ALTCIP

The American
Long Term Care
Insurance Program

The American Long Term Care Insurance Program (ALTCIP):

A New Public-Private Model for Financing and Delivering Long Term Services and Supports

Paul E. Forte

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Abstract

This paper addresses the decades-old, unsolved, and increasingly urgent problem of long term services and supports (LTSS) financing in the U.S. It proposes a new model for a national, cooperative public-private program: the American Long Term Care Insurance Program (ALTCIP). The ALTCIP would shift a portion of the financial burden of LTSS from government to individuals while increasing consumer protection and awareness. Assuming that current fiscal reality prohibits the introduction of another taxpayer-financed entitlement, it argues that a voluntary long term care insurance program offering basic benefits and administered equitably will attract potentially many hundreds of thousands, even millions of people in the middle market. Such a program, which could conceivably be implemented within the next five years, would reduce the number of people who will rely on Medicaid to cover LTSS, a major problem for federal and state government budgets. The ALTCIP would employ powerful internet sites with interactive tools and highly-trained customer service representatives so that it could be managed direct-to-consumer at a relatively low cost in relation to premium and still meet or exceed best-in-class service standards. The following pages provide the rationale, operational structure, financing mechanism, and regulatory blueprint for the program. Further details will be forthcoming.

PAUL E. FORTE is Chief Executive Officer of Long Term Care Partners, LLC.

The opinions and positions voiced in this paper are my own and do not represent the opinions of Long Term Care Partners, its parent company, John Hancock Life Insurance Company (U.S.A.) and subsidiaries, the Department of Health and Human Services (DHHS), or the U.S. Office of Personnel Management (OPM). While I have received help from others, I alone am responsible for any errors or misjudgments it may contain.

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I. Why a New Public-Private Approach to Long Term Care Insurance?

Recently the viewpoint that only a mandatory approach will solve the U.S.'s long term services and supports[1] financing needs has gained some traction. According to this line of thinking, a critical mass of people cannot be achieved via a voluntary approach, regardless of whether people are enrolled in a public or private long term care insurance program.[2] Such a view is not surprising in the wake of CLASS on the one hand and LTC insurance carrier exits on the other. Nevertheless, it has not taken into account what could be accomplished via a properly designed national voluntary program. Moreover, it fails to address the concerns that would accompany any attempt at introducing another mandate. Such a mandate would come hard upon the heels of the Patient Protection and Affordable Care Act (PPACA), which will impose increasingly stiff penalties upon those who do not purchase health insurance.[3] Finally, our record levels of budget deficits and long term sovereign debt, and their effect on our economy, cannot be ignored. Any solution to the LTSS financing problem that relies on levying additional taxes would appear to run straight in the face of such obstacles, prompting the question of whether there isn't a better way.

The voluntary approach presented in this paper argues that there is such a way. It would rely on voluntary premiums rather than taxes to create a large national risk pool. However, it would operate under the auspices of the federal government, while engaging the full resources and expertise of the private sector[4]. This would ensure that LTSS costs do not fall too heavily on the public sector.

America will spend in excess of $250 billion on LTSS in 2013. The sources of LTSS financing are well known and require little elaboration here. As the Henry J. Kaiser Family Foundation and other research groups have made clear, Medicaid is by far the largest source of LTSS

[1] For the most part this paper uses the term "long-term services and supports" ("LTSS"), the generally preferred term in academic and governmental contexts. However, in keeping with the variation more commonly used by private industry, "long term care" ("LTC") is used when referring to LTC insurance or in regards to historical groups or documents that existed before "LTSS" came into widespread use.

[2] For a recent example, see Anne Tumlinson, Eric Hammelman, Elana Stair, and Joshua M. Wiener, "Insuring Americans for Long-Term Services and Supports: Challenges and Limitations of Voluntary Insurance," *Avalere*, March 2013. The authors state flatly that "Voluntary approaches to increasing coverage will not cover substantial numbers of people with disabilities or change the trajectory of Medicaid spending in any significant way." Conversely, "Mandatorily enrolling all who are eligible…increases the number of people for whom the insurance would lengthen the spend-down period prior to Medicaid eligibility and for whom the insurance would replace some Medicaid spending after reaching eligibility." The authors would appear to have reflected on the likely outcomes of the Community Living Assistance Services and Supports (CLASS) Act withdrawn by the Obama Administration in January of this year.

[3] The postponement of the employer mandate from 2014 to 2015 underscores the problems with this approach, including concerns about its effect on hiring.

[4] By "private sector" I refer not only to those involved in non-governmentally managed health care delivery systems, but those expert in risk assessment, finance, systems development, enrollment and premium administration, claims adjudication, and information technology.

financing (accounting for 43% of LTSS spending in the U.S. in 2009), with Medicare covering some 24% of post-acute care. Out of pocket payments accounted for 19% in the same year. 7% more was paid by other private and public sources. Private LTC insurance covered only the remaining 7% of the total cost.[5]

Proponents of social insurance often cite private LTC insurance's low take up rate—around 7.35 million policies in total, nationally[6]—as evidence that it cannot serve as a major component of the country's LTSS financing. However, this viewpoint does not take into account many factors that have made it challenging for private LTC insurance to thrive in recent years, including the relative newness of the product itself compared with other mainstream insurance products that have been around for more than 50 years (LTC insurance did not really begin to be distributed until the late 1980s); the difficulty in setting accurate actuarial assumptions for an event decades out; the financial crises of 1987, 2001, and 2008-2009, all of which increased unemployment and personal debt; and the effect of low interest rates on long-dated liabilities. There is also the "crowd-out" effect of Medicaid LTC, described by Brown, Coe, and Finkelstein[7] and well-documented by Steve Moses, which suggests that the availability of Medicaid—whose relatively lenient eligibility provisions may be easily navigated by estate planning attorneys—tends to discourage purchase of private LTC insurance in particular and the taking of individual responsibility for LTSS financing in general.

The point here is that while the amount of benefits paid by private insurance to date has been modest, private insurance could contribute far more than it has, assuming conditions are right. The high cost of LTSS, coupled with the sporadic incidence of need, makes it well-suited to insurance, as has often been noted. Considerations of price aside, a 2008 study conducted by the U.S. Department of Health and Human Services indicates very high satisfaction levels among consumers who actually hold private LTC insurance policies with respect to plan design and customer service.[8] Indeed, private LTC insurance buyers have proved tenacious after purchase, with policy lapse rates remaining among the lowest in the insurance industry. Further, surveys indicate a higher than average satisfaction among

[5] Estimates based on CMS National Health Accounts data, 2009. From *Kaiser Commission on Medicaid Facts*, "Medicaid and Long-Term Care Services and Supports," June 2012.
[6] Life Insurance Marketing Research Association (LIMRA), "LTCI Market at a Glance: 2012", Karen Fisherkeller, 2013, p. 3.
[7] Jeffrey R. Brown, Norma B. Coe, and Amy Finkelstein, "Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey," January 2007.
[8] Jessica S. Miller, Xiaomei Shi, and Marc A. Cohen, "Private Long-Term Care Insurance: Following an Admission Cohort over 28 Months to Track Claim Experience, Service Use and Transitions," U.S. Department of Health and Human Services, April 2008.

claimants with the way their claims are handled[9], due in part to insurer efforts to improve claims processes and in part to state and federal regulation.

The LTC insurance industry frequently draws criticism for its perceived failure to address the twin issues of access and affordability. Prospective buyers who want to purchase insurance may be deemed ineligible due to pre-existing health conditions, and of course major carriers have attempted to adjust for emerging actuarial experience through rate increases in recent years, driving up costs already widely perceived as too high.

Such complaints deserve to be acknowledged and addressed. However, they do not disprove the utility of insurance to transfer the large financial risk of LTSS to a third party. LTSS costs can run into the hundreds of thousands of dollars, yet Americans' 401(k) plan savings averaged just $71,000 in 2010[10] —less than a year of nursing home expenses in many states. Paying out of pocket for LTSS expense can mean putting as much as $1,000 aside each and every month for 30 years, starting at age 50, assuming a 5% or 6% compounded rate of return. Such a rate assumes the individual not only has, or has access to, investment expertise, but is also lucky enough to avoid living through a difficult financial environment (such as 2000-2009, commonly referred to by investment professionals as a "lost decade" for investors). When the latter is the case, the challenge is greater still.

