losses that are highly likely to occur in an acute setting with services provided by trained professionals (i.e., physicians, nurses) within specialized settings (i.e., hospitals, medical centers).[50] Finally, disability insurance provides coverage for an uncertain event with established benefits and a limited end-point according to the individual's age (most policies end coverage once a policyholder is sixty-five years old).[51] Private LTC insurance adopts the benefit trigger model used in disability insurance, the benefit features of health insurance, and the premium structure implemented in life insurance.[52]

Approximately 7.2 million LTC insurance policies were in force in 2014.[53] As it is currently designed, LTC insurance is a product for the upper class and well educated. Individuals who purchase policies are more likely to be college-educated (sixty-eight percent of purchasers),

44. *Id.* at 18.

45. Jeffrey R. Brown & Amy Finkelstein, *The Private Market for Long-Term Care Insurance in the United States: A Review of the Evidence*, 76 J. RISK & INS. 5, 10 (2009).

46. *Id.*

47. NORDMAN, *supra* note 42, at 9.

48. Kenneth S. Abraham, Note, *Four Conceptions of Insurance*, 161 UNIV. PA. L. REV. 653, 686 (2013).

49. Lawrence A. Frolik, *Private Long-Term Care Insurance: Not the Solution to the High Cost of Long-Term Care for the Elderly*, 23 ELDER L.J. 371, 376 (2016).

50. *See generally* LOUIS C. GAPENSKI, UNDERSTANDING HEALTHCARE FINANCIAL MANAGEMENT 42-44 (4th ed. 2007).

51. *Do Disability Benefits End at Age 65?*, DISABILITY BENEFITS CTR., https://www.disabilitybenefitscenter.org/faq/do-disability-benefits-end-at-age-65 (last visited Jan. 4, 2019).

52. DOTY & SHIPLEY, *supra* note 23, at 4.

53. NORDMAN, supra note 42, at 8.

employed (sixty-eight percent of purchasers),[54] and have relatives who have experienced LTSS needs.[55] The average age of purchasers is fifty-eight years old.[56] Individuals with higher incomes are more likely to have LTC insurance than others.[57] Approximately nineteen percent of adults over fifty-five years old with annual incomes over $100,000 have LTC insurance policies, while only around nine percent of individuals with incomes between $20,000 to $50,000 have LTC policies.[58] Similarly, the average income of purchasers has increased from $27,000 in 1990 to $87,500 in 2010; this increase was also matched in average assets owned by the purchaser.[59]

Individuals with LTC insurance policies receive more hours of paid LTSS than un-insured counterparts.[60] Caregivers of individuals with LTC insurance provide different types of care as compared to their counterparts of individuals without LTC insurance, shifting care provided from hands-on intensive care to companion care.[61] This has the effect of greatly reducing caregiver burden and restoring familial relationships.[62] Average monthly savings for an individual with a policy using LTSS range between $3000 to $5000.[63] For individuals living in a nursing home, the average monthly savings are $4838.[64] The average purchaser, who enrolls at age sixty-five, pays approximately $52,000 in premiums and can be entitled to nearly $550,000 in maximum benefits at the age of eighty-two.[65] Despite reducing unmet needs and providing monthly savings, LTC insurance policies still leave coverage gaps for individuals' LTSS needs.[66]

54. *Id.* at 20; WHO BUYS LONG-TERM CARE INSURANCE? TWENTY-FIVE YEARS OF STUDY OF BUYERS AND NON-BUYERS IN 2015-2016, LIFEPLANS 15 (Jan. 2017).

55. DOTY & SHIPLEY, *supra* note 23, at 4.

56. NORDMAN, *supra* note 42, at 53.

57. DOTY & SHIPLEY, *supra* note 23, at 4.

58. *Id.*

59. NORDMAN, *supra* note 42, at 20.

60. *Id.* at 24.

61. *Id.* at 25.

62. *Id.* at 42.

63. *Id.* at 23.

64. *Id.*

65. *Id.* at 36.

66. Kali S. Thomas & Robert Applebaum, *Long-Term Services and Supports (LTSS): A Growing Challenge for an Aging America*, 25 GERONTOLOGICAL SOC. OF AMERICA 56, 57 (2015).

2. Medicaid LTSS Coverage

Medicaid is a federal and state run program that provides health care benefits to individuals who meet means based eligibility requirements.[67] Medicaid is the largest payor for health care and LTSS in the United States providing coverage for nearly seventy-three million individuals.[68] In 2013, over seventeen million individuals with disabilities and adults over sixty-five years old (5.5% of the total population) relied on Medicaid.[69] Approximately forty percent of these individuals were over the age of sixty-five.[70] Medicaid, the primary source for financing LTSS in the United States, pays for over sixty percent of all LTSS expenses.[71] In 2016, state and federal Medicaid expenditures for LTSS equaled nearly $167 billion, an increase from $159 billion in 2015.[72] LTSS' reliance on Medicaid cost federal and state Medicaid programs nearly $152 billion in 2014.[73]

Medicaid eligibility criteria require individuals to demonstrate that their income and assets meet the "means test."[74] This means that the individual has less than a set amount in assets (usually less than $2000).[75] An individual or family may "spend down" their assets to meet these requirements, by using up any assets that are over the threshold amount. Approximately ten percent of adults over fifty "spend down"[76] resources to qualify for Medicaid to access services.[77] Nearly forty percent of individuals who "spend down" to meet Medicaid eligibility requirements are in the middle class.[78] The 2005 Deficit Reduction Act created additional restrictions in order to close loopholes

67. *Medicaid Eligibility*, MEDICAID, https://www.medicaid.gov/medicaid/eligibility/index.html (last visited Jan. 9, 2018).

68. *Id.*

69. Fox-Grage, *supra* note 22.

70. *Id.*

71. CONG. BUDGET OFF., *supra* note 16.

72. Steve Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports in FY 2016*, MEDICAID INNOVATION ACCELERATOR PROGRAM (May 2018), https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.

73. Fox-Grage, *supra* note 22.

74. *Id.*

75. *Id.*

76. *Spending Down Assets to Qualify for Medicaid*, ELDER LAW ANSWERS (Aug. 1, 2018), https://www.elderlawanswers.com/spending-down-assets-to-qualify-for-medicaid-12003.

77. Fox-Grage, *supra* note 22.

78. *Id.*

in meeting the means test, including prohibiting individuals to transfer assets to family members or set up trusts.[79] During the spend down period individuals must cover costs of LTSS until they meet eligibility requirements.[80]

Medicaid coverage is incomplete in two aspects. First, the coverage provided under Medicaid limits access to services that are provided under state plans.[81] State Medicaid plans must include nursing home care, but other services are optional.[82] Reimbursement rates for Medicaid programs are typically set between ten and thirty percent below private pay rates for nursing homes.[83] State plans may place limits on community-based programs.[84] Enrollment caps for community-based services lead to waitlists and substandard care.[85] Additionally, Medicaid programs may exclude some disabling conditions or prohibit assistance with some daily activities.[86] Second, individuals may go without access to appropriate care while working to meet the means tests to qualify. The reliance on Medicaid to provide financing for LTSS adds an upwards of 10,000 individuals per day without access to paid LTSS.[87]

Medicaid programs have a direct impact on LTC insurance purchase rates due to a "crowd out effect."[88] Data demonstrates that the availability of Medicaid as a safety net reduces individual willingness to pay for long-term care insurance for all but the wealthiest individuals.[89] Data from a 2007 study demonstrates that the broad

79. DOTY & SHIPLEY, *supra* note 23, at 4.

80. NORDMAN, *supra* note 42, at 145.

81. LONG-TERM CARE COMM'N, *supra* note, 1 at 14.

82. *Id.*

83. Daniel Barczyk & Matthias Kredler, *Evaluating Long-Term-Care Policy Options, Taking the Family Seriously*, 85 REV. OF ECON. STUD. 766, 770 (2017).

84. LONG-TERM CARE COMM'N, *supra* note, 1 at 3.

85. Judy Feder, *The Challenges of Financing Long-term Care*, 8 ST. LOUIS U. J. HEALTH L. POL'Y 47, 55 (2014).

86. *See* Hoffman, *supra* note 35, at 170.

87. NORDMAN, *supra* note 42, at 33.

88. Jeffrey R. Brown & Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, 98 AM. ECON. REV. 1083, 1091-92 (2008). "Crowd out" is commonly referred to as the phenomenon that occurs, where, as a result of Medicaid as an option to pay for LTSS, individuals – particularly those in the middle class – are less like to purchase LTC insurance. Instead, individuals assume that when services are needed, they will be able to rely on Medicaid. *See* Frolik, *supra* note 49, at 377-79.

89. *Id.* at 1092-1093.

availability of Medicaid leads to an unwillingness to purchase an LTC insurance policy.[90] This study found that even when other market failures were resolved to provide an actuarially fair and comprehensive LTC insurance policy that individuals were unwilling to pay for insurance.[91] Populations in the sixtieth percentile of wealth in men and seventieth percentile of wealth in women were the only reported exceptions to unwillingness to purchase LTC insurance when Medicaid is available.[92] Without solutions to incentivize purchase rates of LTC insurance in non-wealthy populations, the rising demands on LTSS and reliance on Medicaid will place fiscal pressure on state and federal budgets.[93] In 2003, a National Governors Association report indicated that states paid as much in LTSS costs as K-12 education.[94] This financial pressure will squeeze out budgets for other priorities, particularly with looming pressure to "trim" Medicaid at the federal level.[95]

C. Regulation of Long-term Care Insurance

LTC insurance is regulated primarily through state law, with minimal federal legislative or regulatory influence.[96] Federal law establishes a bare-bone foundation for (1) minimum coverage provided by long-term care policies, and (2) generally defining long-term care policies.[97] Federal law does not, however, regulate LTC insurance underwriting or coverage practices.[98] Additionally, LTC insurance is not subject to major federal anti-discrimination laws including the

90. *Id.* at 1093.

91. *Id.* at 1092-1093.

92. *Id.* at 1093.

93. Brown & Finkelstein, *supra* note 45, at 2.

94. *Id.*

95. *Id.*

96. Jalayne J. Arias et al., *The Proactive Patient: Long-term Care Insurance Discrimination Risks of Alzheimer's Disease Biomarkers*, 46 J. OF L. MED. & ETHICS 485, 485 (2018).

97. Treatment of Qualified Long-Term Care Insurance, 26 U.S.C.A. § 7702(B)(c)(1) (2015).

98. *See id.*

Affordable Care Act (ACA)[99] and the Genetic Information Non-Discrimination Act (GINA).[100] Limited federal law is consistent across insurance types, leaving states at the helm of regulating insurance practices.

The McCarren-Ferguson Act delegates the regulation of insurance to states.[101] States have broad discretion to establish standards for insurers through legislation and regulation.[102] Typically, this includes legislation and regulations, as well as oversight provided by the Insurance Commissioner.[103] An insurance commissioner may have different powers in individual states, but they are generally charged with leading the state's Department of Insurance and overseeing insurance regulation.[104] This has led to varying approaches for standards and practices across states.[105] These variations create barriers to broad and effective solutions at a national level.

