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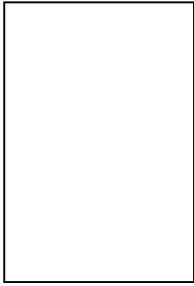
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LONG-TERM CARE INSURANCE IN OHIO

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April 2002



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**Long-Term Care Insurance
In Ohio**

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April 2002

Executive Summary

Because of demographic changes and increased life expectancy, the need for long-term care services by older Ohioans is substantial and growing rapidly. Today, persons aged 65 and over represent 13 percent of the population in the state; by 2030, when the baby boomers will have reached age 65, they will represent 21 percent of the population. In addition, persons aged 85 and over, who are at the greatest risk of needing long-term care services, are one of the fastest growing age groups in the state.

Given this anticipated increase in demand for services and the limitations of existing publicly funded long-term care coverage, the financing and delivery of long-term care for older Ohioans has been and will remain an important policy issue. There has been interest in private sector approaches to financing long-term care because of concern over the cost of expanding publicly financed long-term care benefits. Consequently, considerable attention has focused on private insurance for long-term care. Furthermore, private insurance for long-term care provides one of the few available mechanisms for older Ohioans to protect themselves against the catastrophic costs of long-term care.

This report provides a snapshot of the current long-term care insurance market in the state of Ohio and nationally; discusses the evolution of the market, provides an in-depth look at current products and choices in the state of Ohio, discusses the business of long-term care insurance, examines long-term care insurance regulations, outlines consumers' ability to make informed decisions; and assesses the adequacy of protection for purchasers against the costs of long-term care and the ability of products to meet consumer needs. Finally, it concludes by offering policy recommendations for the further development of long-term care insurance in Ohio.

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Introduction & Background

Because of demographic changes and increased life expectancy, the need for long-term care services by older Ohioans is substantial and growing rapidly (Mehdizadeh, Kunkel, & Ritchey, 2001). Today, persons aged 65 and over represent 13 percent of the population in the state (U.S. Census Bureau, 2001); by 2030, when the baby boomers will have reached age 65, they will represent 21 percent of the population (U.S. Census Bureau, 2001). In addition, persons aged 85 and over, who are at the greatest risk of needing long-term care services, are one of the fastest growing age groups in the state (Mehdizadeh, Kunkel, & Applebaum, 1996).

Given this anticipated increase in demand for services and the limitations of existing publicly funded long-term care coverage, the financing and delivery of long-term care for older Ohioans has been and will remain an important policy issue (Applebaum, Mehdizadeh, & Straker, 2000). There has been interest in private sector approaches to financing long-term care because of concern over the cost of expanding publicly financed long-term care benefits (Landes, 1987; Mulvey & Stucki, 1998; Alexih & Lutzky, 1995). Consequently, considerable attention has focused on private insurance for long-term care (Wiener, Tilly, & Goldenson., 2000; Cohen & Kumar, 1997).

Private insurance for long-term care provides one of the few available mechanisms for older Ohioans to protect themselves against the catastrophic costs of long-term care. The National Association of Insurance Commissioners (National Association of Insurance Commissioners [NAIC], 1998) defines long-term care insurance as:

any insurance policy or rider which provides coverage for not less than twelve consecutive months on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital (p. 1).

Thus, in contrast to health insurance, long-term care insurance is distinguished by two major characteristics: (1) it provides coverage for extended care services (at least 12 months); and (2) it covers services not provided in acute care settings (i.e., hospitals) (NAIC, 1998).

Like other types of health insurance, long-term care insurance varies greatly in cost, covered benefits, and benefit criteria (U.S. Congress Senate Special Committee on Aging, 2000). Most long-term care insurance policies sold in Ohio are indemnity products, which cover both nursing home stays and home care visits at a fixed rate per day or per home care visit (Ohio Department of Insurance [ODI], 1999). Typically, the policies will pay for between two and an unlimited number of years in a nursing home, with a deductible period (e.g., no coverage for the first 20 to 100 days).

The state of Ohio has an interest in long-term care insurance to help potentially reduce the state's expenditures for long-term care and to ensure that consumers receive adequate protection from products they purchase.

Although long-term care insurance currently pays for only a small portion of the total cost of long-term care, it is expected to become more important in the future (Weiner, 1996). The state of Ohio has an interest in long-term care insurance to help potentially reduce the state's expenditures for long-term care and to ensure that consumers receive adequate protection from products they purchase (ODI, 2001). As an illustration, the Ohio Department of Insurance stated that, "The Department's mission is consumer protection through financial solvency regulation, market conduct regulation and consumer education" (ODI, 2001).