Some financial planners recommend home equity conversions to address long term services and supports expenses. These are a possibility for some people, but care must be taken to ensure that the terms of such mortgages are clear and understood, so that there are no unpleasant surprises.[11] Continuing Care Retirement Communities (CCRCs) are still another option, but the significant upfront investment required places them beyond the financial reach of many Americans.[12]

Given such facts, private LTC insurance would appear the best and most reliable way for many—especially those in the broad middle market—to manage the risk posed by LTSS

[9] Marc A. Cohen, "Long-Term Care Insurance: Are Consumers Protected for the Long-Term?" Testimony Before the U.S. House Committee on Energy and Commerce Subcommittee on Oversight and Investigation July, 2008.
[10] Emily Brandon, "Average 401(k) Balance Finally Tops 2007 High"; *U.S. News & World Report*, February 25, 2011.
[11] Such surprises can include large liens with the full amount of the unpaid balance due upon the decease of a spouse or the requirement to vacate the premises. See Jessica Silver-Greenberg, "A Risky Lifeline for the Elderly is Costing Some Their Homes," *New York Times*, October 16, 2012.
[12] The popularity of CCRCs has fluctuated over the years, with some CCRCs facing occupancy and solvency issues. Per "Beyond Long Term Care," Kelly Greene's February 2013 *Wall Street Journal* article: "Since 2008, a few communities around the country and one large operator, Erickson Retirement Communities, have sought bankruptcy protection…Other CCRCs have cut staff, reduced services or postponed opening assisted-living or skilled-nursing units. And even financially stable CCRCs have drawn their residents' ire, sparking lawsuits in a few places, by using their capital to acquire other facilities on shakier footing." It is not surprising CCRCs have been affected, given that entry fees average almost $300,000 and monthly fees follow. CCRCs have never been an option for those without resources.

expense. This segment includes those with too many resources to qualify for public assistance but too few to shoulder the burden of long term services and supports expense alone. The problem is not one of whether insurance makes sense, but rather one of getting sufficient numbers of people covered to achieve a good spread of anti-selection and other risks.

The remainder of this paper offers an overview of the ALTCIP. Drawing inspiration from public and private sector models, including the Federal Long Term Care Insurance Program (FLTCIP), now in its 11th successful year of operation, and the new Affordable Care Act exchanges, or "marketplaces", which become effective in January 2014, the ALTCIP would combine private sector insurance and risk management expertise with the level of consumer protection and oversight only possible via a large national risk pool. While other models are conceivable, this model has the best chance of meeting the objectives of providing large volumes of insurance protection transparently and in time to meet growing needs without adding to government expense.

II. The American Long Term Care Insurance Program (ALTCIP): Concept and Outline

Program Structure and Eligibility

The ALTCIP aims to bring high-quality, affordable private LTC insurance coverage to large numbers of people in the near term, by which I mean the next five years, a period in which large cohorts of baby boomers will be preparing to retire.

The ALTCIP would be established as a public-private partnership between the federal government and the private LTC insurance industry with advice and input from the National Association of Insurance Commissioners (NAIC). Hence, it would require federal legislation in the form of a congressional bill which would, if enacted, become federal law. The regulations would be based on statute.

The program would be financed by voluntary premium contributions whose adequacy would be demonstrable for all risks assumed on a present value basis out to 75 years. *There would be no cost to the government or to taxpayers, as all program costs, including administration and regulatory oversight, would be built into the premiums.* Such premiums would be payable monthly, quarterly, or annually by automatic payroll deduction, annuity deduction, automatic bank withdrawal, or direct bill. Like other private LTC insurance policies that meet the requirements of HIPAA '96, premiums would be tax-deductible and benefits tax-free. To keep administrative costs low, the ALTCIP would make use of current technology, such as powerful education websites and self-service portals upgraded to reflect the latest in security and privacy protections. Such tools would not only ensure that prospective buyers can educate themselves and apply for coverage with confidentiality, but also enable enrollees to perform functions ranging from updating personal information and interacting with customer service to checking a plan of care and filing claims online.

The ALTCIP would be open to all Americans who are legal residents of the U.S., whether or not they are U.S. citizens. The precise nature of the guidelines involving medical evidence of insurability would have to be determined. While underwriting could conceivably be modified in favor of a risk adjustment (via the reinsurance mechanism described on p.12-13) for any insurance carrier subject to higher than average anti-selection, uncertainty about the size of a voluntary enrollment compels either some underwriting criteria or a lengthy qualification period in which no claims would be accepted. However, the large number of potential enrollees, which could rise into the millions, should enable an optimal spread of risk with economies of scale not feasible under current private market arrangements. Steady growth of the pool would allow for less stringent underwriting standards down the road.

Sponsorship, Oversight, and Administration

The ALTCIP would be established under the auspices of the Department of Health and Human Services (DHHS), the lead federal agency managing large health programs, or the U.S. Office of Personnel Management (OPM), or both. OPM is the sponsor and regulator of the Federal Long Term Care Insurance Program (FLTCIP), the largest LTC insurance program in the country, covering some 270,000 federal active civilian, postal, and military personnel and their eligible family members.[13] The considerable level of federal oversight now in place for the FLTCIP would be brought to bear on the ALTCIP. DHHS or OPM would promulgate regulations governing all aspects of the program, select the insurance carrier or carriers from among those operating in the market and whose products are deemed competitive, and would audit results, with reports made publicly available. This is the method OPM has long followed with respect to the Federal Employee Health Benefits (FEHB) program and will be expected to follow when qualifying health plans to be offered on the new ACA Multi-State Exchanges. Carriers would have to be licensed in all states in which they were going to issue policies, but the actual work of regulation, including approval of rate increases, would take place at the federal level. This is to simplify administration and to allow for greater uniformity and portability. Each carrier contract with the enrollee would be the carrier's own contract, but the ALTCIP would incorporate numerous standardized provisions making the contracts comparable although not identical.

DHHS/OPM would choose the administrator (or administrators) for the ALTCIP exchange via public bid conducted under Federal Acquisition Regulation (FAR). The administrative entity would consist of one general contractor subcontracting various relevant functions to other firms specializing in marketing, enrollment, premium administration, information technology, customer service, care management, claims, and other tasks, or of several contractors performing different functions independently but under a larger regulatory framework coordinated by a central administrator. Appointing such functions to a central administrator or administrators, rather than to each individual carrier, could raise issues from the standpoint of loss of carrier control and even solvency. However, any centralized administrative tasks resulting in loss or diminution of direct control by the carrier that are especially sensitive would follow agreed-upon policies established in consultation with the carrier. This would minimize solvency risk where underwriting or claims adjudication is concerned, while allowing for streamlining and automation of routine administrative functions across the program (e.g., premium administration, customer service, and portal maintenance) would result in efficiency gains and cost reduction, saving enrollees money over time.

[13] Created by the Long Term Care Security Act of 2000, PL 106-265, the FLTCIP began operations in early 2002 (www.ltcfeds.com/about).

Plan Design, Marketing, and Distribution

The ALTCIP would offer qualified LTC insurance plans featuring protection for different levels and sites of care, depending on the plan chosen, but every ALTCIP plan would meet minimum standards, incorporating patient-centric care and accountability, while making use of private market insurance plan design expertise, actuarial analysis, internet technology, and established cost management controls. All ALTCIP plans would include expert care coordination to assist enrollees, family members, and/or health proxies with counseling, care planning, and resource management.

ALTCIP benefits would be paid based on reimbursement for actual expenses incurred up to the daily maximum limit chosen. While some policy experts prefer cash benefits for ease and flexibility, the reimbursement method has been proven to be effective for enabling insureds to access resources while keeping unnecessary utilization under control.

ALTCIP coverage would be guaranteed renewable, meaning that an individual policyholder, once enrolled in the ALTCIP, cannot be denied coverage provided all scheduled premiums are paid. Premiums may be raised, but only for the entire class or group of which an enrollee may be a part. As is now the case with the FLTCIP, rate increases would have to be approved by the federal regulator based on actuarial evidence.

To encourage enrollment, premium rates would be guaranteed for a period of five years beginning with the first effective date of coverage. In addition, premium would be discounted by 10% for the first three years for all who enroll during the first open enrollment event. At the start of the fourth policy year and thereafter, the full, undiscounted premium would be due. It is hoped that this discount will encourage enrollment and discourage lapse in the first few years of the program. This will allow marketing and start-up costs to be amortized and recovered.