II. BROKEN LONG-TERM CARE INSURANCE MARKET

LTC insurance is a failing market. Scholars, policymakers, and the media have regularly recognized the challenges burdening the market.[106] Prior criticisms of the market have focused on poor purchase rates and

99. *Long-Term Care Insurance Tax-Deductibility Rules – LTC Tax Rules*, AM. ASS'N FOR LONG-TERM CARE INS., http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php (last visited Nov. 18, 2018); The ACA prohibits health insurers from discriminating against an individual based on a preexisting condition for underwriting decisions. Prohibition of Preexisting Condition Exclusions, 45 C.F.R § 147.108 (2015).
The ACA prohibits health insurers from discriminating against an individual based on a preexisting condition for underwriting decisions. Prohibition of Preexisting Condition Exclusions, 45 § 147.108.

100. GINA prohibits employers and health insurers from using genetic information, including family history, to discriminate against individuals. Genetic Information Nondiscrimination Act, Pub. L. No. 110-233, 122 Stat. 881 (2008).

101. McCarren Ferguson Act, 15 U.S.C.S. § 1012 (1945).

102. *Id.*

103. *See About the Department*, CAL. DEP'T INS., https://www.insurance.ca.gov/0500-about-us/02-department/ (last visited Oct. 12, 2018).

104. *About the NAIC*, NAT'L ASS'N OF INS. COMMISSIONER, https://www.naic.org/index_about.htm (last visited Dec. 10, 2018).

105. Arias et al., *supra* note 97.

106. Frolik, *supra* note 49, at 414; Howard Gleckman, *The Traditional Long-Term Care Insurance Market Crumbles*, FORBES (Sept. 8, 2017), https://www.forbes.com/sites/howardgleckman/2017/09/08/the-traditional-long-term-care-insurance-market-crumbles/#71eddbf63ec3.

limited policy values for individual purchasers.[107] This section will highlight data to evaluate the causes and effects of essential flaws in the LTC insurance market, including poor purchase rates and market failures.

A. Poor Purchase Rates

Among adults between the ages of sixty and sixty-five, only ten percent hold LTC insurance policies.[108] Only 89,000 individuals purchased new LTC insurance policies in 2016, almost a fourteen percent drop from the number purchased in 2015.[109] Declining insurance purchase rates have been attributed to multiple factors, including underwriting practices, insufficient benefit and incentive structures, and high premiums.

1. Underwriting Standards

Underwriting is the collection of individual information to evaluate an applicant's risk for future benefit claims to determine eligibility and premium rates.[110] Standard underwriting practices rely on collecting and evaluating an applicant's "past and current use of health services, medical conditions, lifestyle, and limitations in physical and medical functioning."[111] While underwriting may lead to denials and prohibitively high premium rates, it also is critical for insurance market stability.[112] Underwriting guards against adverse selection and protects insurers against profit losses resulting from actual claims exceeding projected or expected claims.[113]

State law and regulation provides significant discretion to LTC insurers in the context of underwriting practices.[114] Unlike health insurers, LTC insurers are broadly permitted to collect and use health information for underwriting decisions.[115] Individuals with past medical histories may be denied a policy or face increased and prohibitively high

107. Gleckman, *supra* note 107.

108. Portia Y. Cornell et al., *Medical Underwriting in Long-Term Care Insurance: Market Conditions Limit Options for Higher-Risk Consumers*, 35 HEALTH AFF. 1494, 1495 (2016).

109. Gleckman, *supra* note 107.

110. Helena Temkin-Greener et al., *Long-term Care Insurance Underwriting: Understanding Eventual Claims Experience*, 37 INQUIRY 348, 349 (2000).

111. *Id.*

112. *Id.* at 356-357.

113. *Id.* at 349.

114. Arias et al., *supra* note 97, at 485.

115. *See id.* at 488.

premiums.[116] Explicit legislative and regulatory provisions permitting medical underwriting[117] exacerbate consequences of current practices.

Insurers' underwriting practices are proprietary information and are not easily accessible. However, publicly available guidance documents for purchasers and underwriters may provide insight on standards used by a specific company. For example, underwriter guides issued by insurers recommend careful observation for evidence of disability obtained through in-person observation and tailored interview questions to elicit risk for a collection of named conditions.[118] Guides also provide lists of uninsurable conditions, commonly known as "knock-out" conditions. These conditions include AIDS, Alzheimer's disease, uncontrolled depression, diabetes (if outside weight parameters), and some organ transplants.[119] When a knock-out condition does not immediately disqualify an individual from LTC insurance, other risk factors may lead to varying rates based on "preferred" or risk status.[120]

Approximately twenty-four percent of individuals who apply for LTC insurance are denied a policy due to medical underwriting.[121] Individuals who are in the target population for LTC insurance (between the ages of sixty and seventy-one), are likely to experience higher rates of denial (up to forty percent).[122] Several factors are most influential in determining eligibility, including age and medical history of diabetes or stroke.[123] When controlled for other factors, "each ten-year increase in age significantly decreased approval probability."[124] Among applicants over eighty years old, forty-four percent are denied coverage, compared to less than seven percent of those under forty-five years old.[125] A medical history of diabetes and stroke were the most

116. *See id.* at 486.

117. *See e.g.,* Utah Code Ann. § 31A-22-1406 (2011).

118. *Long Term Care Insurance Underwriting Guide*, GENWORTH FIN., at ii (2007), http://www.resourcebrokerage.com/pdfs/ltci/underwriting/genworth.pdf.

119. *Id.* at vi; *See Underwriting Guidelines for the Enhanced Care Benefit Rider and Long Term Care Acceleration of Death Benefit Rider,* METLIFE, https://croweandassociates.com/wp- content/uploads/2016/07/FIX_ECB_UW_Flyer.pdf (last visited Dec. 17, 2018).

120. GENWORTH FIN., *supra* note 119, at iv; Temkin-Greener et al., *supra* note 111, at 351.

121. Cornell et al., *supra* note 109, at 1495-1496.

122. *Id.* at 1500.

123. *Id.* at 1498.

124. *Id.*

125. U.S. DEP'T HEALTH & HUM. SERV., LONG-TERM CARE INSURANCE RESEARCH BRIEF 6 (2012).

influential in adversely affecting approval ratings in comparison to history of other chronic diseases.[126] Individuals who are extremely obese or underweight had similar rates of denial.[127] Lastly, recent data demonstrates that parental medical history may now also influence underwriting practices, particularly when considering premium rates.[128]

The denial rates-based health information provides no evidence on the accuracy of actuarial practices. At least one study has shown that underwriting practices, including the use of knock-out conditions, does not accurately predict high users of LTSS who would be "high risk" policy holders.[129] A simulation of underwriting practices demonstrated that individuals who would be rejected from policies were not consistently likely to have higher uses of LTSS.[130] Inaccurate underwriting practices impede access to LTC insurance without appropriate justification and unnecessarily narrow the population of potential purchasers.

Adverse decisions based on health information may appear discriminatory. However, discriminatory behavior is consistent with risk classification practices that are broadly accepted under the guise of efficiency.[131] Risk classification practices provide insurers with information to determine eligibility and premiums that are consistent with an individual's risk for loss covered under the relevant policy.[132] Insurers use individual information to identify risk of loss for underwriting practices protects the insurer and its pool of insured. At the federal level, across insurance types, only four statutes and one regulation have placed limits on insurers' use of individual information in underwriting.[133] None of these federal laws extend protections to LTC insurance.[134]

126. Cornell et al., *supra* note 109, at 1496.

127. *Id.*

128. Juliette Fairley, *Parental Medical History Now Influencing the Cost of Long-term Care Premiums*, FIN. ADVISOR (Sept. 12, 2014), https://www.fa-mag.com/news/parental-medical-history-now-influencing-the-cost-of-long-term-care-premiums-19134.html.

129. Temkin-Greener et al., *supra* note 111, at 355.

130. *Id.*, at 356.

131. Ronen Avraham et al., *Understanding Insurance Antidiscrimination Laws*, 87 S. CAL. L. REV. 195, 197 (2014).

132. *Id.* at 204; GEORGES DIONNE & CASEY G. ROTHSCHILD, CIRRELT, RISK CLASSIFICATION AND HEALTH INSURANCE 1 (2011).

133. Avraham et al., *supra* note 132, at 199.

134. AMERICAN ASS'N FOR LONG-TERM CARE INSURANCE, *supra* note 100.

2. Policy Benefits and External Incentives

Insufficient policy benefits and external incentives have limited the perceived value of LTC insurance policies to potential purchasers.[135] Benefit triggers serve as an additional barrier to claiming benefits for LTSS. Most LTC insurance policies do not cover all costs incurred by LTSS users due to benefit limits and elimination periods.[136] As a result, individuals and families remain responsible for some out-of-pocket expenses associated with LTSS.[137] This, in combination with a lack of insufficient external incentives (e.g., tax incentives), limits the appeal of LTC insurance, particularly those who have other financial priorities that take the place of monthly premiums.[138]

a. Benefits

Individuals with policies are not free from financial responsibility for LTSS. Benefit triggers, elimination periods, and benefit caps limit the portion of LTSS expenses covered and protect insurers from excessive losses due to claims.[139] These policy mechanisms reduce the benefits available to policy holders, adversely impacting the value of the policy to a potential purchaser.

"Benefit triggers" are qualification criteria a policyholder must meet to make a claim for LTSS benefits under an LTC insurance policy.[140] Benefit triggers are met when an individual has impairment that interferes with managing ADLs as determined by a licensed professional (i.e., physician, nurse, social worker).[141] In the case of cognitive impairment, supervision and verbal cueing are sufficient to meet benefit triggers.[142] If a policy is "tax qualified," benefits are triggered when a policy holder is unable to perform at least two ADLs for a period of at least 90 days.[143] Insurers are prohibited from conditioning eligibility of benefits on prior hospitalization or other "high level" institutional care.[144] Insurers are required to disclose benefit

135. ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, CHOOSING LONG-TERM CARE INSURANCE POLICIES: WHAT DO PEOPLE WANT 8 (2016).

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.* at 393-94.

140. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION (2017).

141. *Id.* at §§ 29-30.

142. *Id.* at §§ 29(D)(2).

143. *Id.* at § 30.

144. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 6(D)(1)(b) (2017).

triggers for policy holders.[145] Benefit triggers create a barrier by which insurers can decline coverage. A lack of trust in insurers and anecdotal evidence of unjustified adverse coverage decisions may discourage individuals from purchasing LTC insurance.[146]

Most policies do not provide coverage immediately upon meeting criteria for benefit triggers.[147] Elimination periods, also referred to as deductibles or waiting periods, require that an individual has experienced impairment for a specified number of days before coverage is provided.[148] Elimination periods are on average ninety-three days,[149] but range from twenty to 100 service or calendar days.[150] As a result, even individuals who have invest in LTC insurance will need to rely on out-of-pocket payments for LTSS until they meet the elimination period requirements.

Benefit limits establish thresholds for costs covered daily, annually, and within a lifetime. Most LTC insurance policies place caps on the costs covered, which will not meet the full cost of care.[151] In 2015, the average daily benefit limits were $159 for nursing home care and $152 for home care.[152] Additionally, insurers are unlikely to sell policies without a benefit duration cap, averaging four years, to avoid liability for an unlimited period.[153] This has been a change in policy design since the 1990s. In 1990, thirty-three percent of policies offered lifetime benefits and, in 2015, this declined to eleven percent.[154] Benefit duration caps are inconsistent with data demonstrating that twenty percent of LTSS users will need services for more than five years and another twenty percent will need services for between two and five years.[155] Similar to elimination periods, the use of benefit limits can discourage

145. *Id.* at § 6(G)(2)(b).