This report is designed to provide a snapshot of the current long-term care insurance market in the state of Ohio and nationally; discuss the evolution of the market; provide an in-depth look at current products and choices in the state of Ohio; examine long-term care insurance regulations; outline consumers' ability to make informed decisions; and assess the adequacy of protection for purchasers of long-term care products to meet consumer needs. Finally, it concludes by offering policy recommendations for the development of long-term care insurance in Ohio.

Long-term care insurance incorporates aspects of health, disability, and life insurance into a unique, relatively new form of insurance (Wiener, Hixon-Illston, &

Hanley, 1994). Like health insurance, it offers coverage for health-related needs, typically on a fee-for-service basis. Like disability insurance, policies cover a wide array of services that are necessitated by a long-term disabling functional or cognitive impairment (Alexih, Kennell, Fox, & Rice, 1995); in addition, some policies provide monthly cash payments (Wiener, Hixon-Illston, & Hanley, 1994b). Long-term care insurance, like life insurance, depends on prefunding a benefit typically needed many years in the future. The hybrid nature of the product has implications for regulation, purchasing decisions by consumers, the likelihood that consumers will have coverage for the services they desire, and pricing of the product (Lencsis, 1997; Weiner & Harris, 1991).

Insurers began offering long-term care insurance widely in the mid-1980s. By 1998, 5.8 million policies had been sold (LifePlans, 2000). Current policyholders are dominated by purchasers of individual policies. However, recent growth in new sales has increasingly come from employer-sponsored products (Pincus, 2000b). A federal long-term care insurance offering available in 2002 to federal employees is expected to double the number of employer-sponsored policyholders by the middle of the decade (Pincus, 2000a).

Current long-term care insurance policies typically include nursing home, assisted living, and home and community-based care coverage (LifePlans, 2001; ODI, 1999). The purchaser generally can select a daily amount of coverage up to which the policy will pay benefits if the policyholder receives services from a certified provider and meets the insurer's disability eligibility criteria (Lutzky & Alexih, 1999; Crown, Capitman, & Leutz, 1992). Purchasers also have the option of automatically increasing

the level of coverage over time or buying increased coverage at specified intervals (inflation protection)(LifePlans, 2001). In some cases, purchasers also have the option to purchase nonforfeiture benefits that return some of the insured’s investment in his or

her policy if he or she stops paying premiums (lapses) (Lencsis, 1997). Typical features purchased have changed over time with many more recent purchasers opting for more complete coverage (see Table 1).

Table 1
Characteristics of Individual Long-Term Care Insurance Policies
Purchased in 1990, 1994 and 2000

Policy Characteristic	1990	1994	2000
Policy Type			
Nursing home only	63%	33%	14%
Nursing home and home care	37%	61%	77%
Home care only	----	6%	9%
Daily Benefit Amount for Nursing Home Care	\$72	\$85	\$109
Daily Benefit Amount for Home Care	\$36	\$76	\$106
Nursing Home Benefit Duration	5.6 years	5.1 years	5.6 years
Individuals Choosing Inflation Protection	40%	33%	40%
Annual Premium	\$1,071	\$1,505	\$1,677

Note. From *Who buys long-term care insurance in 2000? A Decade of Study of Buyers and Nonbuyers* by Lifeplans, 2001, Health Insurance Association of America: Washington, DC.

Over the past five years, most insurance companies have switched to offering a single pool of money rather than separate pools that can only be used for certain services (i.e. nursing home or home and community-based care)(LifePlans, 2000). This single pool maximizes the flexibility of service-based benefits because an insured individual can apply the money to services and facilities she or he needs and desires, as long as it is for a covered service. The benefit duration under this model is dependent on how long it takes the insured to spend his or her pool of money rather than a certain specified time period. For example, a policy with separate pools of money with four years of coverage for nursing home care at \$100/day and home care at \$50/day would allow the insured to receive up to \$100 a day in a nursing facility or \$50 a day of home care for only four years. On the other hand, the same policy with a single pool of money policy would offer \$219,000 that could be used for either type of care. Thus, the policy could be stretched out to cover 12 years of home care coverage if an average of \$50 a day were spent or it could cover six years of nursing home care if the facility cost \$100 a day.

THE BUSINESS OF LONG-TERM CARE INSURANCE

Three key issues that could determine the success of long-term care insurance include how adequately companies: 1) screen poor risks (underwriting), 2) set premiums, and 3) manage claims.