Studies of private LTC insurance buyer and non-buyer groups conducted in recent years suggest that middle-class consumers of LTC insurance seek products that are simple and easily understood, are affordable and likely to remain so[14]. While plan design must be both attractive to consumers and actuarially sustainable, there is no question that LTC insurance products could be streamlined to everyone's benefit with fewer and more basic choices, and that this would be advantageous with respect to marketing. The ALTCIP would be geared to covering a significant portion of LTSS risk, but would be positioned more as a supplement than as a fully fledged financial solution. Risks would be assumed by the insurance carrier, but not on a first and last dollar basis. Benefits like home and community-

[14] AHIP/LifePlans, "Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers (In the Individual Market)," February 2012, p. 48.

based care would be featured, with options for assisted living and nursing home accommodation; higher cash flow utilization features like unlimited benefits or high compound inflation adjustment would be restricted, if not eliminated altogether.

Simpler plan designs would make them more amenable to presentation via the internet. The FLTCIP has demonstrated the utility of recent web-based innovations, e.g., self-education tools, self-service portals, including the option to apply online, online applications, interactive voice response systems, webinars, online videos, and other automated features designed to educate consumers, speed the claims process and facilitate communication between provider, consumer, and insurer. All of these tools could be marshaled for the ALTCIP to promote sales and facilitate service at a competitive cost.

The ALTCIP could incorporate the services of brokers, agents, and other intermediaries, although a more direct approach is also feasible—and perhaps more cost-efficient, as demonstrated by the FLTCIP, whose sales are transacted without agents, eliminating commission expense. Funds not used for marketing support could be put into education, technology, care coordination, or other high value-added features.

III. ALTCIP Single Administrator/Multi-Carrier Model

The ALTCIP is capable of accommodating different models. The one featured in this paper, the ALTCIP Single Administrator / Multi-Carrier Model, is predicated on several insurance carriers offering one or more products via an exchange run by a common administrator (see diagram on p.11). Thus enrollees have freedom of choice with respect to insurance carriers, who must compete based on plan design, reputation, and price. Once vetted and selected by DHHS/OPM, carriers would enter into an agreement that would cap experience, risk, and profit charges. Administrator performance could be assured by means of performance metrics carrying rewards and penalties, and monitored—as is the FLTCIP—by a Quality Assurance Surveillance Plan (*see sidebar for details*).

By definition an exchange assumes multiple carriers with different pricing and risk management strategies. Incorporating a separate account mechanism like the FLTCIP's Experience Fund would help to make choice more equitable for all enrollees by recapturing experience gains

What is a Quality Assurance Surveillance Plan (QASP) and why is it part of the ALTCIP?

A method used by the federal government to encourage and reward high-quality service by its contractors, the QASP establishes a set of quality standards and measures ("metrics") through which the ALTCIP administrator and carriers earn a percentage of their profit. Some metrics are empirically measured, while others may be subjectively evaluated by the regulator. Examples of ALTCIP carrier *metrics might include quality and timeliness of actuarial and investment reports and analyses. Examples of ALTCIP* administrator *metrics might include: timeliness of underwriting decisions or claim payments, speed of answering phone calls or emails, customer satisfaction survey results, successfully keeping annual expenses under budget and overall responsiveness.*

Tying a percentage of annual profits to service level requirements allows the ALTCIP regulator to track a vendor's performance and grant or withhold profit accordingly. QASP metrics would be tied to premiums and would therefore not be changeable, except by agreement among sponsor, carrier, and administrator.

for the enrollees themselves (see box below). Each carrier would establish a separate account or "experience fund" for premium and invested assets, with claims and authorized expenses charged to this same account. Excess funds from better than expected claims expense or investment experience would remain in the account as surplus to be reinvested for future program use. In the event that an insurance carrier chooses to terminate its participation, or is dropped from the program by the sponsor, the value of that carrier's assets in the experience fund would be transferable to a successor carrier, along with its existing insureds. If no successor carrier is found, the carrier's ALTCIP insureds would be distributed to the remaining ALTCIP exchange carriers in proportion to each carrier's existing volume of ALTCIP enrollees. In cases where premiums were not adequate, a conversion plan would be offered.

Each experience fund would hold special incentives or performance awards that would be credited back to a carrier upon successful documented fulfillment of specific service functions (e.g., quality and timeliness of actuarial and investment reports and analyses). Any premium not distributed due to the administrator's and/or carriers' failure to meet performance standards would remain in the experience fund as unallocated surplus for the program's use.

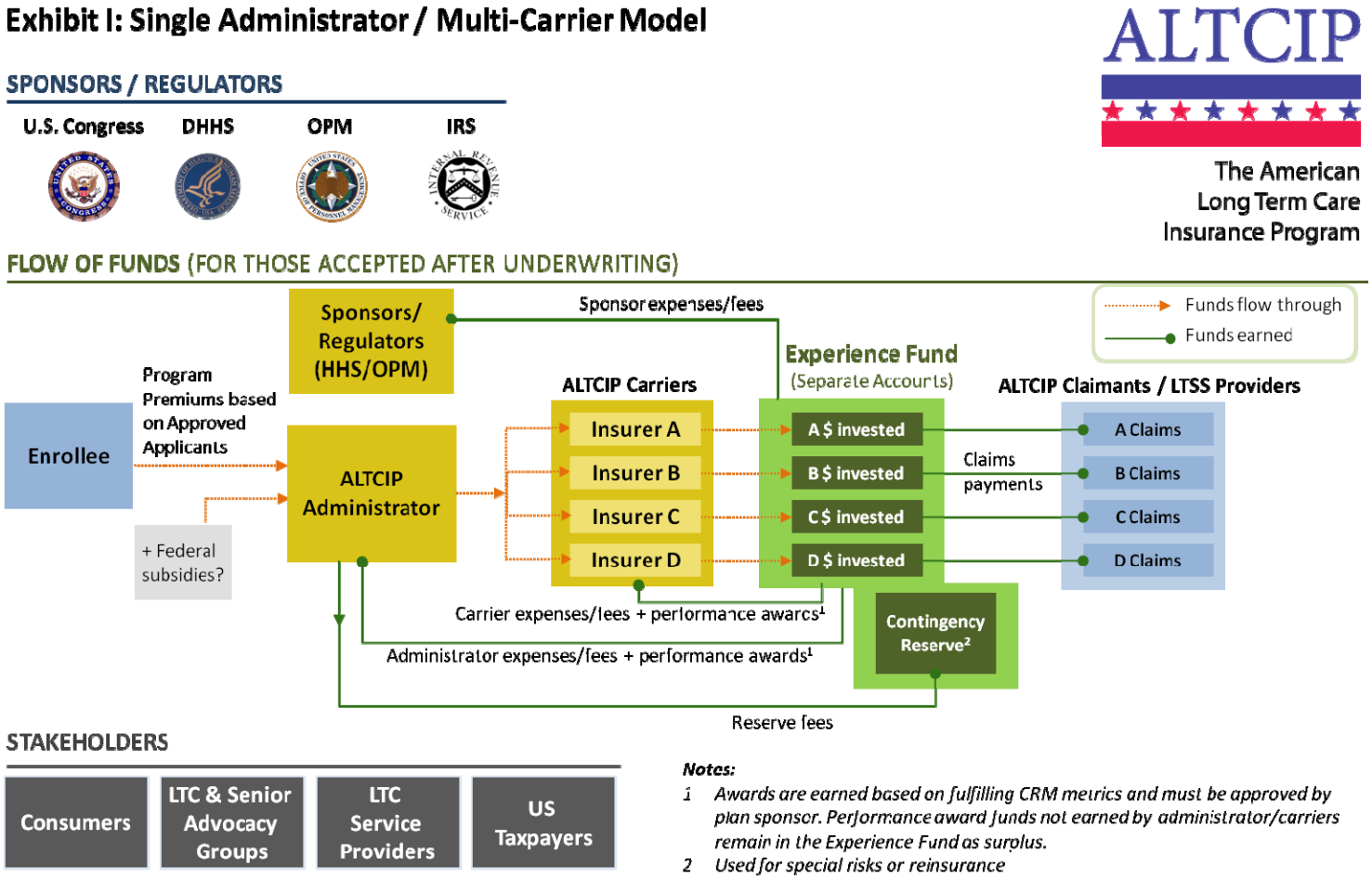
In addition to the separate accounts, the ALTCIP maintains a Contingency Reserve, expressed as a percentage of carrier premiums. Participation by carriers would be mandatory. This Reserve would be established for the reinsurance mechanism described on p. 12-13. Any funds not used to purchase reinsurance would serve as a special claim stabilization reserve to be accessed if needed by carriers and approved by the sponsor and regulator.

What is the FLTCIP Experience Fund?