146. Frolick, *supra* note 49, at 385, 393.

147. *Id.*

148. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION §§ 29-30.

149. NORDMAN, *supra* note 42, at 18.

150. NAT'L ASSOC. INS. COMMISSIONERS, A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE 23 (2013).

151. *Id.*; *Health Insurance Caps Leave Patients Stranded*, NBC NEWS, http://www.nbcnews.com/id/25644309/ns/health-health_care/t/health-insurance-caps-leave-patients-stranded/#.W93E_hNKiu4 (last updated July 13, 2008).

152. NORDMAN, *supra* note 42, at 18.

153. LIFEPLANS, *supra* note 54, at 22.

154. *Id.* at 23.

155. LONG-TERM CARE COMM'N, *supra* note, 1 at 3.

potential purchasers, given the continued need for out-of-pocket payment for expenses.

b. External Incentives

External incentives, including tax benefits, can be beneficial to offset the costs associated with purchasing an LTC insurance policy. However, tax incentives have yet to motivate purchase rates in the middle class.[156] Current federal policies permit individuals to include premiums for tax-qualified policies as part of medical expense tax deductions.[157] An individual can deduct medical expenses that are greater than 7.5% of their income in 2017 and 2018.[158] Beginning in 2019, deductions will only be available for medical expenses that exceed ten percent of an individual's income.[159] In addition to federal tax incentives, twenty-four states offer tax incentives that reduce the average tax premium costs by an average of five percent.[160]

Additionally, individuals who purchase "tax-qualified" policies are not required to report benefits as income.[161] A policy is tax-qualified if it meets regulated criteria, including: (1) the policy only provides coverage for LTSS; (2) the policy is guaranteed renewable; (3) the benefits are triggered by impairment interfering with two ADLs; (4) the policy has requirements that chronic illness or disability continues for at least ninety days; and (5) the policy's benefits are triggered by cognitive impairment only when the impairment requires "substantial supervision."[162] Additionally, tax-qualified policies must include inflation protection, dramatically increasing the cost of premiums.[163] This incentive does not help offset premium costs for the years before an individual claims their benefits. As a result, this benefit may increase adverse selection by not encouraging individuals to purchase a policy prior to identifying a potential need for LTSS. Insurers also cite

156. *Id.*

157. Dena Bunis, *How You Can Deduct Your Medical Expenses*, AARP (Jan. 12, 2018), https://www.aarp.org/money/taxes/info-2018/medical-deductions-irs-fd.html.

158. *AGI Threshold for Medical Expenses Restored to 7.5%*, IRS, https://www.irs.gov/forms-pubs/agi-threshold-for-medical-expenses-restored-to-75 (last updated Feb. 9, 2018).

159. Tax Cuts and Jobs Act of 2017 Pub. L. No. 115-97 (2017).

160. DOTY & SHIPLEY, *supra* note 23, at 8.

161. *Do I Have to Report Benefits From a Long-Term Care Insurance Policy to the IRS?,* MCCANN INS. SERV., https://mccannltc.net/resources/faq/reporting-benefits-to-the-irs (last visited Nov. 18, 2018).

162. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 30.

163. *Id.* at § 13.

requirements to meet the criteria as impediments to innovative product design.[164]

3. High Premiums

High premiums are simultaneously a cause and effect of low purchase rates. The average annual policy premium was $2772 in 2015.[165] Premium rates vary depending on individual risk profiles and the benefits selected by the policy holder.[166] Once a risk profile is determined through underwriting, an insurer will make an eligibility determination and offer the policy to accepted candidates based on specified premium rates.[167] Some insurers will assign the individual to a rate class.[168] For example, an individual who is high risk may be assigned to a "lower preference" category that assigns higher premiums.[169] Premiums rates will also differ based on an individual's benefit elections (i.e., length of coverage, benefit limits, covered services).[170] For example, an individual's age at the time of enrollment and selecting inflation protection can dramatically influence a premium.[171] An enrollee who purchases a policy at age fifty for $200 daily benefits for four years of coverage will pay an average of $4349 in an annual premium with inflation protection.[172] Without inflation protection, the annual would be $1294. The same policy would be $13,500 and $8146 respectively for an individual who is seventy-five at the time of enrollment.[173] If an individual enrolled at fifty-five and then sought benefits at age eight-five, the policyholder would have paid over $81,000 in premiums, assuming that rates were not raised. In 2012, ASPE reported that in the preceding ten years almost all LTC insurers

164. NORDMAN, *supra* note 42, at 26.

165. *Id.* at 18.

166. Temkin-Greener et al., *supra* note 111, at 351.

167. *Id.*

168. *Id.* at 350.

169. *Id.* at 351.

170. NAT'L ASSOC. INS. COMMISSIONERS, *supra* note 151.

171. *How Insurance Companies Set Health Premiums,* HEALTHCARE.GOV, https://www.healthcare.gov/how-plans-set-your-premiums/ (last visited Nov. 18, 2018).

172. Robert Powell, *How to Handle Long-Term Premium Hikes*, USA TODAY (Mar. 16, 2014), https://www.usatoday.com/story/money/columnist/powell/2014/03/16/powell-long-term-care-insuranceretirement/6428373/.

173. NAT'L ASSOC. INS. COMMISSIONERS, *supra* note 151, at 33.

had substantially increased their rates.[174] Similar data reported that between 2010 and 2015 premiums increased by nineteen percent.[175]

High premium rates are a significant contributor to low purchase rates.[176] The high cost of LTC insurance narrows the pool of individuals who would be financially suitable for purchasing an LTC insurance policy. Only approximately forty-five percent of individuals have sufficient incomes and assets to be financially suitable candidates for LTC insurance.[177] The most conservative recommendations indicate than an individual is financially suitable if (1) LTC insurance premiums would make up less than five percent of the individual's income, and (2) the individual has over $50,000 in assets.[178] Purchasers on average have an income of $87,500 and eighty-two percent of purchasers have assets valued over $100,000.[179] Among individuals who are financially suitable for LTC insurance policies, only sixteen percent of those over sixty-five and five percent of those between forty-five and sixty-five years old have policies.[180] Non-buyers specifically reference competing demands and other priorities for finances.[181] This sentiment is further reflected in a continued decline in purchase rates in the middle class.[182]

B. Market Failures

Market sustainability has been a critical flaw for LTC insurance. The sustainability of an insurance product relies on the willingness of individuals to pay for it.[183] LTC insurance, as described above, has struggled to incentive purchases. In the 1980s and the 1990s, the private LTC insurance market saw a growth.[184] In 2002, approximately 100

174. DOTY & SHIPLEY, *supra* note 23, at 5.

175. LIFEPLANS, *supra* note 54, at 24.

176. 55% of adults over 50 report that high costs deterred purchase. NORDMAN, *supra* note 42, at 22.

177. Cornell et al., *supra* note 109, at 1499.

178. *Id.*; *Long-Term Care*, NAT'L ASS'N INS. COMMISSIONERS, https://www.naic.org/cipr_topics/topic_long_term_care.htm (last updated July 11, 2018).

179. LIFEPLANS, *supra* note 54, at 5.

180. MARC A. COHEN ET AL., U.S. DEP'T HEALTH & HUM. SERV., EXITING THE MARKET: UNDERSTANDING THE FACTORS BEHIND CARRIERS' DECISION TO LEAVE THE LONG-TERM CARE INSURANCE MARKET 20 (2013).

181. JOSHUA M. WIENER ET AL., ASPE, FINDINGS FROM THE SURVEY OF LONG-TERM CARE AWARENESS AND PLANNING 4 (2015).

182. NORDMAN, *supra* note 42, at 138.

183. Frolik, *supra* note 49, at 375.

184. NORDMAN, *supra* note 42, at 7.

insurers were actively selling LTC insurance policies, but by 2012, this number dropped to twelve.[185] Insufficient profits are the most cited reason for insurers' decisions to leave the market.[186] Low purchase rates have individual and societal consequence, as well as major consequences for the sustainability for the market based on loss of profits.

Actuarial sustainability requires that revenues (through collected premiums) must be ample enough to meet the needs of future payouts (claims).[187] A 2016 NAIC Report on the market reported that current earned premiums total under $12 billion, in contrast to the $28 billion earned in group life insurance.[188] Despite the decline in LTC insurance policy purchases and premiums collected, the number of claims has continued to increase.[189] As a result, loss ratios (the difference between the claims paid to the premiums collected) have steadily increased reflecting data that actual claims have exceeded expected claims.[190]

1. Actuarial Challenges

LTC insurance actuarial analysis faces unique challenges to maintain sustainable loss ratios. The market has struggled to accurately price policies and anticipate costs of claims.[191] Predictors for use of LTSS are not well described.[192] As a result, collected health and personal information to determine risk may not be sufficient for a full actuarial analysis. Accuracy in actuarial analysis is further complicated because of significant uncertainties unique to LTSS, including individual preferences and the availability of informal caregivers to defer the need for paid services. LTC insurance assumes the risk for care which is provided in multiple settings (home or institution), LTSS is labor intensive but does not always require highly skilled caregivers, the period of care is unpredictable, and the potential risk of needing access to coverage is uncertain. Adverse selection and more hazards contribute to limitations of actuarial analysis in LTC insurance.

As a voluntary program, LTC insurers are exposed to increased risks of adverse selection.[193] Adverse selection is the use of information

185. Ami Ko, 18th Ann. Joint Meeting of the Retirement Res. Consortium, Selection in the Long-Term Care Insurance Market (Aug. 4-5, 2016).

186. NORDMAN, *supra* note 42, at 3.

187. AM. ACAD. OF ACTUARIES, *supra* note 10.

188. NAT'L ASS'N INS. COMMISSIONERS, 2016 ANNUAL REPORT 8 (2016).

189. NORDMAN, *supra* note 42 at 8, 163.

190. *Id.* at 15 (actual claims exceed expected claims by 107%).

191. *See id.* at 17.

192. Temkin-Greener et al., *supra* note 111, at 356-357.

193. AM. ACAD. OF ACTUARIES, *supra* note 10.

unknown to the other party (here, the insurer) to inform a decision.[194] For purposes of LTC insurance, adverse selection refers to the population of individuals who seek LTC insurance after learning information that increases their risk of LTSS need in the future.[195] High rates of adverse selection increase the proportion of individuals who are "high risk" policyholders within an insured pool.[196] An insurance pool with an increase proportion of "high risk" policyholders negatively influences the risk loss ratio, due to an increased demand for claims, ultimately resulting in high premiums rates.[197]

"Moral hazard" references the concept that an individual with insurance protection will be more likely to use services or engage in risky behavior, than they would without a policy.[198] Moral hazard is distinct in LTC insurance. First, individual preference is likely to inform the type and location of care sought under an LTC insurance policy benefit. It is feasible to think that having an LTC insurance policy would result in utilization of more expensive care.[199] Second, having a policy increases the access to and availability of types of services, in comparison to limited services provided under Medicaid programs.[200] And finally, informal caregivers may simultaneously provide care and serve as decision makers for the type and level of LTSS.[201] Elimination periods may serve as a counter to moral hazard risks by encouraging policyholders and caregivers to explore less expensive services. Yet, this does not eliminate the possibility that once coverage is available an individual will select more expensive LTSS. Moral hazards increase the complexity of actuarial analysis.