Three key issues that could determine the success of long-term care insurance include how adequately companies: 1) screen poor risks (underwriting), 2) set premiums, and 3)

manage claims (Wiener, Hixon-Illston, & Hanley, 1994a). Underwriting is the process through which insurance companies determine whether someone who applies for a policy should be issued a policy. Companies underwrite policies to avoid adverse selection by using written health questions, interviews, medical record reviews, and assessments (Lutzkey & Alexih, 1999; Wiener, Hixon-Illston, & Hanley, 1994b). The depth of the assessment conducted on an applicant generally increases with age. Insurers generally have a more difficult time screening for mild to moderate cognitive impairment than physical impairment and severe cognitive impairment (Kolb, Veysey, & Gocke, 1991).

The premiums that insurers charge influence whether consumers will purchase the policies and whether the product is profitable for the company (Doerpinghaus & Gustavason, 1999; Kumar, Cohen, Bishop, & Wallack, 1995; Cohen, Kumar, & Wallack, 1993). Premium levels vary significantly depending upon the level of benefits, age of purchaser, and risk factors such as smoking (as well as claims expectations, interest rates, and profit margins)(LifePlans, 2001). Most long-term care insurance policies are sold with level premiums (i.e., premiums are set to remain the same over time as long as the assumptions used to develop the premiums are borne out)(Kumar, et al.). Premiums range widely depending on coverage amount, age, and typical services. For example, a two-year policy with no inflation protection that covers nursing home, assisted living and home care and is issued at age 55 costs about \$300 per year, compared to a policy with similar benefits that includes inflation protection and is issued at age 75 costing over \$3100 annually (see Table 2)(ODI, 1999).

Table 2
Policy Premiums for the Six Leading Long-Term Care Insurance Sellers in Ohio, 1999

Company	Number of LTC Customers in Ohio	Age 55	Age 55 w/inflation protection	Age 65	Age 65 w/inflation protection	Age 75	Age 75 w/inflation protection
Bankers Life and Casualty	8,270	\$326	\$693	\$693	\$1276	\$1808	\$2687
Continental Casualty	11,631	\$336	\$627	\$694	\$1187	\$1747	\$2610
GE Financial Assurance	7,725	\$378	\$720	\$765	\$1323	\$2124	\$3105
IDS Life	9,168	\$440	\$860	\$840	\$1440	\$1960	\$3120
John Hancock Mutual Life	7,947	\$416	\$844	\$781	\$1348	\$2016	\$3037
Penn Treaty Network America	5,048	\$313	\$520	\$776	\$1304	\$2139	\$3102

Note. From *Ohio Shopper's Guide: Long-Term Care Insurance* by Ohio Dept. of Insurance, 1999. ODI: Columbus, OH.

REGULATION

Traditionally, states have had the primary responsibility for regulating the insurance industry. The McCarran-Ferguson Act of 1945 (P.L. 79-15) granted states the power to regulate the business of insurance, removing all Commerce Clause limitations on the states' authority in this area.

The National Association of Insurance Commissioners (NAIC) developed uniform legislation for states (Hanson,

Dineen, & Johnson, 1974). At this point, regulation of long-term care insurance industry is a state function. Although specific laws, resources, and regulatory philosophies vary among the states, state insurance regulatory agencies generally perform the same functions (NAIC, 2000). These include (1) implementing requirements for regulating insurance premium rates and the content of insurance policies, (2) licensing insurance companies and agents to conduct business in the state,

(3) enforcing consumer protection standards and unfair trade practice laws, and (4) examining the financial condition of insurance companies (ODI, 2001).

States' insurance regulatory agencies are linked through the NAIC, which includes the heads of regulatory agencies in each state, the District of Columbia, and the U.S. territories (NAIC, 2001a). It provides a forum for state insurance officials to discuss common problems, standardize the annual reporting of financial information by insurance companies, and develop model legislative acts for adoption by the states (NAIC, 2000).

In 1985, the NAIC established an advisory committee on long-term care. The next year, the committee developed a legislative proposal in the form of a model act. A year after that, NAIC adopted model regulations for implementing the model act (Wiener, et al., 2000). The NAIC amended its models in 1987 and 1988 to improve policyholders' coverage and strengthen consumer protection. NAIC's model law and regulation suggest that states should adopt minimum standards with regard to long-term care insurance policies (NAIC, 2000).