In the FLTCIP model, a separate account mechanism is used for all income and outgoes. Premiums are deposited in the Experience Fund and serve as the payment source for all approved expenses, such as claims, marketing costs, systems development and maintenance, regulatory compliance, and for allowable earnings (profit). Certain items, such as carrier expenses allowances and earnings, are capped and payable only with the approval of the federal contracting entity. All premiums are invested in accordance with an approved plan based on prudent financial management practices. This plan utilizes a range of securities, including stocks and bonds, whose performance cycles and maturity dates are aligned with the expected payout of liabilities, such as claims. Any gains, whether from underwriting, investment, or administration, stay in the Experience Fund. Federal auditors monitor transactions periodically and file regular reports on their findings.

Such an arrangement has several advantages: it ensures that all program assets are segregated from other assets in the general accounts of the insurer(s), and so cannot be used to meet non-program obligations incurred by the carrier(s); it allows for the accumulation of experience unique to the program and thus discounts based on actual and unique program data, and it facilitates audits.

Exhibit I: Single Administrator / Multi-Carrier Model



The ALTCIP Single Administrator / Multi-Carrier Model assumes several offerors but one administrator, which would function like a general contractor and could subcontract various functions. Premium would flow through the ALTCIP administrator to the carriers who would establish separate accounts called Experience Fund(s). A percentage of the premium would be withheld by the ALTCIP administrator in a special Contingency Reserve. This would be used to finance a credit system for special risks assumed or to purchase reinsurance. Additional fees taken from the Experience Fund would be used to provide incentive for the administrator and insurers to hit certain annual performance metrics designed to ensure good customer service, such as telephone support, turning around applications, and managing claims. Any credits or performance awards not made would be held in the Experience Fund and become unallocated surplus.

Other Plan Elements

Premiums would be actuarially determined and set on a level or step-rated basis, in accordance with National Association of Insurance Commissioners (NAIC) premium stability guidelines for adverse experience. Premiums would be adjusted periodically to reflect actual and projected claims experience as it evolves, using the same loss ratio rules and new business rate caps currently followed by state insurance regulators for approving rate increases. It is assumed that the federal regulator will address expeditiously any request for rate increases, either for new or existing policyholders, as carriers will have given up their potential for experience gains via the separate account they have in place. They must be able to protect themselves from downside losses, an expectation that reinsurers would insist on also.

To ensure that claimants do not fail to receive a fair assessment with respect to benefit eligibility, independent third-party review of disputed benefit trigger determinations would be incorporated into the program. Other consumer protections would apply, such as contingent non-forfeiture benefits if future premium increases rise above a certain level, and the ability to reduce benefits and keep coverage in force if a rate increase makes premium unaffordable.

The ALTCIP could be designed to be in full compliance with Medicaid LTC Partnership plan regulations.[15] This, however, could add to program costs. An alternative regulatory mechanism, uniform across all states, would achieve similar results at far less cost. Such a federal mechanism does not exist, but could easily be developed via legislation.

Reinsurance Mechanism

The amount of capital a private LTC insurance carrier must set aside to back up normal active life and disabled reserves, stipulated by the NAIC, remains a source of complaint among insurance company managers and thus a concern for any carrier writing a large amount of LTC insurance. While most economists predict that interest rates will rise once the Federal Reserve backs off from stimulus efforts, it is unlikely insurers will feel comfortable with their returns on assets under management for some years to come. Thus, any large scale program must plan for relief of carrier capital strain.

[15] Per AALTCI, "Through the Partnership program states promote the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules should additional LTC coverage (beyond what the policies provide) be needed." Generally, partnership policies (currently available in 31 states) allow policyholders, upon exhaustion of their LTC insurance benefits, to keep an amount of their assets equal to what they received in private LTC insurance benefits and still qualify for Medicaid benefits. See www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php.

Reinsurance could help to reduce capital strain, as it would spread risk. However, use of reinsurance in the LTC insurance market has been less prevalent of late as reinsurers have experienced some of the same difficulties as primary LTC insurance carriers: changing assumptions about the number and duration of claims, rate increases that did not get approved, and low interest rates. From the carrier standpoint, there is also the matter of control: reinsurers wish to play an active role in managing the blocks of business they reinsure, including the timing of rate increases. Carriers have been reluctant to cede this control, and many have cut back sales to avoid having to rely on reinsurance to counter capital strain. It is not surprising that reinsurance plays a minimal role in the LTC insurance market today.

The ALTCIP makes reinsurance a structural feature, with automatic mandatory participation by all insurance carriers. It is designed to protect insurers from both the direct consequences of emerging experience not correspondent to actuarial assumptions and from market conditions that lie outside of their control, such as quantitative easing by the Federal Reserve. The cost of such reinsurance will be built into the cost of premiums and would be deducted from regular premium paid into the experience fund so as to be available as needed. The ALTCIP would offer a standard reinsurance agreement (to be determined) with the opportunity for carriers to opt out in favor of any one of a number of reinsurance forms, including coinsurance, quota share, excess of loss, or aggregate stop-loss. Such reinsurance would help to reduce excess carrier losses by spreading risk. Reinsurance premiums should be reasonable in the early years, both because of the large volume of business being presented at once and because claims will not be great. Presumably reinsurers will find such premiums attractive enough in relation to their actual risk to warrant participation.

An alternative would be to have the federal government create an *immediate* backstop at the very inception of the ALTCIP. The availability of federal resources in the time prior to the pool's growth would be a strong incentive for insurers to enter the program and stay in it.[16] This is certainly an advantage for consumers who worry about disintermediation, the withdrawal from the market of a carrier who no longer offers LTC insurance and passes administration onto other entities. The backstop being described is envisioned purely as a temporary measure to create a market environment in which large numbers of people can purchase coverage comfortably, that carriers are willing to sell with confidence. Premiums must be affordable, but must also be adequate to the risk assumed.

[16] The federal government has performed this kind of service on a number of occasions when markets have been unable to continue unimpaired. A recent example is the assumption by the government of some 90% of all home mortgage risk, which has allowed homeowners to receive reasonable loans and to refinance.

IV. ALTCIP, Social Insurance, or Both?

Benefits and Limitations of Social Insurance

Some may object that the purpose of the ALTCIP—to provide a safe and reliable form of insurance protection for long term services and supports risk at an affordable price—could be better achieved through social insurance. They would likely point to the examples of Germany and Japan, which have implemented universal mandatory plans that provide both institutional and home-based care.[17] Germany's public LTC insurance program, which covers about 70 million people, is funded by a 1.95% payroll tax divided equally between workers and employers; nine million more individuals (generally higher paid workers) opted out to purchase private LTC insurance coverage.[18] The example of Israel might also be cited; in that country more than 60% of total spending on LTSS in the community in 2010 was covered via the LTCIP, a mandatory social security program administered by the National Insurance Institute (NII).[19] Closer to home, there is the example of the Hawaii State Commission on Long Term Care Reform, which recommended in January 2012 the adoption of a mandatory home and community based care program.[20]

Social insurance may in fact be necessary, long term. There may be no other way to provide coverage to persons who have serious health conditions that predispose them to needing LTSS, to say nothing of the millions of persons already disabled. But whether, aside from the issues of cost and political feasibility already raised, it is necessary or sufficient for the entire population is another matter. According to a 2010 study by Webb and Zhivan, the expected out-of-pocket LTSS costs over the remaining life years for a couple turning 65 is $63,000, with a 5% chance of incurring over $260,000 in such costs.[21] The Hawaii program, as set forth by the Commission, would provide a limited daily benefit of $70 with an inflation adjuster and a maximum coverage period of one year—a maximum that totals just

[17] Anthony R. Kovner and James R. Knickman, "Jonas and Kovner's Health Care Delivery in the United States," 8th edition, 2005. Germany's plan, instituted in 1994, is paid for jointly by employers and employees. In the Japanese system (started in 2000), half is paid through general revenue and the other half through premiums collected from individuals starting at age 40.

[18] Howard Gleckman, "Long-Term Care Financing Reform: Lessons from the U.S. and Abroad," The Urban Institute, February 2010, p.7.

[19] This program, implemented in 1988, provides LTSS for some 80% of the elderly in Israel requiring formal assistance. It is financed by both employers and employees via payroll deduction. The program limits eligibility to those above retirement age (67 for men and 62 for women) and benefits to a maximum of 22 hours per week. Those with the highest incomes are excluded. See Sharon Asiskovitch, "The Long Term Care Insurance Program in Israel: solidarity with elderly in a changing society," *Israel Journal of Health Policy Research*, 2013, 2:3.

[20] See Hawaii Long-Term Care Commission, "Long-Term Care Reform in Hawaii, Final Report," January 18, 2012.