2. Market Instability for Policyholders

In 2016, only seventeen insurers sold LTC insurance policies;[202] another report cites that in 2012 only twelve insurers remained in the

194. *Id.*

195. Frolik, *supra* note 49, at 383-85.

196. *Id.*

197. *Id.* at 385.

198. *Id.* at 385.

199. Helmuth Cremer et al., *The Design of Long Term Care Insurance Contracts*, 50 J. HEALTH ECON. 330, 331 (2016).

200. Richard Elsenberg, *Medicare, Medicaid and Long-Term Care: Your Questions Answered*, FORBES (Nov. 21, 2017, 1:04 PM), https://www.forbes.com/sites/nextavenue/2017/11/21/medicare-medicaid-and-long-term-care-your-questions-answered/#6b2a070976c9.

201. NAT'L ACAD. SCI., ENGINEERING & MED., FAMILIES CARING FOR AN AGING AMERICA 88-89 (2016).

202. Gleckman, *supra* note 107.

market.[203] This is a sharp decline from the nearly 100 insurers selling LTC insurance products in 2002.[204] The declining number of insurers in the market hinders access due to a limited supply, also increasing premium rates. The consequences of an insurer no longer offering LTC insurance policies or leaving the market likely informs non-purchasers' opinions about the value and security of a potential policy. However, purchasers are protected from losing the value of their policy in the circumstance where an insurer "leaves" the market. An insurer may leave the market either by suspending sales of new LTC insurance policies or by going bankrupt.[205] If an insurer suspends policies sales, no longer selling new policies, the company must honor the individual's policy under Guaranteed Renewable Clauses.[206] The Guaranteed Renewable Clauses required under state law prohibit insurers from canceling a policy.[207] Therefore, in this circumstance, an individual purchaser would still have coverage under their policy according to the agreed terms. If an insurer goes bankrupt, the Insurance Guarantee Pool protects the purchaser.[208] In this situation, two outcomes may arise: first, another insurer could purchase the bankrupting insurers' assets and would be required to honor the policies purchased.[209] Second, if another insurer does not purchase the assets, the state-run Insurance Guarantee Pool will honor the liabilities of an insurance policy up to a specified amount.[210] However, the rate of insurers leaving the market raises concerns about the viability of private LTC insurance, as it is currently modeled.

203. NORDMAN, *supra* note 42, at 12.

204. *Id.*

205. *What Happens When My Insurance Company Leaves the Market?,* LTC CONSUMER, https://ltcconsumer.com/newsletter/what-happens-when-my-insurance-company-leaves/ (last visited Feb. 7, 2018).

206. *Id.*

207. *Id.*; Ed Beeson, *Long-Term Care Insurance Market Shrinking as Prudential, Others Pull Back*, NJ.COM (Mar. 25, 2012), http://www.nj.com/news/index.ssf/2012/03/insurers_including_njs_prudent.html.

208. Hersh Stern, *State Guaranty Associations ("SGAs")*, IMMEDIATE ANNUITIES (Oct. 21, 2018), https://www.immediateannuities.com/state-guaranty-associations/.

209. Dana Anspach, *What Happens If Your Insurance Company Files Bankruptcy?*, BALANCE (Oct. 23, 2018), https://www.thebalance.com/what-happens-if-your-insurance-company-files-bankruptcy-2388607.

210. *Id.*

III. PRIOR SOLUTIONS

Challenges associated with LTSS financing are not new and multiple scholars and policy makers have proposed solutions. However, none of these solutions have yet to fully address the issues plaguing the system. New proposals must incorporate prior lessons learned to develop feasible solutions that will influence LTSS financing. This section will examine prior proposals, including a critical assessment of why proposals were less successful. Proposals vary as to (1) promoting public or private insurance solutions; (2) the beneficiary of benefits provided under insurance (i.e., the care-recipient or "next-friend");[211] and (3) the potential use of innovative structures (i.e., hybrid products). This section highlights some key proposals but does not cover all solutions. International models, including those implemented in Germany and Japan, have also been raised as models for financing LTSS through social models.[212] Because they are less feasible to implement, models that rely on a health care system which greatly differs from the United States' health care system will not be reviewed here. Instead, key details of the CLASS Act, the 2013 Report by the Commission on Long-term Care, Partnership Programs, Hybrid Products, and the integration of family and friends in developing solutions will be reviewed.

A. The CLASS Act

In 2010, the Patient Protection and Affordable Care Act's (ACA) efforts to reform health care included the Community Living Assistance Service and Supports Act (CLASS Act).[213] As a final priority of Senator Edward (Ted) Kennedy, the CLASS Act aimed to provide a federal voluntary LTC insurance program for individuals needing LTSS.[214] The CLASS Act targeted the needs of the middle class by providing an affordable option to enroll in LTC insurance and prepare for future LTSS expenses.[215] The CLASS Act was a controversial measure prior to its passage, even along party lines. Just four months before the ACA was signed into law, eleven Democrats urged Senate leadership to remove the CLASS Act from the ACA before passage.[216] Critics

211. Hoffman, *supra* note 35.

212. Barczyk & Kredler, *supra* note 84.

213. Patient Protection and Affordable Care Act, P. Law No. 111-148, § 8002, 124 Stat. 119 (2010).

214. *Id.*

215. Gardener Harris & Robert Pear, *Still No Relief in Sight for Long-term Care Needs*, N.Y. TIMES (Oct. 24, 2011), http://www.nytimes.com/2009/12/14/health/policy/14care.html.

216. *Id.*

questioned the actuarial soundness of the proposed program.[217] They argued that the bill did not have sufficient funding for marketing necessary to promote participation and that it lacked sufficient eligibility requirements.[218] Despite these criticisms, the CLASS Act was kept as part of the ACA and was signed into law in March 2010.[219]

The CLASS Act sought to establish a federal voluntary insurance program, enrolling participants through employers who elected to participate.[220] Employees of participating employers would be automatically enrolled unless they opted out, modeled after retirement savings programs.[221] Consistent with the group insurance model, underwriting would not be used to determine eligibility or premiums.[222] The Department of Health and Human Services (HHS) would be responsible for establishing premium rates according to age of enrollees, with nominal rates for individuals who were below the poverty line and students.[223] Enrollees in the insurance program would receive cash benefits.[224] Amounts would have been determined according to functional need, but be no less than $50 per day without aggregate or lifetime limits.[225] Enrollees would become eligible for benefits after five years of paying premiums if unable to perform at least two ADLs.[226] Finally the CLASS Act placed significant limitations on the program's ability to increase premiums, including barring a raise of premiums for individuals over sixty-five or who are no longer employed.[227] The CLASS Act relied on the Secretary of HHS to implement the program and structure it to remain solvent over a seventy-five-year period funded entirely through premiums.[228]

217. Kate Pickert, *Should Long-Term-Care Insurance Be-Part of Health Reform?,* TIME (Dec. 8, 2009), http://content.time.com/time/politics/article/0,8599,1946431,00.html.

218. Specifically, concerns were raised that work requirements were not sufficient, by permitting those were employed seasonally to enroll. *Id.*

219. *Id.*

220. Patient Protection and Affordable Care Act, P. Law No. 111-148, § 8002, 124 Stat. 119 (2010).

221. *Id.*

222. *Id.*

223. *Id.*

224. *Id.*

225. *Id.*

226. *Id.*

227. *Id.*

228. *Id.*

Shortly after the ACA's enactment, the Secretary of HSS determined that the CLASS Act was actuarially insolvent.[229] A financial analysis of the program determined that in the initial nine years of the program there would be a net Federal savings of approximately $38 billion due to the five-year vesting period.[230] The savings from the program would decline beginning in 2015 as enrollees begin using benefits.[231] Projected benefits would exceed premium revenues beginning in 2025 leading to a Federal net cost for the program long term.[232] In addition to failing to meet the CLASS Act's requirement for solvency over a seventy-five-year period, the program would fail to significantly increase participation in LTC insurance.[233] Approximately two percent of potential participants (an estimated 2.8 billion) were projected to enroll by the third year, compared to the four percent of potential participants enrolled in private insurance through employers.[234] The estimated average premium needed to adequately fund the program was $240 per month, given the estimated low participation rate.[235]

The program's flaws resulted from interconnected consequences of a voluntary program, without a federal subsidy to encourage enrollment, that lacked a mechanism to screen for high risk participants, leading to a high risk of adverse selection.[236] Adverse selection was determined to be the nail on the actuarial coffin for this program.[237] The lack of underwriting and expected higher premiums was would have likely deterred healthy individuals from enrolling in the program.[238] Additionally, there was no method to prevent already disabled individuals from enrolling and seeking benefits once they have vested.[239] The program, offering $50 per day benefits, would have

229. Chris Fleming, *Health Policy Brief: The CLASS Act*, HEALTH AFF. (May 18, 2011), https://www.healthaffairs.org/do/10.1377/hblog20110518.010958/full/; U.S. DEP'T HEALTH & HUM. SERV., A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM (2011).

230. Memorandum from Richard S. Foster, Dept. Health and Human Serv. CMS Office of the Actuary, (Apr. 22, 2010).

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.* at 15.

238. *Id.*

239. *Id.*

difficulty competing with private LTC insurance with higher daily benefits which would be more appealing to healthy individuals seeking policies. As a result, those who would have most incentive to enroll would be those who are already in need of or know they will have a high risk for needing LTSS in the near future – a trait that would create the "insurance death spiral."[240] Ultimately, the Administration determined that this program could not succeed under the statutory requirements; the CLASS Act was repealed in 2012.[241]

B. Commission for Long-term Care Services and Supports

The Taxpayer Relief Act of 2012 (Relief Act) simultaneously repealed the CLASS Act and created the Commission on Long-term Care (LTC Commission).[242] The Relief Act mandated that the LTC Commission develop a "plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system" for LTSS.[243] The LTC Commission released its report to Congress in September 2013 with recommendations on service delivery, the workforce, and financing.[244] Unlike other sections of its report, which included specific and actionable recommendations, the LTC Commission was unable to reach consensus on a single approach to financing LTSS.[245] The LTC Commission offered two alternate approaches. The distinctions between the approaches reflect tensions over what to prioritize: solutions to improve the private insurance market *or* public solutions through social insurances.[246] The LTC Commission simultaneously recognized limitations of government programs serving as the safety net given budget constraints and argued for a more robust private insurance market and emphasized LTSS as a social challenge requiring a societal solution.[247] The proposed solutions reflected the tension over public versus private market priorities.

1. Commission on Long-term Care: Approach A

Approach A recommended strengthening the private market through individual and market incentives.[248] The LTC Commission

240. *Id.*

241. Am. Taxpayer Relief Act, P. Law No. 112-240, § 642, 126 Stat. 2313 (2012).

242. *Id.* at § 643.

243. *Id.*

244. LONG-TERM CARE COMM'N, *supra* note 1.

245. *Id* at 3.