In addition, although not a regulation, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 defined qualified plans for the purpose of tax deductibility, including an eligibility trigger floor to control the tax revenue loss associated with this provision and refers to 1993 NAIC model regulations related to consumer protection. Consequently, although HIPAA's benefit triggers are more restrictive than those that the NAIC recommends for long-term care insurance policies, almost all insurers have modified their benefit eligibility requirements to reflect HIPAA requirements. Although

HIPAA brought tax deductibility for long-term care insurance, insurance companies argue that it has burdened them with inflexible criteria that cannot adapt easily to the continuing innovation of the product.

OHIO DEPARTMENT OF INSURANCE (ODI)

In Ohio, the Department of Insurance is the agency responsible for regulating long-term care insurance (ODI, 2001). ODI was created by section 121.02 of the Ohio Revised Code (ORC) and has functioned as the regulator of the insurance industry since 1872. ODI is responsible for protecting the interests of the public by making sure insurance companies adhere to the standards established by Ohio law in a fair and consistent manner.

ODI has identified several regulatory goals which guide the Department's decision making process and enable it to effectively administer and enforce Ohio's Insurance Laws related to long-term care insurance. These goals include:

- ❖ Assuring that high quality, understandable long-term care insurance products are available at fair and reasonable prices.
- ❖ Assuring that long-term care insurance companies are financially sound and capable of meeting their contractual obligations.
- ❖ Assuring that insurance agents are competent and knowledgeable in the long-term care insurance business and conduct their activities according to acceptable standards of business conduct.

- ❖ Assisting in developing increased public understanding of long-term care insurance and thereby helping consumers make sound insurance purchasing decisions.

The Consumer Services program within ODI provides direct services to consumers by responding to general inquiries, investigating insurance complaints against companies and agents, providing health insurance counseling, developing and distributing insurance publications, and conducting educational outreach. In 1999, the program responded to over 96,000 telephone requests for information or assistance. In addition, the Ohio Senior Health Insurance Information Program (OSHIIP) has assisted over 340,000 Medicare beneficiaries, saving consumers approximately 2.5 million dollars.

OSHIIP is a consumer education program designed to encourage wise buying and addresses consumer misconceptions about long-term care and its costs. Working through trained volunteers, the OSHIIP program conducts public meetings and media campaigns to educate consumers about a range of insurance-related topics, including long-term care insurance. Topics covered include Medicare and Medicaid eligibility and program benefits, as well as comparison of available long-term care insurance policies in the state. OSHIIP also publishes a number of guides for consumers including: *Ohio Shoppers' Guide to Long-Term Care Insurance*; *Shoppers' Guide to Medicare Supplemental Insurance*; *Shoppers' Guide to Managed Care*; and a *Shoppers' Guide to Health Insurance*.

The *Ohio Shopper's Guide to Long-Term Care Insurance* contains material on Medicare and Medicaid benefits, materials to aid prospective purchasers in evaluating the adequacy of benefits, and a proposed disclosure statement to be given to purchasers explaining policies in uniform language. Finally, it has a list of "Questions to Ask [about long-term care insurance]" and a glossary of long-term care terms. The NAIC also publishes a consumer's guide to long-term care insurance entitled: "*Shopper's Guide to Long-Term Care Insurance*" (NAIC, 2001b).

STATE INVOLVEMENT WITH LONG-TERM CARE INSURANCE

State actions have included two major approaches: requiring insurers to offer long-term care insurance, and encouraging market development through tax incentives and consumer education.

A number of states have encouraged the purchase of long-term care insurance (Somers & Merrill, 1991). State actions have included two major approaches: requiring insurers to offer long-term care insurance, and encouraging market development through tax incentives and consumer education (see Appendix for an alternative approach). Tax incentives to encourage particular actions are a common strategy in many situations. For example, in 1999 the state of Ohio enacted an income tax deduction for long-term care insurance premium payments (see Table 3).