[21] A. Webb and N. Zhivan, as cited in "Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance" (Frank, Cohen, and Mahoney, the SCAN Foundation, 2013), from "How Much is Enough? The Distribution of Lifetime Health Care Costs," Center for Retirement Research Working Paper, CRR WP 2010-1, 2010.

over $25,000. Such a benefit would scarcely support the cost of a semi-private room in a nursing home, which exceeds $85,000 per year in metropolitan areas, nor assisted living, which can run as much as $65,000 per year. The Hawaiian Commission acknowledges that the aim of the program is not to cover nursing homes or assisted living facilities, but to support home and community-based care, a far less costly option and one perhaps better suited to the close-knit communities associated with traditional island culture. Presumably, facilities-based care would be reimbursable under the Kupuna Care program[22]. This is fine as far as it goes, but does not solve the LTSS problem for cultures lacking tight-knit communities or for seriously disabled patients requiring more supervision than can be provided easily or cheaply in a home or community setting. For such persons, high quality nursing homes are needed and desirable. These may not be readily affordable under a social insurance solution, whereas the ALTCIP, which is based on voluntary premiums and not taxes, should have the flexibility to accommodate more service- and expense-intensive demands.

It may be wondered what would happen to ALTCIP enrollees in the event that a social program is deemed necessary and implemented, specifically, whether the premium paid by ALTCIP enrollees would not be redundant. This would not be the case for two reasons. First, any tax-based social insurance program is likely to offer only minimal benefits. Such benefits would not match those of the ALTCIP. Second, a social insurance program may have to be means-tested, even if based on a mandated universal tax; otherwise, it may not be feasible. This has already been the case in Germany, while a similar scenario has been discussed in the U.S. for years in relation to Social Security. In the unlikely event that a social insurance program were actually to make the ALTCIP redundant, the risk could be covered by a contingent non-forfeiture benefit that would return to enrollees at least a portion of the premium paid in over the years.

Benefits and Potential Market for Voluntary Long Term Care Insurance

I have noted the contention of social insurance advocates that voluntary enrollment approaches will not be effective in generating the large numbers of people needed to form viable risk pools. It is true that under a voluntary approach such risk pools would not be formed immediately, which means a continuing dependency on Medicaid as the payer of last resort for longer than anyone would like. Still, voluntary insurance has other advantages. Many people like the idea of having choice. Private LTC insurance presents such choice in the way mandated approaches often do not, and is not dependent on politics. Observe the refusal until recently of Medicaid to allow eligible persons to receive care in

[22] Hawaii Long-Term Care Commission, p.3.

home and community-based settings, which is less expensive than care in institutional ones, and for many, more desirable.

Just what level of resources makes one a suitable candidate for purchasing private LTC insurance is debatable, and will vary depending on individual circumstances. But according to an AHIP survey, in 2010 over 79% of existing LTC insurance purchasers had liquid assets of over $100,000 and "44 percent of the general population age 50 and older had liquid assets in [this amount]."[23] In short, the potential market for LTC insurance among the segment that might be most expected to buy it is enormous.

Purchase of private LTC insurance will be facilitated by the ALTCIP. Accessibility will be continuous, information will be abundant, transparency will be assured, and price will be competitive. Under strong federal oversight, the ALTCIP will comply with regulations that govern everything from supporting premium stability to safeguarding data. ALTCIP enrollees will be able to rely on the ALTCIP, as will their family members. This should offer peace of mind that has been lacking in the private LTC insurance market in recent years.

True, lack of a mandate would mean that adequate enrollment might depend too much on marketing. But those who enroll and make the commitment required would be largely removed from the liability pool that continues to grow in the public sector. Moreover, the federal government could subsidize those purchasing LTC insurance. This might consist of a nominal amount or it could be more. In any event, it would be enough to tilt the axis back in the direction of heavier participation and better spread of risk.

ALTCIP as "Stop-Gap"

Could social insurance and the ALTCIP be designed to work together? Yes. The ALTCIP could be designed to supplement a mandatory social insurance policy, even as private Medicare-supplement polices wrap around the core Medicare offering. This would require some thought, as the ALTCIP would then be a secondary, as opposed to a primary payor, posing somewhat different risks. But the likelihood of the ALTCIP needing to change to a supplementary form of coverage would not likely occur until well into the future, if at all. The Affordable Care Act may be instructive: even if it goes as planned, it will have taken nearly a decade to implement all elements of the program. Meanwhile, the demand for long term services and supports is accelerating as the already staggering cost of Medicare and Medicaid continues to grow. Because the ALTCIP could be made operational quickly it could help stem the tide of the so-called "age wave", providing a stop-gap solution while longer-range LTSS solutions are being worked out. If successful, it could become a major part of that solution.

[23] Kathleen Ujvari, AARP Public Policy Institute, "Long Term Care Insurance: 2012 Update," June 2012, p.1.

V. Final Considerations

As envisioned here, the creation of a national program for LTC insurance, if properly executed, could result in the enrollment of hundreds of thousands—perhaps even millions—of persons still independent, still able to plan for retirement contingencies, and still without immediate need of LTSS services themselves. That is, it would attract the number and caliber of enrollees that would allow such a plan to achieve critical mass and thus financial stability.

Of course, optimal results could only be expected from a national educational awareness campaign, generating heightened energy and interest. The growth of e-commerce, the ease with which many now use the internet to compare and purchase products online, the convenience of self-service portals through which personal account information can be obtained, and the public's increasing comfort level in making independent buying decisions online would all work in the ALTCIP's favor.

Backed by the federal government, such a campaign would succeed. That is, it would result in a number of ALTCIP enrollees large enough to lighten the nation's entitlement burden and the resultant drag on our economy down the road. This might not be the case in the first year, but it would certainly gain traction over time. The success of the FLTCIP's initial "Open Season" enrollment of 200,000 persons in 2002-2003, and second Open Season enrollment in 2011, which resulted in more than 45,000 new enrollees within twelve weeks, underscores the potential for large, well-orchestrated, multi-media campaigns to effectively generate private LTC insurance enrollments. The "Own Your Future" campaign conducted by the Administration on Aging in conjunction with the private LTC insurance industry in 2005 is another model for study. Such campaigns could enlist the resources of federal, state, and private entities, since all would have an interest in—and benefit from—the program succeeding.

The ALTCIP is not a panacea for all that ails us, LTSS-wise. However, it would provide a regulated, transparent, and reliable framework that would encourage people to make good decisions regarding LTSS, likely reducing the numbers spending down to qualify for Medicaid. The options currently available to the mass of people now without insurance are limited, to say the least. The vast majority will not be able to cover out of pocket the costs of a long term services and supports event. And those who can afford to buy private LTC insurance on their own may not feel confident about current LTC insurance products or the companies offering them. Federal backing and oversight would likely bring the confidence necessary to persuade many who are on the fence to enroll.

Most experts say our economy will not match its historic levels of growth. The challenges that yet lie ahead with rating new pools of insureds, managing tax subsidies, Medicaid

expansion and the impact of PPACA on individuals and employers, would seem to work against the implementation of any mandatory social insurance program in the short-term, yielding ground to the more palatable voluntary approach. Conversely, the right voluntary program with the right sponsorship and consumer safeguards, presented with authority and attractive price points, could succeed, while rising interest rates would offer relief to insurance carriers who must pre-fund long term liabilities years in advance.