246. *Id.*

247. *Id.*

248. *Id.*

proposed a tax preference through retirement and health accounts by allowing individuals to pay for LTC insurance premiums by withdrawing from 401(k) or other retirement funds or by creating a subsidy to pay for premiums through Social Security distributions.[249] Other components of the proposal included promoting hybrid products through a change of tax law and supporting Long-term Care Partnership Programs (described in further detail below). To promote market incentives the LTC Commission proposed removing regulatory burdens that are hampering private insurance carriers but did not specify which regulations were barriers.[250] Finally, the LTC Commission recommended addressing Medicaid "crowd out" by increasing qualification criteria to encourage individuals to take responsibility for preparing for the future cost of care.[251]

Among their recommendations, only the shift in Medicaid qualification criteria would influence purchase rates in the middle class. Tying LTC insurance purchase rates to 401(k), life insurance, or annuity assumes that purchasers have resources to invest in these products, which have largely been accessible only to those with significant incomes and assets. As a result, these products are unlikely to be available to a majority of individuals. For example, in 2017 only about one-third of individuals were contributing to a 401(k) account, even though seventy-nine percent of individuals have employers who are offering 401(k) benefits.[252] Moreover, offering additional incentives does not address limitations of prior tax incentive models that were not successful in improving purchase rates, particularly for the middle class. The LTC Commission's recommendations failed to evaluate the core issues limiting the private LTC insurance market.

2. Commission on Long-term Care: Approach B

Approach B proposed two models to offer social insurance. First, the LTC Commission proposed a comprehensive LTSS benefit in Medicare Part A, triggered by physician certification that an individual meets criteria.[253] Under this proposal an individual would meet criteria if they required assistance with at least two ADLs for more than ninety

249. *Id.*

250. *Id.*

251. Jeffrey R. Brown et al., *Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey*, (Nat'l Bureau of Econ. Research, Working Paper No. 12536, 2006).

252. Ben Steverman, *Two-Thirds of Americans Aren't Putting Money in Their 401(k)*, BLOOMBERG, (Feb. 7, 2018, 4:00 AM) https://www.bloomberg.com/news/articles/2017-02- 21/two-thirds-of-americans-aren-t-putting-money-in-their-401-k.

253. LONG-TERM CARE COMM'N, *supra* note 1, at 7.

days and were expected to continue to need services.[254] Individuals whose mental or cognitive health interfered with independence would also meet criteria.[255] Benefits would cover "reasonable and necessary LTSS." For example, skilled nursing facility care, home health care, adult day center services, and respite care options to support family or other volunteer caregivers would be covered.[256] The LTC Commission proposed covering costs associated with the new benefits through an increased Medicare payroll tax or the creation of a premium. The LTC Commission recognized that because not all people who need LTSS are Medicare eligible, some consideration needed to be given to expanding eligibility for individuals who meet criteria but do not otherwise qualify for Medicare.[257]

The LTC Commission's second proposed model developed a basic LTSS benefit within Medicare that would provide limited catastrophic coverage.[258] Under this proposal, individuals would be responsible for providing private coverage or otherwise covering LTSS costs that do not constitute financially "catastrophic" risks.[259] Individuals would qualify for benefits when they met a "specified threshold of functional impairment" after a waiting period.[260] The benefit would be a specified dollar amount per day according to the level of impairment, individuals would be able to elect a direct pay for service benefits instead of a cash benefit.[261] To pay for this proposal, the LTC Commission recommended a surcharge on income tax for individuals near or at retirement age.[262]

These proposals provided potentially viable public options to improve access to LTSS through a federal program, Medicare. However, despite emphasizing the potential role of social insurance, the LTC Commission recognized that such proposals will not be sufficient to

254. *Id.*

255. *Id.*

256. *Id.*

257. To qualify for Medicare Part A, individuals must be older than 65, have received disability benefits for more than 24 months, or receive regular-dialysis or have had a kidney transplant. CTR FOR MEDICARE & MEDICAID SERVICES, ORIGINAL MEDICARE (PART A & B) ELIGIBILITY AND ENROLLMENT (last visited Oct. 28, 2018), https://www.cms.gov/Medicare/EligibilityandEnrollment/OrigMedicarePartABEligEnrol/index.html; LONG-TERM CARE COMM'N, *supra* note 1, at 8.

258. LONG-TERM CARE COMM'N, *supra note 1,* at 8.

259. *See id,* at 60.

260. *Id.*

261. *Id.*

262. *Id.*

address LTSS needs alone.[263] As such, private insurance and Medicaid will continue to serve critical roles in financing services.[264] Given this reality, to otherwise be successful, these approaches require that a thriving private LTC insurance model be available to reduce the burden on social programs.

3. Additional Recommendations, Limitations, and Challenges

The LTC Commission provided recommendations outside the two larger approaches for changes to the current system, including improving benefits for individual who need LTSS to continue employment, amending Medicare requirements for skilled nursing facility coverage, and reevaluating Medicare coverage for home or community-based services.[265] The LTC Commission's potential approaches were broad sweeping. In the current political dynamic, with high tensions over publicly funded state programs (i.e., Medicaid), implementing LTC Commission's recommendations would likely not be feasible. The approaches also lack critical details, particularly regarding the private market, to operationalizing proposals. A lack of a clear recommendation from the LTC Commission runs the risk of piecemeal adoption of solutions without evaluating the larger issues that undermine the potential promise of a consistent and balanced solution.

C. Partnership Programs

The Long-term Care Insurance Partnership Program (Partnership Program) began with Programs in four states in the 1980s (California, Connecticut, Indiana, and New York).[266] The Federal Deficit Reduction Act (2005) expanded the program nationally.[267] The LTC Commission also reiterated recommendations for support of Partnership Programs in 2013.[268] A Partnership Program attempts to reduce the burden on Medicaid by incentivizing private LTC insurance purchase,[269]

263. *Id.*

264. *Id.*

265. *Id.* at 12.

266. *Frequently Asked Questions*, FED. LONG-TERM CARE INS. PARTNERSHIP PROGRAM, https://www.ltcfeds.com/help/faq/miscellaneous_partnership.html (last visited Nov. 18, 2018).

267. *Id.*

268. LONG-TERM CARE COMM'N, *supra note 1,* at 8.

269. Enid Kassner, *Long-Term Care Insurance Partnership Programs*, AARP (Apr. 2016), https://www.aarp.org/health/medicare-insurance/info-2006/fs124_ltc_06.html.

specifically encouraging the middle class who would otherwise rely on Medicaid.[270]

Partnership Programs are federally-supported, but state-operated.[271] In states with Partnership Programs, individuals who purchase a tax-qualified LTC insurance policy may still qualify for Medicaid after policy benefits have been depleted.[272] Participants benefit from the program through a mitigated spend down requirement to meet Medicaid means eligibility tests.[273] An individual with a qualified LTC insurance policy receives a dollar-for-dollar asset protection for each benefit dollar received under the LTC insurance policy.[274] For example, if an individual purchases a policy, then receives $50,000 in benefits under that policy before applying for Medicaid coverage, the individual is permitted to have the maximum state designated assets *plus* $50,000 to qualify under the means test for Medicaid.[275]

Nearly every state has implemented Partnership Programs.[276] Despite the widespread adoption, Partnership Programs have demonstrated a modest effect on LTC insurance purchase rates.[277] Additionally, the programs have not successfully impacted purchase rates in the middle class.[278] Partnership Programs have had the most impact on individuals with high asset levels, above the eightieth percentile of asset ownership.[279] The lack of success may be related to under-education of individuals who would be appropriate candidates. Recent reports demonstrate that up to seventy-five percent of individuals over seventy-five years old are not aware that their state offers a Partnership Program.[280] This is particularly alarming in light of data demonstrating that forty-five percent of adults report that a Partnership Program would increase the attractiveness of an LTC

270. *Id.*

271. *Id.*

272. *Id.*

273. *See id.*

274. FED. LONG-TERM CARE INS. PARTNERSHIP PROGRAM, *supra* note 268.

275. James C. Skeeles et. al., *Basic Estate Planning: The Nursing Home Dilemma*, OHIO ST. UNIV.: SCH. OF FOOD, AGRIC., & ENVTL. SCI. (Jul. 6, 2012), https://ohioline.osu.edu/factsheet/EP-10.

276. Haizhen Lin & Jeffrey Prince, *Determinants of Private Long-Term Care Insurance Purchase in Response to the Partnership Program*, 51 HEALTH SERV. RES. 687, 688 (2016).

277. *Id.*

278. *Id.*

279. *Id.*

280. *Id* at 697.

insurance policy.[281] However, other flaws may be hindering the programs' success. Partnership Programs do not address high premiums which impede purchase rates among the middle class.[282] Because the purchased LTC insurance must be tax qualified,[283] the policy will include inflation protection and other features that increase premium costs. As a result, these programs have not accounted for a lack of access to LTC insurance by those who remain "financially unsuitable" to purchase a policy.

D. Hybrid Options

Hybrid product proposals aim to address consumer concerns regarding the value of benefits provided under traditional LTC insurance policies. Hybrid products combine LTC insurance with other types of insurance, for example a life or annuity policy.[284] "Combination products" were included in the LTC Commission's Approach A, as a mechanism to further reduce adverse selection risks, lower premiums, and relax underwriting standards.[285] The LTC Commission recommended that a change in tax law that would "allow investment and distribution in the LTC insurance portion through tax-advantaged retirement accounts would encourage creation and uptake of these policies."[286] Two types of hybrid products have been particularly relevant to the market. First, life insurance hybrids allow individuals to pay for LTSS expenses by accelerating the death benefit for a set period (i.e., twenty-four or forty-eight months).[287] If a policy holder never uses the LTC insurance benefit, his or her heir receives the full death benefit.[288] Second, annuity combination products add LTC insurance riders, which allow the individual to pay LTSS expenses out of the existing annuity value.[289] The hybrid structure provides benefits for individual purchasers, including an investment that is not the "use it or lose it" model that is risked in LTC insurance.[290] Additionally, for policies that utilize a single premium, policyholders do not face the risk

281. *Id.*

282. *Id* at 695.

283. *Id* at 691.

284. NORDMAN, *supra* note 42, at 10.

285. LONG-TERM CARE COMM'N, *supra note 1,* at 16.

286. *Id.* at 15.

287. NORDMAN, *supra* note 42, at 11.

288. *Id.* at 10.

289. *Id.*

290. Wade Pfau, *Hybrid Long-Term Care Insurance Policies,* FORBES (Jan. 21, 2016), https://www.forbes.com/sites/wadepfau/2016/01/14/examining-long-term-care-insurance/#50540533afd9.

of premium hikes.[291] Life insurance hybrid products purchase rates have increased in recent years, from nearly 73,000 in 2009 to over 305,000 in 2013.[292] In 2015, 200,000 hybrid products were sold,[293] marking an increased interest in hybrid products.