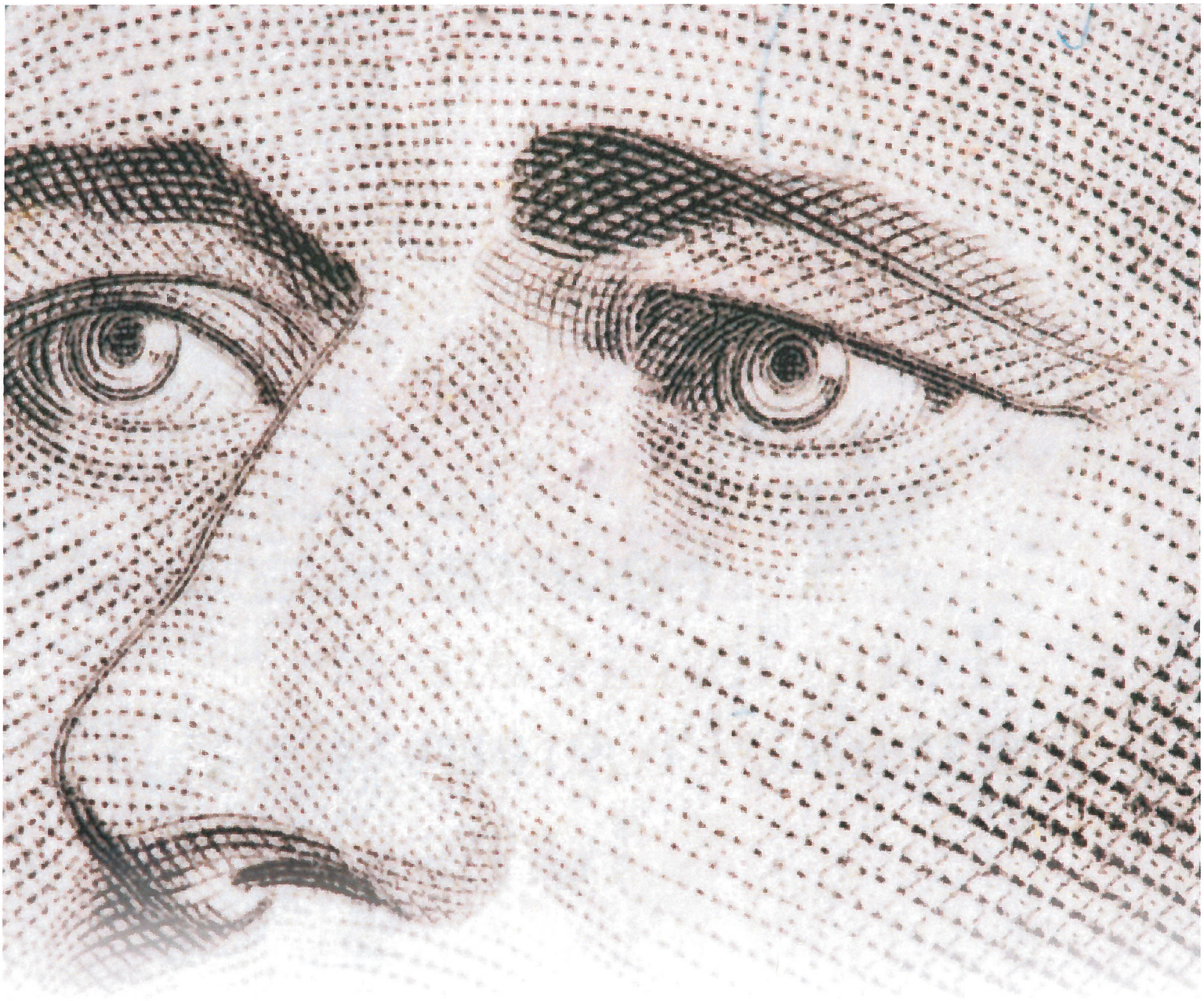
The current U.S. fiscal environment, which favors more moderately priced products and services available on a direct basis, would appear conducive to the success of an ALTCIP. Such a program could reach potentially millions at a crucial point in their personal health and financial histories. This would not prevent an expansion of Medicare or other social insurance program when the country is fiscally ready. I hope that this proposal will receive attention from the community of those now working to identify the best options before us. We are in the woods, and the light is fading. Urgent action is needed before it becomes too dark to find the path.

By Paul E. Forte

The Federal Long Term Care Insurance Program Turns 10

Is there any hope for government-sponsored long-term care insurance in this country? The Federal Long Term Care Insurance Program, which this year celebrates its first decade of successful operation, may lead the way.

THIS YEAR MARKS THE 10TH ANNIVERSARY of the first enrollment in the Federal Long Term Care Insurance Program (FLTCIP). Established on a bipartisan basis and signed into law by President Bill Clinton in September 2000 as the Long Term Care Security Act of 2000, the FLTCIP is a singular achievement in a landscape of failed efforts to expand coverage of long-term care in this country.



When the FLTCIP went live in the spring of 2002, it was the first voluntary benefit offered by the federal government to its employees. Available to military personnel as well as to federal civilians and postal workers, it was also the first truly governmentwide benefit. And because it wasn't regulated by state insurance departments, it became the country's first large-scale long-term care insurance program that was uniform in all aspects, coast to coast.

Although geared to federal employees and retirees, the FLTCIP has reached beyond the federal family to include qualified relatives. And with 100 percent of its costs financed by enrollees rather than taxpayers, the FLTCIP in the past 10 years has become a national model for underwriting a wide range of services while adhering to important benchmarks that have set the standard for financing long-term care services and supports. All of which is remarkable. But make no mistake—launching the FLTCIP was no easy task.

The Back Story

At the time of the FLTCIP's conception, federal employees and retirees—like all Americans—were at risk for needing services and supports when they no longer could live independently. Such services weren't covered by Medicare or by the Federal Employees Health Benefits Program, Veterans Affairs offered only limited benefits, and Medicaid required spending down to poverty levels to qualify for coverage. Private long-term care insurance had been marketed aggressively for more than a decade, but the number of policies issued was small and coverage remained relatively unfamiliar. The federal group also posed special challenges. This was partly because of its size and partly because of the nature of its population, with roughly 7 percent self-reporting some form of disability in 2001.

The impetus for the FLTCIP reaches back to the mid-1980s when several large life insurance companies began to introduce second-generation long-term care insurance products for sale

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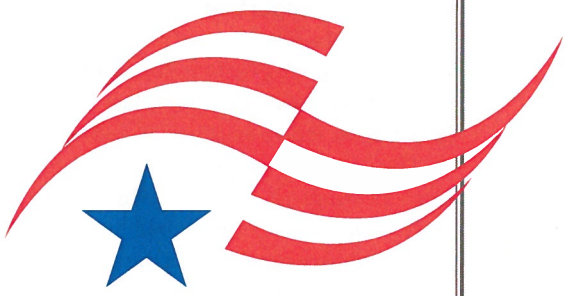
in both the individual (retail) and employer group markets. The earliest long-term care insurance policies, which appeared within a few years of the creation of Medicare in 1965, borrowed their mechanics from that program. In keeping with Medicare's medical orientation, early long-term care policy claims couldn't be approved without prior hospitalization of at least three days, a doctor's assessment of physical debility or sickness resulting in impairment, and other triggers. None of these policies made allowance for dependency brought on by cognitive impairment or for care to be delivered in sites other than a nursing home. There were numerous exclusions for pre-existing conditions and no facility for addressing inflation.

Consumer advocates disliked the early policies, as did state insurance regulators. Insurers responded with new policies that did away with prior hospitalization requirements, made the insurable event dependent on activities of daily living rather than medical status, incorporated a separate "cognitive trigger," eliminated the mental illness exclusion, and offered home health care as an option. Insurers also delivered benefits based on funds that could be accessed at different rates of spend, thereby preserving unused benefits. And they made allowance for inflation, presenting either periodic offerings of inflation adjustment or automatic indexing on a simple or compound basis. These second-generation policies went a long way toward accommodating the widespread preference to age in place through strong home and community-based health benefits and to protect against contingencies such as inflation that could emerge over several decades of an insured's enrollment.

Enrollee Benefits

The Federal Long Term Care Insurance Program (FLTCIP) has a number of features designed to protect consumers, including:



1. **Uniform Benefit Package**—The FLTCIP is regulated by the federal government, not state departments of insurance. An enrollee doesn't have to worry that coverage purchased under the regulations of one state may not conform to regulations in force in a different state in the case he or she moves.
2. **Care Coordination Services**—The FLTCIP pioneered and expanded the use of care coordinators throughout the claims process. All care coordinators are registered nurses with clinical experience. They work with the insured and his or her advisers to ensure that a plan of care is developed, the right facilities are used, and the lowest cost is negotiated through the use of a discount provider network.
3. **Independent Third-Party Review of Disputed Claims**—The FLTCIP was the first long-term care insurance program to refer disputed claims to independent third-party review. This means that a claimant who doesn't agree with a claim decision and who has appealed it unsuccessfully can request the case be reviewed by an independent medical examiner with expertise in the particular condition causing the claim. The decision of the examiner is binding on the insurance carrier and the FLTCIP, although not on the claimant.
4. **International Benefits**—The FLTCIP extends comprehensive coverage for enrollees who choose to receive their care outside of the United States. While not the first program to do so, it has taken the benefit to a higher level by providing translation, documentation, and other services.
5. **Self-Service**—The FLTCIP is the first long-term care insurance program to introduce secure personal online accounts carrying valuable information, such as benefits in force, inflation adjustments elected, claims activity, and plan of care. It's the first to accept fully underwritten applications online and the first to introduce an online consultant tool that helps a prospective insured make decisions concerning what care might be needed and how to make the right policy choices. In addition, it offers potential enrollees an instant FLTCIP quote.
6. **No-Load Sales Support**—The FLTCIP is offered to prospective enrollees on a direct basis and doesn't rely on intermediaries who receive commissions for enrollments. Interactive website tools help applicants make informed decisions, and specially trained customer service representatives are available to assist those who want to talk to a person.
7. **No War Exclusion**—The FLTCIP has no war/act of terrorism exclusion. It was the first long-term care insurance program to offer comprehensive protection to enrollees serving in a theater of war.