The strengths of the potential value of these products must be evaluated in the context of some weaknesses. First, these products do not address accessibility challenges limiting purchase rates in the middle class. Life insurance and annuity products require costly investments upfront. For example, Fidelity offers a life insurance hybrid product to individuals between the ages of thirty-five and sixty-nine years old (sixty-five if he or she is a smoker) with a single premium of $25,000.[294] However, this is at the low end of single premium models, other reports of premiums range up to $100,000.[295] Thus, purchase rates are consistently limited to those with significant assets. Some financial advisors advise these products only to individuals with $500,000 to $2 million in assets.[296] Second, hybrid products lack some benefits that are included within traditional LTC insurance products. Hybrid products may have more limitations on coverage, limited benefit periods, and surrender periods (i.e., a waiting period before you can seek benefits).[297] Third, hybrid products do not offer the same tax incentives associated with LTC insurance policies because they are not "tax-qualified policies."[298] Finally, analysists have also argued that such an investment does not provide the best financial benefit, particularly in contrast to purchasing an LTC insurance policy and investing the remainder of available funds.[299]

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291. *Id.*

292. NORDMAN, *supra* note 42, at 11.

293. Eleanore Laise, *Hybrid Insurance Policies Gaining Steam*, KIPLINGER (Jan. 2017), https://www.kiplinger.com/article/insurance/T036-C000-S004-hybrid-policies-gaining-steam.html.

294. *Long Term Care*, FIDELITY.COM, https://www.fidelity.com/life-insurance/ long-term-care/details (last visited Nov. 13, 2018).

295. *Universal Life Insurance*, FIDELITY.COM, https://www.fidelity.com/life-insurance/universal-life-insurance/overview?print=true (last visited Nov. 13, 2018).

296. John F. Wasik, *Hybrid Long-Term Care Policies Provide Case and Leave Some Behind*, N.Y. TIMES (Mar. 4, 2016), https://www.nytimes.com /2016/03/06/business/retirementspecial/hybrid- long-term-care-policies-provide-cash-and-leave-some-behind.html.

297. *Id.*

298. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 4(A).

299. Laise, *supra* note 295.

E. Family and Informal Caregiver Insurance and Financial Responsibility

The critical role of informal caregivers in LTSS has spurred several recommendations that focus on the family and friends of individuals needing LTSS. These proposals, either recommend that the family member be the beneficiary of an insurance product or holding family members responsible for financial consequences of LTSS.[300] Below are two examples representing a larger literature on the role of family members and other informal caregivers.

Allison Hoffman argues that costs to family members and friends as caregivers should be the focus of evaluation.[301] In her argument, she provides extensive evidence of the "next friend" risk.[302] Professor Hoffman describes "next-friend" risks as those that "arise in service of something that we expect people to do and that we perceive as a public benefit: providing care for people with serious illness or disability."[303] In addition to providing evidence of caregiver burden, Professor Hoffman details the historical changes in policy and law that have increased the probability that care is provided at home with the use of informal caregivers.[304] Professor Hoffman proposes a social insurance for next friend risk, which would rely on an individual with qualifying disability designating a next friend.[305] The next friend would receive benefits through the social insurance to provide care or pay for services.[306] This proposal relies on an individual electing to enroll in a social insurance and selecting an individual to serve in the "next friend" role. While this proposal highlights key challenges facing caregivers, it does not account for LTSS needs that extend beyond what informal caregivers can provide. As a result, "next friend" social insurance would likely serve as a supplement to a broader LTSS financing solution.

Legal scholars have also promoted the use of filial laws to hold family members responsible for the costs of LTSS to mitigate Medicaid burden.[307] Filial responsibility laws are statutory obligations for family members to be financially responsible for a family member, traditionally

300. Hoffman, *supra* note 35, at 219-20; *See* Jamie P. Hopkins et al., *Leveraging Filial Support Laws Under the State Partnership Programs to Encourage Long-Term Care Insurance*, 20 WIDENER L. REV. 165, 189 (2014).

301. Hoffman, *supra* note 35, at 152.

302. *Id.* at 195.

303. *Id.* at 196.

304. *Id.* at 159-167.

305. *Id.* at 219, 220.

306. *Id.* at 220.

307. *See id.* at 177-178.

used to hold parents responsible for children.[308] Professor Hopkins and colleagues recommend that these laws provide incentives for purchase of LTC insurance through partnerships, by creating a disincentive for not purchasing LTC insurance.[309] This recommendation is limited by inconsistent enforcement between states.[310] An additional limitation of this recommendation is the assumption of traditional familial structures, which have continued to evolve. It is possible that the enforcement of the filial law could result in an estranged family member being held financially responsible for an individual with whom they have no real relationship.

It is clear that family members and friends serve essential roles and accept significant risks when serving as an informal caregiver. As a result, there may be some place for providing insurance that assists caregivers and reduces the burden of serving in this role. It is unclear, however, whether the implementation of such a program would resolve solutions for individuals who lack access to caregivers and or do not exist within traditional family structures.

IV. Proposal

This proposal aims to (1) increase accessibility to LTC insurance by amending regulation of underwriting practices; (2) improve incentives for younger and healthier purchasers to balance the insurance pool; and (3) motivate the market through improved regulations that protect insurers from consequences of actuarial challenges. The proposal prioritizes state legislative amendments as the primary mechanism for regulating insurance broadly. To accomplish broad adoption of proposed state legislative amendments, I argue for revisions to the National Association of Insurance Commissioners (NAIC) Long-term Care Insurance Model Act and Regulation. The NAIC Model Act and Regulation serve as an efficient and feasible tool to spur state amendments. However, this proposal recognizes that such amendments alone are not sufficient to address challenges to finance LTSS in the United States. A successful LTSS financing system will include a balance of private and public financing. This proposal seeks to increase the role of private LTC insurance and reduce the burden on public funding, particularly Medicaid. Reducing this burden will increase feasibility to reform public insurance. The proposal begins at the federal law, using federal legislation to incentivize states to amend their legislation. Second, the proposal describes the NAIC Model Act and Regulation as a proxy for state law to identify legislative and regulatory

308. Hopkins et al., *supra* note 302, at 189.

309. *Id.* at 197-98.

310. *Id.* at 192.

sections that impede a thriving private LTC insurance market. Lastly, this proposal will detail specific amendments to the NAIC Model Act, with the intention that these amendments will be broadly adopted by state legislators and regulators.

A. Federal Law to Create State Incentives

A federal law that triggers state action is the initial step necessary to triggering widely adopted changes. While current political dynamics may create barriers for legislative amendments that increase regulation of LTC insurers at the state level, a well-structured legislative proposal could offer benefits to individuals and insurers. This proposal begins with a federal act that would create a Medicaid program to provide additional funding to states specific to LTSS and create a new Medicaid LTSS insurance program that builds upon current coverage, available only to individuals who purchase LTC insurance. This borrows from the Partnership Programs, with some key differences. First, the Medicaid program would supplement LTC insurance by covering qualifying LTSS costs during the policy elimination period. This would create an additional incentive by mitigating the out-of-pocket expenses for individuals with LTC insurance policies. A second option would be to tie legislative amendments to Medicaid LTSS catastrophic coverage for individuals with LTC insurance policies who experience LTSS costs that exceed LTC insurance coverage.

This proposed federal law will likely face challenges, including those challenges raised against the ACA.[311] However, historically, federal law has used the tax and spending power to encourage state action.[312] These actions, including Medicaid expansion under the ACA, have previously been challenged as violating state rights.[313] By creating a new fund, and not restricting funds for current programs, this proposal may meet relevant constitutional requirements. The full constitutionality of this proposal would need an in-depth evaluation, which will be saved for another day. For purposes of remodeling the private LTC insurance market, the constitutionality of such a federal law and its ability to trigger broad state legislative amendments will be assumed.

The NAIC is a standard setting and regulatory supporting organization with membership of insurance commissioners from all fifty states, the District of Columbia, and five United States Territories.[314]

311. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

312. *See id.*

313. *See A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion*, THE KAISER COMM'N ON MEDICAID & THE UNINSURED (Aug. 1, 2012), https://www.kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/.

314. NAT'L ASSOC. INS. COMMISSIONERS, *About*, http://www.naic.org/index_about.htm (last visited Feb. 8, 2018).

The NAIC provides peer review, conducts oversight, and establishes best practices for insurance regulation in individual states.[315] To accomplish these goals, the NAIC develops educational materials, collects data on state law, and develops model laws to inform state legislation and regulation standards and best practices.[316] The NAIC promulgated the Long-term Care Insurance Model Act (Model Act) and Regulation (Model Regulation) to establish standards for LTC insurance policies.[317] The Model Act aims to promote LTC insurance by establishing protections for long-term care applicants from unfair and deceptive practices.[318] The Model Act provides model language among fourteen sections, for example: Definitions, Disclosure and Performance Standards for Long-Term Care Insurance, Incontestability Period, and Nonforfeiture Benefits.[319]

The Model Act was initially promulgated in 1987 and has been regularly amended, most recently in 2017.[320] Amendments often reflect changes in federal law or other policy standards. For example, the Model Act and Model Regulation added definitions and standards for implementing criteria for "tax-qualified policies" in response to the 1996 passage of the Health Information Portability and Accountability Act (HIPAA), which included a tax benefit for qualified LTC insurance policies.[321] Since the Model Act's initial publication in 1987, state legislatures have widely adopted it. As of 2015, all fifty states have legislation that is either derived from or have fully adopted the Model Act.[322] In a study examining the Model Act's "preexisting condition" provision,[323] twenty-four states were consistent with the Model Act and a majority of the remaining states were substantially similar.[324] Evidence of the broad adoption of the Model Act demonstrates the influence of the NAIC on informing state LTC insurance legislation and regulation. As a result, the NAIC Model Act and Model Regulation serve as tools for understanding state law on LTC insurance and for amending state law to improve market standards.

315. *Id.*

316. *Id.*

317. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 1; NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 1.

318. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 1.

319. *Id.*

320. *Id.* at § 14.

321. *Id.* at § 4.

322. *See id.*

323. *Id.* at § 6(B).

324. *See* Arias et al., *supra* note 97, at 490.

Several Model Act sections have a direct impact on access to LTC insurance, benefits and incentives, and protections for the LTC insurance market. Premium setting standards permeate multiple challenges to a strong private LTC insurance market. First, the Model Act and Model Regulation establish baseline standards for setting premiums. Premium rate increases require commissioner approval which can interfere with insurers' abilities to adjust rates, even when justified by actuarial risk.[325] Under the NAIC Model Regulation, seventy percent of the premium increases collected must be applied to benefits, and insurers must offer a new and comparable policy to individuals affected by the increase without underwriting.[326] Second, the NAIC Model Act and Regulation Insurers provide discretion to regulate and approve loss ratios and premium setting practices.[327] Under the Model Regulation, a loss ratio is reasonable if it is no less than sixty percent; meaning that sixty cents of every dollar collected through premiums must be used to pay for benefit claims.[328] The remainder of the proposal will address NAIC Model law as a proxy for state law that impacts underwriting and incentives and benefits.

B. Underwriting

Medical denials reduce the pool of eligible participants and limit access to LTC insurance. Current state law supports the broad use of health information during underwriting.[329] The Model Act and Model Regulation explicitly permit the use of health information in underwriting in multiple sections.[330] This can first be seen in the mandate that insurers use clear and unambiguous questions to "ascertain the health condition of the applicant" accompanies the prohibition of post-claim underwriting.[331] The same section provides mechanisms to rescind a policy or deny benefits due to misrepresentation on an application.[332] In a related section, the Model Regulation requires that the insurer request specific documentation of

325. NORDMAN, *supra* note 42, at 71.

326. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 20(C), (H).

327. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 6.

328. *Id.* at § 5(C).

329. *See* Arias et al., *supra* note 97, at 492.

330. *See id.*

331. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 11(A).

332. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 11(C); NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 11(C).

the applicant's health status if the applicant is over eighty years old.[333] Lastly, the Model Act includes a preexisting condition provision that prohibits insurers from using preexisting condition status for coverage decisions after a six-month limitation period following enrollment.[334] Importantly, the same provision explicitly permits insurers to use health information for underwriting purposes.[335] Forty-three states have legislative or regulatory provisions that are consistent with the Model Act,[336] which states "[t]he definition of 'preexisting condition' does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with the insurers established underwriting standards."[337]

This language creates broad unlimited discretion for collecting and using health information. Yet, this broad discretion has not yet led to accurate actuarial analysis.[338] The proposed revised Model Act, and subsequently state law, will:

1) create disincentives for withholding health information on an application for LTC insurance;

2) remove the barrier for individuals who know of an increased risk status from applying for insurance;

3) remove LTC insurance eligibility as a barrier to seeking health information that could offer benefit to the individual;

4) protect insurer profitability and sustainability by permitting insures to collect and use health information, in a limited structure, to mitigate adverse selection;

5) reduce the percentage of individuals medically denied;

6) improve accuracy in underwriting practices; and

333. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 11(C)(3).

334. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 6(C)4.

335. *Id.*

336. Arias et al., *supra* note 96, at 493.

337. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL ACT § 6(C)4; SHORT-TERM CARE INSURANCE MODEL ACT § 6(B)(4) (NAT'L ASS'N OF INS. COMMN'R 2017).

338. Temkin-Greener et al., *supra* note 111, at 356.

7) ultimately increase the eligibility pool for LTC insurance.

Proposed amendments will create an improved structure that specifies boundaries for the use of medical information in underwriting. The new structure minimizes the use of knock-out conditions in exchange for risk evaluation based on stage and traits of health conditions for determining eligibility and premiums. The proposed amendments prohibit insurers from using predictive health information (i.e., genetic information) from constituting a knock-out condition. Insurers would, however, be permitted to use that information to set premiums within rate limits established by the insurance commissioner and informed by scientific value of predictive information. The amendments establish boundaries regarding underwriting for chronic conditions that have manifested based on expected disability.

The proposed amendments incorporate the known loss doctrine to reduce potential adverse selection and moral hazard risks for insurers.[339] The known loss doctrine permits insurers to deny coverage for losses that the individual insured knew were probable at the time of enrollment.[340] This would accomplish two purposes (1) protect insurers from liability for coverage of claims that the insured knew would occur at the time of enrollment; and (2) further discourage insureds from failing to disclose risks that were known.

The proposed amendments harness advances to detect disease risks and predictive information and improve actuarially analysis accuracy. Diseases that lead to significant functional loss (e.g., Alzheimer's disease) can now be identified at earlier stages.[341] Looking to Alzheimer's disease as an example of these advancements can demonstrate the outdated approach to LTC insurance underwriting currently implemented. Researchers have identified biomarkers of the hallmark plaques and tangles associated with Alzheimer's disease.[342] These biomarkers, which are currently not used clinically for asymptomatic individuals, have the capacity to identify disease

339. Diana S. Donaldson & Jennifer DuFault James, *The "Known Loss" Doctrine – Whose Knowledge and of What?*, 8 ENVTL. CLAIMS J. 43, 47-48 (1996).

340. *Id.*

341. G. McKhann et al., *Clinical Diagnosis of Alzheimer's Disease: Report of the NINCDS-ADRDA Work Group Under the Auspices of Department of Health and Human Services Task Force on Alzheimer's Disease*, 34 NEUROLOGY 939 (1984).

342. Clifford R. Jack et al., *NIA-AA Research Framework: Toward a Biological Definition of Alzheimer's Disease*, 14 ALZHEIMER'S & DEMENTIA 535-36, 539 (2018).

pathology up to twenty years prior to symptom onset.[343] Individuals who are positive for these biomarkers are at an increased risk for developing symptomatic Alzheimer's disease, a leading cause of dementia.[344] Additionally, genetic markers can identify individuals who are at an increased (but rarely certain) risk of Alzheimer's disease.[345] The widespread movement to diagnose, detect, and treat diseases at earlier stages will offer critical public health benefits to reduce disease burden. Individuals at risk for disease are, however, likely to be denied or face prohibitively high premiums in the LTC insurance underwriting process. LTC insurance underwriting practices are unfavorable to individuals who will likely need LTSS and could benefit from LTC insurance. But, by excluding a population of at-risk enrollees, insurers could forgo up to twenty years of premiums without claims. These advancements should encourage legal amendments to increase eligibility, structure underwriting practices to use different kinds of health information, and emphasize the inclusion of scientifically accurate information regarding disease to inform actuarial risk assessments.

C. Proposed Provision: Underwriting Standards Using Health Information

Health information is to be defined as information collected during a clinical encounter between an individual (patient) and a health care provider with the purpose of improving individual health. Health information may include, but is not limited to: diagnostic information, treatment status, genetic or other biomarker test results that confer an "at risk status," predictive information indicating future disease status, or family health history.

1. *(a) Insurers are permitted to use comprehensive applications to collect health information regarding an applicant's current or future health status as relevant to current or future use of long-term care services and supports.*

   (b) Health information is not relevant and may not be collected if it does not relate to a current or future (1) disability that will interfere with activities of daily living, or (2) cognitive impairment requiring supervision.

2. *Insurers are prohibited from denying an insurance policy application based on genetic information, biomarker*

343. *See id.* at 537, 539.

344. *Id.* at 539-40.

345. Donald H. Taylor Jr et. al., *Genetic Testing for Alzheimer's and Long-Term Care Insurance*, 29 HEALTH AFF. 102, 104 (2010).

information, or family history for a risk of future disease: (1) if the disease has not yet manifested; and (2) without evidence of risk for disease and future loss of function, according to medical opinion or documentation in the individual's disclosed medical record.

(a) Insurers may develop a risk scale for determining eligibility or premium rates that incorporates applicants' risk for future loss according to genetic or biomarker information along with other factors. Factors are to be approved by the insurance commissioner and must include, at a minimum, the applicant's age and projected age of onset for the relevant disease.

i. Insurers must submit a list of "knock-out" conditions and seek approval from the insurance commissioner for conditions that the insurer will deny based on genetic or biomarker risk for a debilitating illness, when the disease has yet to manifest.

ii. Insurers are not permitted to limit or deny benefit claims based on genetic information or biomarkers for a disease that is inconsistent with treatment of other preexisting conditions as established in National Association of Insurance Commissioners Model Act §5(C) (year).

(b) An insurer may deny an application based on genetic or biomarker risk information for a condition if:

i. The disease has manifested and the applicant is projected to seek benefits from the policy within 3 years of enrollment based on current medical opinion and standards; or

ii. The disease has not yet manifested, but the applicant is within 2 years of expected age of onset with a rapid progressing disease, according to current medical standards related to the specific disease process.

3. (a) An insurer may deny a policy application for an individual who is diagnosed and symptomatic for an illness or condition that the insurance commissioner has designated "high risk."

(b) The insurance commissioner shall maintain criteria and a list of conditions that constitute "high risk." "High risk" shall not be defined more restrictively than a condition that will

lead to catastrophically high LTSS costs which cannot be covered by projected premiums.

4. *Insurers may develop an underwriting "scale of risk" to be used internally for determining eligibility or premium rates that incorporates applicants' risk for future loss based on diagnoses of a chronic condition or illness that will lead to loss of function. A proposed scale must be approved by the insurance commissioner and be based on the individual's age and projected long-term care services and supports needs.*

5. *(a) An insurer is prohibited from denying an application for conditions that constitute a "minimal risk."*

   (b) The insurance commissioner shall maintain criteria and a list of conditions that constitute "minimal risk." "Minimal risk" shall not be defined more restrictively than a condition that will not lead to significant long-term care services and supports costs, is unlikely to lead to disability that would interfere with daily activities, or is unlikely to require the use of long-term care services and supports within 20 years of enrollment.
6. *Insurers may develop a risk scale for determining eligibility or premium rates that incorporates applicants' risk for future loss according to past medical history only as predictive of future functional loss. A proposed scale must be approved by the insurance commissioner and be based on the individual's age and projected long-term care services and supports needs.*

7. *The known loss doctrine shall apply. Insurers are not liable for coverage of long-term care services and supports costs associated with disability that the insured knew would occur at the time of enrollment. This doctrine does not grant insurers the authority to require or request diagnostic, risk, or predictive biomarker or genetic tests.*

D. Discussion of Proposal

The proposed amendments' language incorporates new standards for using health information for underwriting purposes. The amendments adopt a balance between absolutely prohibiting LTC insurers to use health information and providing broad discretion. The proposed regulation would provide additional implementation language, including a medical certification process for amendments that include prognostic information (e.g., "within 2 years of the expected onset"). The proposed language and amendments are extensive and add additional layers of complexity. However, this additional detailed

approach of evaluating policyholder risk will lead to improved accuracy in the underwriting process. An alternative approach would be to implement a community rating structure; a consistent rate set across all individuals would reduce the consequences of medical underwriting.[346] In the context of a voluntary enrollment program, community rating may increase adverse selection. Community rating may dissuade younger and healthier individuals from enrolling if they will face similar premiums as their older and less healthy counterparts.

A revised underwriting structure provides the core revisions to this proposal and seeks to provide access to LTC insurance to an expanded population. This will also increase the size of the insured population. Therefore, risks will be more broadly distributed. The continued, but restricted, use of health information permits insurers to screen for high risk policyholders. This restricted structure addresses one of the limitations in the CLASS Act. The proposed underwriting amendments will trigger other changes throughout the LTC insurance market, including lowering premiums. Therefore, in order to protect the market, additional measures must be initiated, including improving the quality of LTC insurance as a product and providing market incentives.

E. Incentives and Benefits

Incentives and policy benefits will be critical to motivating younger and healthier individuals to purchase LTC insurance policies. Increasing the number of younger and healthier purchasers is essential to maintain a voluntary market and support the newly revised underwriting practices. Incentives can include the benefits provided under a policy as well as the external incentives which influence individual or insurers' decision to participate in the market. This proposal recommends improved benefits that reduce barriers to accessing LTSS, external incentives to encourage individual participation, and market incentives for insurers.

1. Improving Purchase Rates and an Improved Insurance Product

Incentives include positive and negative influences to motivate behavior. In the context of LTC insurance a balance between the two may be most successful. Policy benefits and external incentives increase the value of a policy in relationship to the associated premiums. Disincentives, including penalties, may discourage individuals from waiting to enroll until later in life or when chronic conditions begin.

346. Thomas D. Snook & Ronald G. Harris, *Adverse Selection and the Individual Mandate,* MILLIMAN HEALTH REFORM BRIEFING PAPER, Oct. 2009.

a. Policy Benefits

LTC insurance policy benefits are limited by benefit triggers, benefit caps, and elimination periods. As a result, LTC insurance policyholders must still pay for a portion of LTSS expenses. In order to improve the value of an LTC insurance policy, the entire structure must be redesigned to increase the benefit to the purchaser without overly increasing premiums.