The 1990s saw a significant increase of such policies, especially in the group market. They appeared first among *Fortune* 500 companies and then among smaller employer groups. By the late 1990s, there were several thousand private-employer group long-term care insurance plans in existence around the United States, covering hundreds of thousands of persons. A number of group long-term care insurance plans also were introduced into state governments, colleges, universities, labor unions, professional associations, and affinity groups.

The most notable among these many plans was the one introduced in 1995 by the California Public Employees' Retirement System (CalPERS), which also runs the nation's largest pension fund. As the second-largest public entity in the country, CalPERS already had dealt with issues that would become familiar to federal designers as they began to frame the FLTCIP.

Building on Experience

Building on the experience of others, the creators of the FLTCIP studied various proposals in close consultation with public policy experts, the heads of large civilian and military organizations, labor unions, retiree associations, and informed private citizens.

The proposed program was the subject of two congressional hearings—in 1999 and 2000—by the House Committee on Government Reform chaired by Rep. Joe Scarborough (R-Fla.). A primary stipulation in the development of FLTCIP was that the entire cost of the program, including claims and administration, had to be carried by enrollees through voluntary premium contributions. There could be no government appropriations. Insurance industry experts provided valuable papers and reports, as well as testimony. While some experts pushed for including individual policies in the mix, others advocated a single insurer or a consortium of insurance companies acting as a single insurer. The latter approach, it was argued, was the best way to ensure a sufficiently large pool of enrollees over which to spread anti-selection risk and fixed costs. This, in turn, would ensure a relative degree of premium stability.

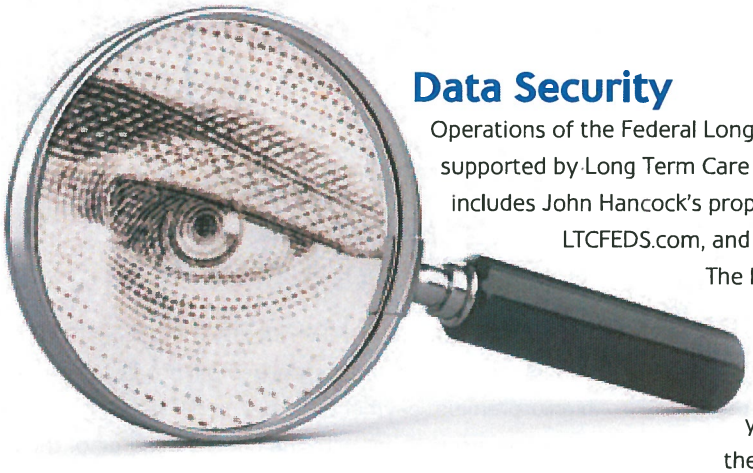
In the end, the program's architects decided to pursue the group approach. A wise decision, as it helped to avoid the confusion and inertia likely to have resulted from simultaneous offers from numerous vendors. This approach also helped to focus attention on a single unified program that was coextensive with the federal community. But acceptance within that community wasn't instantaneous. There was reluctance on the part of many who had come to think of long-term care as something that the government took care of. (This despite evidence suggesting that there was small appetite for expanding existing social insurance programs or for introducing new ones to do it.) Education—a great deal of it—was necessary to demonstrate the need for personal insurance protection for long-term care, as well as the utility of transferring long-term care expense risk to a third party rather than absorbing it yourself.

Another important decision by the program's framers was to allow medical underwriting of applicants. The FLTCIP wasn't obliged to enroll any individual who would be eligible for benefits immediately, and higher standards of underwriting, if required, might be applied if a potential participant declined his or her initial opportunity to enroll. The decision to require evidence of insurability helped to guarantee that the FLTCIP wasn't overwhelmed by claims right out of the gate. At the same time, the framers decided to treat spousal applicants (to the extent practical) in much the same way as active employee applicants—thus encouraging planning for long-term care at the family level. Other qualifying relatives, such as parents, parents-in-law, and adult children of living federal retirees, also could apply but would be required to furnish more evidence of insurability

The program's enabling statute stipulated that the FLTCIP be fully insured via a policy that met all the requirements for a tax-qualified long-term care insurance contract as defined by the Internal Revenue Service. It required guaranteed renewability, with coverage available as long as premium payments were made. It also provided for full portability so that, once enrolled, an individual could maintain coverage even if no longer employed by the federal government. Eligibility for coverage was tied to regulations for participation in federal employee health plans, with some exceptions (such as employees of the District of Columbia and the Tennessee Valley Authority).

Designated as the program's regulator, the U.S. Office of Personnel Management (OPM) drafted and published the regulations necessary to implement the law and to ensure compliance with the consumer protection provisions of the Health Insurance Portability and Accountability Act of 1996. (These have been amended from time to time in the *Federal Register* and are posted at www.opm.gov/insure). Further oversight was granted to congressional committees and to the Government Accountability Office, which was charged with conducting audits of the FLTCIP after its third and fifth years and thereafter as advisable.

The OPM's insurance unit worked on requirements throughout the fall of 2000, paying particular attention as to how to market and communicate the program to active employees given the fact that it possessed no centralized eligibility file for that target segment. The OPM also conducted informational briefings with prospective bidders in the early months of 2001 to further assess the capabilities and limitations of the market with respect to certain benefit designs. The OPM couldn't know, in its initial bid process, how many insurers would respond to the request for proposals issued in June 2001 and whether those insurers would be ready to implement by early 2002—the OPM's preferred date. But the statute permitted the formation of partnerships of insurers and administrators as bidding entities. This enabled prospective bidders to pool strengths and left them with



Data Security

Operations of the Federal Long Term Care Insurance Program (FLTCIP) are supported by Long Term Care Partners' advanced technology platform. This includes John Hancock's proprietary CARE System, the program's website, LTCFEDS.com, and the network infrastructure on which it rests. The FLTCIP takes seriously the security of its data and has enjoyed a solid track record for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Going beyond security measures stipulated in HIPAA, the FLTCIP meets or exceeds the requirements for federal agencies under the Federal Information Security Management Act of 2000. Using the National Institute of Standards and Technology framework, the FLTCIP has been certified and accredited by the chief information officer of the Office of Personnel Management. The certification includes an approved three-year plan going forward that will make the FLTCIP an even safer and more reliable repository for protected health information and personally identifiable information.

considerable latitude as to how they would structure risk, invest assets, deploy systems, and set up operations.

Going Live

In December 2001, OPM awarded the first seven-year contract to a consortium made up of John Hancock Life Insurance Co. and Metropolitan Life Insurance Co., two of the largest life insurance companies in the country and each with significant experience in the private long-term care insurance market. The carriers proposed that a third entity be created to ensure a single point of administrative contact for OPM, and work began on founding the new company—Long Term Care Partners, LLC.

Long Term Care Partners was given responsibility for all of the daily operations of the FLTCIP, including marketing, customer service, underwriting, new business enrollment, premium administration, claims, systems development, and financial reporting. The parent companies were responsible for pricing/actuarial valuation, underwriting policy, and fund management, including investment of assets, and contract negotiation.

The first FLTCIP applications were accepted in March 2002, with an effective date of May 1. The formal open season began on July 1, 2002, and continued into early 2003. A massive national advertising and marketing campaign paved the way with more than 2,200 informational seminars coast to coast. A website, LTCFEDS.com, also offered detailed consumer-oriented information and established a strong online presence for the fledgling program.

The first open season yielded almost 200,000 enrollments, not counting dependents and qualified relatives such as parents, parents-in-law, and other family members. Approximately 66 percent were active federal civilian employees or their spouses, with 34 percent civilian annuitants or retired uniformed services personnel and their spouses.

Because the FLTCIP was underwritten, applicants had to apply for coverage. No policy was issued on a guaranteed basis. Actively-at-work employees, including new hires and spouses, however, could apply using a modified abbreviated form that asked relatively few health questions. Many applicants went this route. Underwriting acceptance rates exceeded 75 percent and have remained above this level every year since the program's inception.