The proposed new structure shifts LTC insurance from a premium model to an accumulation or savings model. This proposal is consistent with evidence of consumer criticism that policies do not include non-forfeiture benefits, which would allow policyholders to receive a refund on a portion of premiums.[347] An accumulation model would provide purchasers with the option to receive a refund of a percentage of premiums at a designated time point (i.e., a given age or years paid into a policy). Here the model would incorporate a non-use premium refund that would provide policyholders with a refund if, at reaching the given time point, they have not needed LTSS or sought benefits under their policy. The refund would increase based on premiums paid, which would encourage younger purchasers. This model could also be used as a disincentive by requiring purchase by a specified age to qualify for the non-use refund benefit. An accumulation model could also encourage healthy behavior and address risks of moral hazards to limit the use of LTSS.

There are potential consequences of incentivizing non-use of benefits, including sub-par care. Additionally, specific protections would be needed to limit the risk of abuse and conflict of interest for caregivers who serve as decision-makers. A caregiver may be improperly motivated by the refund and refrain from seeking LTSS on behalf of the individual, despite needs for services. Criteria and regulation of refunds could address these risks (e.g., requiring certification of "non-need" by a health care provider).[348] Practically, policy makers would need to conduct analysis to establish standards, including the "purchase by" age and refund percentages. This will also require negotiation with insurers to avoid disrupting the market by loss of profit associated with refunds. This restructuring would require new legislative language and re-defining LTC insurance.

Current use of benefit triggers, elimination periods, and benefit limits serve an important role to reduce claims costs and reduce premiums. However, these are the same mechanisms which are cited as impeding individuals from perceiving LTC insurance as a valuable

347. DOTY & SHIPLEY, *supra* note 23, at 4.

348. COMMITTEE ON FAMILY CAREGIVING FOR OLDER ADULTS, FAMILIES CARING FOR AGING AMERICA, 13 (Richard Schulz & Jill Eden, eds., 2016).

product.[349] Benefit triggers provide an important role in assuring appropriate use of LTC insurance benefits for LTSS services. Under the NAIC Model regulation, an LTC insurance policy "shall condition the payment of benefits on the determination of the insured's ability to perform activities of daily living and on cognitive impairment." While benefit triggers create a hurdle for individuals, the availability of an appeal process under the Model Regulation provides oversight on the process.[350] To mitigate the adverse consequences of the elimination period, the proposed Medicaid fund provided to states would provide coverage during the elimination period.

This leaves the adverse effects of benefit caps. There are two underlying components of addressing caps. First, excessive LTSS costs could contribute to the gap between policy benefits and cost of care. Cost reform is not a focus of this article but should be recognized as a contributor to financing issues. Second, benefit caps are important to protect insurers from losses exceeding premium contributions of policyholders. Insurer protections, including the "vesting" period proposed in the CLASS Act, may provide a mechanism to assure that policyholders have contributed sufficient funds to support increasing benefit caps and minimize the gap between benefits and LTSS costs. Addressing the consequences of benefit triggers, elimination periods, and benefit caps will increase the value of an LTC insurance policy and motivate purchasers. These revisions do not address the need to incentivize purchase in the middle class. External benefits may help fill that role.

b. External Benefits

Prior tax incentives have been nominally successful at improving purchase rates and unsuccessful at motivating the middle class to purchase policies.[351] Prior research has demonstrated that tax and other financial incentives are broadly supported, including government support of LTC insurance purchase using funds from an individual retirement account.[352] A strategic approach which accounts for the financial realities of the middle class will be the key element of a successful external incentive. I propose a tax incentive available only to individuals whose income classify them as "middle class" in their geographical area. Such a mechanism would overcome a critical hurdle of incentivizing purchase by individuals in the middle class, an outcome not previously achieved. A specific tax benefit or subsidy as part of this

349. *See* NORDMAN, *supra* note 42, at 51.

350. NAT'L ASSOC. INS. COMMISSIONERS LONG-TERM CARE INS. MODEL REGULATION § 31(D)(1).

351. NORDMAN, *supra* note 42, at 21.

352. DOTY & SHIPLEY, *supra* note 23.

model would require a larger analysis to determine what degree of incentive would motivate the target population to change behavior.

c. Disincentives

An individual mandate for LTC insurance is politically implausible.[353] However, other potential disincentives could encourage earlier purchase of LTC insurance. For example, implementing penalties for enrolling after a specific age may increase younger purchase rates. There are multiple options for developing penalties, depending on fiscal and economic feasibility. For example, individuals who enroll after sixty-five face a penalty, but not a total block, for seeking coverage within two years of the policy enrollment date. This type of penalty would need to be designed to not override current preexisting condition protections, which currently prohibit insurers from denying coverage based on a preexisting condition after a six-month limitation. Regardless of the type of disincentive chosen, a successful disincentive will balance encouraging purchase rates and protecting the market, but not creating barriers to accessing LTC insurance or services. In this context, penalties (e.g., standardized increased premiums), criteria for incentives, and the non-benefit refund that are focused towards specific populations (i.e., older purchasers) would motivate purchase without barring access.

2. Market Incentives

The primary focus of this proposal is to improve LTC insurance as a product, make it more accessible, and increase purchase rates. However, this proposal must include incentives for insurers to join and stay in the market. Without such incentives, the proposal is at risk of failure by over emphasizing protections which will benefit policyholders, but potentially deplete profits of insurers to the detriment of the market. Specifically, increasing the eligibility and accessibility of insurance can disrupt the market by increasing rates of adverse selection.[354] Additionally, without additional regulatory market incentives, insurers may attempt to compete by making their policies less attractive to "sicker" or less ideal policy holders through the benefits offered or terms of their policies (e.g., elimination periods), undermining the goals of the proposal.[355] This article proposes a time limited federal subsidy for LTC insurers and modeling mechanism implemented in the ACA. The ACA incorporated measures including reinsurance, risk corridors, and risk adjustment (the "Three R's") to

353. Feder, *supra* note 86, at 59.

354. CYNTHIA COX ET AL., HENRY J. KAISER FAM. FOUND., EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS (2016).

355. *Id.*

accomplish broader goals, reduce the consequences of adverse selection, and minimize the impact of moral hazard.[356]

Risk adjustment aims to de-incentivize risk selection practices that prioritization of "ideal" candidates.[357] Risk adjustment balances the market by distributing funds from insurers with practices that lead to healthier enrollees to insurer who accept high risk enrollees.[358] Reinsurance insures against the potential catastrophic consequences for insurers who experience high expenses or costs due to rare claims by policy holders.[359] The program was implemented to stabilize the health insurance market.[360] Under the ACA, the federal government reinsures companies by paying a percentage of the rare policy holder claims that exceed a specific amount.[361] This program had a step down and limited application between 2014 and 2016.[362] The government paid the highest percentage in 2014, decreased the percentage in 2015, and ended the program in 2016.[363] In the three years that the ACA reinsurance program was in effect, premiums dropped in the individual health insurance market as much as eleven percent.[364] Risk corridors aim to incentivize accurate premium calculations by re-distributing financial gains or losses that exceed predicted loss or gains.[365] Under the ACA, if an insurer's gains or losses are within three percent of those predicted, the company absorbed the financial consequences.[366] However, if the gains or losses are between three and eight percent, the company was either reimbursed or contributed fifty percent of the gains or losses for redistribution.[367]

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356. *Id.* at 12.

357. *Id.* at 3.

358. *Id.*

359. *Id.* at 6.

360. *Id.*

361. *Id.* at 10.

362. *See id.* at 11-12.

363. *Id.*

364. Timothy Jost, *CMS Releases 2016 ACA Marketplace Reinsurance and Risk Adjustment Data*, HEALTH AFF. BLOG (July 1, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170701.060929/full/.

365. COX, *supra* note 356, at 2.

366. John Greenberg, *Krauthammer: Obamacare Has Hidden Insurance Company Bailout*, POLITIFACT (Jan. 13, 2014), https://www.politifact.com/punditfact/statements/2014/jan/13/charles-krauthammer/krauthammer-obamacare-has-hidden-insurance-company/.

367. *Id.*

A targeted goal of the ACA was to expand and improve coverage, much like the goals established in this article.[368] In the context of health insurance, the ACA was successful at accomplish those goals through the end of President Obama's presidency.[369] However, the ACA faced political challenges[370] which are informative when considering a reform for LTC insurance, which is engendered with significant complexities. The ACA also included the individual mandate, which has seen been repealed.[371] Given the political challenges associated with the ACA, a reform for LTC insurance must be tempered and avoid the naïve trap of believing that directly modeling any reform after the ACA would necessarily be successful. However, implementing the Three R's approach to incentivize market participation would improve market security to allow for insurers to bare additional risks associated with proposals that increase eligibility. These measures (the Three R's) would protect insurers from losses, incentivize change in underwriting practices, and reduce the impact of adverse selection and moral hazard. However, several challenges will need to be addressed, including the potential consequences of implementing these measures in a market within a market that has fewer insurers than the health insurance market. This is particularly relevant when considering risk adjustment, which incorporates distribution of funds between insurers. As a result, these mechanisms will only be successful with a growth in the number of insurers in the market. A federal subsidy or corporate tax benefit for new insurers to enter the market and for current insurers will help increase the number of insurers and provide the necessary financial environment for adopting the Three R's.

V. CONCLUSIONS AND LIMITATIONS

The proposal has some limitations and challenges that need to be addressed before implementation. Primarily, an economic analysis is needed to simulate potential changes proposed. This would include evaluating feasibility of market changes to adjust premiums and calculate ranges for incentives to appropriately motivate purchase rates. The purpose of this article was to identify a route for revisions through current legal standards, the economic analysis would be a natural next step. Additional practical limitations include political hurdles to

368. Barack Obama, *United States Health Care Reform Progress to Date and Next Steps,* JAMA 525, 526 (2016).

369. *Id.* at 527.

370. *Id.*

371. *See* Sy Mukherjee, *The GOP Tax Bill Repeals Obamacare's Individual Mandate. Here's What That Means for You*, FORTUNE (Dec. 20, 2017), http://fortune.com/2017/12/20/tax-bill-individual-mandate-obamacare/.

propose amendments through the legislative process. Political challenges would be closely related to financial solutions for the proposal, including any investment by public governments.

Resolving failures plaguing private LTC insurance will not "fix" all financing challenges facing LTSS. However, strengthening the private market will reduce the burden placed on individuals and Medicaid. A public option, including those recommended by the LTC Commission, will be central to a balanced solution. Public options are particularly important options for individuals without financial means to purchase private insurance. Despite these limitations, improving the private LTC insurance market is a promising avenue to improving LTSS financing options.

This article proposes redesigning the current LTC insurance model using the NAIC Long-term Care Insurance Model Act to establish new state legislative standards. This proposal is the first to closely evaluating characteristics and insurers' practices that are contributing to LTC insurance market failure and low purchase rates. The solution proposed is the first of its kind and addresses the limitations of previously proposed solutions. The article's proposals to increase access through revised underwriting standards, improve incentives to purchase LTC insurance, and integrate market protections reflect critical changes to save LTC insurance from the "death spiral."