In the years since the first open season, the FLTCIP has grown nearly 40 percent. As the result of a renegotiated contract with John Hancock in October 2009, FLTCIP now offers:

- Higher daily benefit amounts ($100–$450);
- A 100 percent daily benefit amount for home health care;
- Coverage of informal care provided by a family member for up to 500 days;
- Automatic compound inflation adjustment options of both 4 percent and 5 percent;
- A calendar-day waiting period that makes it unnecessary to incur formal expenses before qualifying for benefits;
- A stay-at-home benefit;
- The addition of a two-year benefit period for those who wish to buy essential coverage at less cost.

Fine-tuning

It's appropriate to note that the FLTCIP doesn't offer all of the options found in the best private individual long-term care insurance policies, such as preferred rates for above-average

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health, spousal discounts, and shared care pools in which a spouse can tap any remaining benefit values left in a policy held by the other spouse.

While these discounts and options do meet certain select needs, the value of such features has to be weighed against all the benefits of participating in a very large group program (with its attendant economies of scale) that is designed to be sustainable for the long term. Equity is also a consideration. The FLTCIP treats all enrollees similarly from the standpoint of pricing. There are no advantages (or disadvantages) based on lifestyle or location.

It also been noted that the FLTCIP does not have a "partnership plan" provision. Partnership plans allow those who, through claims, have exhausted benefits from their private long-term care insurance policies to protect a portion of their personal assets (equal to the amount of the policy benefit) from Medicaid spend-down requirements. Few states had partnership legislation on their books when the FLTCIP debuted in 2002. Forty states now have some form of legislation in place supporting sales of partnership plans. OPM is considering the option of introducing partnerships to the FLTCIP.

Many features set the FLTCIP apart from other long-term care insurance programs (see Page 32). But where the FLTCIP demonstrates particular strength is in areas such as the delivery of benefits. In an average month, the FLTCIP generates 40,000 unique website visits, receives 12,000 phone calls, and meets with more than 6,500 people via seminars and webinars. These and other transactions are subject to close inspection by OPM and must be performed according to a quality assurance program that tracks and reports on 20 separate performance metrics. These reflect customer experience in areas such as the speed and accuracy with which requests are processed or the rate that claims are turned around when all relevant information is submitted. OPM monitors progress toward the achievement of each standard on a monthly basis. Failure of the vendor translates into a loss of profits.

Pricing Premiums

The challenge in pricing long-term care insurance is the need to generate adequate premium for a costly event that may not take place until 20, 30, or even 40 years beyond the start of coverage while maintaining affordability over the same time frame. Premium rates must be sufficient to pay claims plus expenses now and over the future lifetime of enrollees. The federal enabling law for the FLTCIP allows for changes to premium rates during the contract term provided that such changes are based on mutual agreement between OPM and the insurance carrier and that they are made on a class basis with no individual singled out.

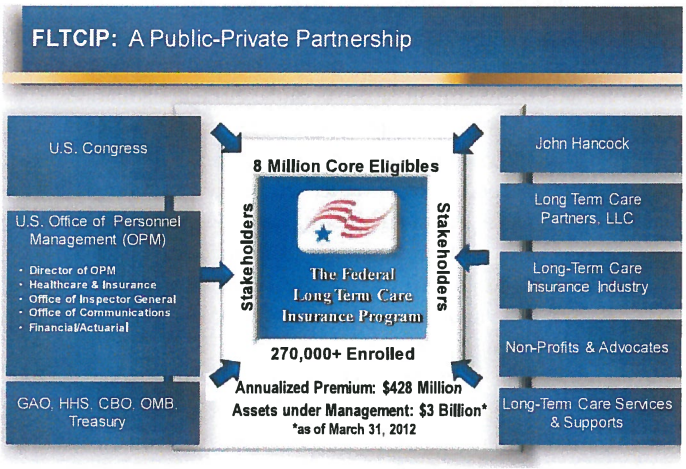
As experience began to emerge over the first seven years of the program, it became apparent that some of the key assumptions used in developing premium rates in the first contract

Experience Rating

NO LONG-TERM CARE INSURANCE PROGRAM can or should guarantee that its enrollees will not be subject to higher premium payments in the future. Such a guarantee would be inconsistent with the fiduciary charge of those responsible to ensure the program's financial soundness over the long term.

The Federal Long Term Care Insurance Program (FLTCIP) enjoys significant oversight by multiple stakeholders (see below) at the same time that its experience fund offers a high degree of accounting transparency. All premiums not needed to cover program expenses and claims stay in the experience fund, even if the carrier or administration changes. As a separate account held in trust for the enrollees by the carrier, the experience fund ensures:

- That all premiums going into the account are used for the FLTCIP alone, not for the carrier's other obligations;
- That all expenses are managed within approved budgets;
- That all investments, tracked and discussed regularly at a quarterly meeting of the Office of Personnel Management (OPM) and carrier financial executives, work for the benefit of FLTCIP enrollees;
- That all profit charges are approved by OPM as part of the annual quality assurance surveillance program assessment, an audited process requiring extensive documentation.



The framers of the FLTCIP believed that a successful federal long-term care insurance program would create a model for private and public employers across the country and help reduce reliance on Medicaid, the Department of Veterans Affairs, and other tax supported long-term care programs. In hindsight, it's evident that this was ambitious.

period were inconsistent with actual experience. In particular, enrollee persistency had been significantly higher than expected, because more people than expected kept their coverage (rather than voluntarily canceling it) and people lived longer than expected when the initial rates were set. In addition, the low interest-rate environment that prevailed for most of the past decade caused assets invested in public and private placement bonds to fall short of pricing targets. In March 2010, it was determined that a rate increase would need to be implemented for those enrollees who had selected the 5 percent automatic compound inflation option—approximately two-thirds of all FLTCIP enrollees.

The amount of the rate increase, which could be as much as 25 percent of premium, varied depending on the age of the enrollee when first accepted into the program. It was decided, however, that enrollees would be able to avoid the increase if they agreed to a guaranteed issue landing spot, allowing them to keep roughly the same premium they were paying in exchange for a benefit reduction. The rate of automatic inflation adjustment was one of the benefit-reduction options, and any previously earned inflation-adjustment amounts were credited to an enrollee's account. This had the advantage of not affecting any of the enrollee's current benefit levels, nor such key provisions as covered service, benefit periods, levels of reimbursement, waiting periods, exclusions, and care coordination. It affected only the rate by which the daily benefit amount would increase in the future.

These actions occurred around the time that FLTCIP unveiled its new plan design containing such significant enhancements as 100 percent coverage of home health care. Almost half of all enrollees chose to keep their original coverage and to pay their stipulated increase. An additional 6 percent chose to move to the new plan with 5 percent inflation adjustment and pay an even higher premium. But 19 percent of enrollees chose to reduce their inflation percentage from 5 percent compound to 4 percent compound, while 26 percent of enrollees moved to the new plan with 4 percent compound.

Some have worried that future FLTCIP growth will be affected adversely by the 2010 rate increase. If the recent 2011 open season is any indication, this is unlikely. During the open season, more than 45,000 individuals enrolled in the program, exceeding the total number of people who enrolled in all other existing employer group programs combined in the first six months of 2011.

An Ambitious Undertaking

The framers of the FLTCIP believed that a successful federal long-term care insurance program would create a model for private and public employers across the country and help reduce reliance on Medicaid, the Department of Veterans Affairs, and other tax-supported long-term care programs. In hindsight, it's evident that this was ambitious.

LIMRA, the research, consulting, and professional development organization for insurance and financial services companies, estimates that the number of employers sponsoring private group long-term care plans has increased significantly in the past 10 years, with more than 11,000 employer groups offering plans covering approximately 2.4 million persons in 2010. But the total number of enrollments in those plans hasn't changed the financing picture as hoped. Reliance on government programs like Medicaid and Medicare for long-term care service expense has also grown, with government in 2009 absorbing roughly 70 percent of the nation's total long-term care bill of more than $294 billion in paid services.

There can be no question, however, that the FLTCIP has made a difference within the large federal community, which numbers 8 million actives and annuitants, not counting eligible family members. It has increased awareness of long-term care as an issue, facilitated decision making, and helped many thousands of federal employees to cover their long-term care expenses, paying out nearly $215 million in claims to date—more than 85 percent to cover home and community-based services.

The success of the FLTCIP offers a template for financing and administering quality long-term care to large numbers of people on a direct basis without federal appropriations. It certainly can be studied with profit by anyone trying to determine the best way to help an aging population manage its growing long-term care risk. □

PAUL E. FORTE is chief executive officer of Long Term Care Partners LLC.

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