Table 3
State Tax Incentives for Long-Term Care Insurance

State	Tax Incentive	Total or Partial Premium Deduction	Tax Credit Limit if Partial	Effective Date	Statute
Ohio	Individual Deduction	Total		1999	Ohio Rev. Code Ann. Sec. 5747.01 (A)(11)(a)(1999)
Alabama	Individual Deduction	Total		1996	Ala. Code. Sec. 40-18-15(a)(26)(1999)
Colorado	Individual Credit	Partial	Lower of \$150 or 25% of premium	2000	Colo. Rev. Stat. Sec. 39-22-122(1999)
Indiana*	Individual Deduction	Total		2000	Ind. Code Sec. 6-3-1-3.5(a)(16)(1999)
Iowa	Individual Deduction	Total		1997	Iowa Code Sec. 422.7(29)(Supp. 2000); Iowa Admin. Code Sec. 701-40.48(422)(1999)
Kentucky	Individual Deduction	Total		1998	KY Rev. Stat. Ann. Sec. 141.010(10)(m)(1998)
Maine	Individual Deduction Employer Credit	Total Partial	Lowest of \$5000, 20% of premium, or \$100 per insured employee	1989 1996	ME. Rev. Stat. Ann. Tit. 36, Sec. 5122(2)(G) (1999); ME. Rev. Stat. Ann. Tit. 36, Sec. 2525 (1999)
Maryland	Employer Credit	Partial	5% of employer costs, less than \$5000, or \$100 per covered employee	1999	MD. Code Ann., Ins. Sec 6-117 (Supp. 1999); MD. Code Ann., Tax-Gen. Sec 10-710 (Supp.1999)
Minnesota	Individual Credit	Partial	Lower of \$100 or 25% of premium	1999	Minn. Stat. Sec. 290.0672 (1999)
Missouri	Individual Deduction	Total		2000	MO. Rev. Stat. Sec. 135.096 (2000)
Montana	Individual Deduction	Total		1997	Mont. Code Ann. Sec. 15-30-121(1)(g)(ii) (1997)
New York	Individual Deduction	Total	Limited by age**	1996	N.Y. Tax Law Sec. 615 (C)(4)
North Carolina	Individual Credit	Partial	\$350 per policy	1999	N.C. Gen. Stat. Sec 105-151.28 (1998)
North Dakota	Individual Credit	Partial	\$100	1997	N.D. Cent. Code Sec. 57-38-29.2 (1993)
Utah	Individual Deduction	Total		2000	Utah Code Ann. Sec. 59-10-114(2)(k) (1999)
Virginia	Individual Deduction	Total		2000	VA Code Ann. Sec. 58.1-322(D)(1)
Wisconsin	Individual Deduction	Total		1998	Wis. Stat. Sec. 71.06(6)(b)(26)

Note. From "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance." By J. Weiner, J. Tilly, and S. Goldenson, 2000, *Elder Law Journal*, 8(1) p. 57-102.

* Indiana's tax deduction applies only to partnership policies.

** Age limitations in 1998 were: \$210 for age 40 or younger; \$400 for age 41 to 50; \$800 for age 51 to 60; \$2120 for age 61 to 70; \$2660 for age 71 and older.

Note: Tax incentive legislation is just one aspect of long-term care insurance legislation in the states. States also are enacting disclosure bills, establishing requirements for coverage, and broaching the idea of long-term care coverage for state employees. A number of states are setting up task forces to examine the viability of offering coverage, while other states that have set up long-term care task forces have placed insurance on their agendas.

Insurance industry advocates and some other analysts contend that private long-term care insurance could play an important role in financing long-term care in the coming decades (LifePlans, 2001). In this view, the state of Ohio would benefit in several ways if more middle-income people could be induced to buy coverage (Cohen, Kumar & Wallack, 1993). Future demand for publicly financed services in Ohio, particularly Medicaid, would be reduced, and people would have superior access to a continuum of long-term care services of high quality and they would be less likely to risk impoverishment (Crown, Capitman, & Leutz, 1992; Wiener & Harris, 1991).

These claims seem plausible enough, although there is disagreement about the potential of long-term care insurance to reduce Medicaid spending (Wiener, et al., 2000). The key question is how Ohioans can be persuaded to buy long-term care insurance. Because premiums increase so sharply with age, relatively few older Ohioans can afford adequate coverage, and even many of these may be screened out by insurers' underwriting practices. For this reason, there is agreement that long-term care insurance would have the greatest impact if people would buy it during their working years, when rates are lower and underwriting rejections less likely. However, people in their working years have other spending priorities and have displayed little interest in buying long-term care insurance (LifePlans, 2001).

Growth in long-term care insurance for younger workers may, then, continue to depend on individual purchasing decisions (Wiener, et al., 2000). Proponents of long-term care insurance offer two basic approaches to encourage greater participation. First, they would make the

policies more affordable, chiefly by providing tax incentives or other subsidies for long-term care insurance purchasers (Marlowe, 1996). Second, they would seek to educate younger people about the benefits of long-term care insurance (Lutzky & Alecxih, 1999). Advocates of this plan point out that many people may not recognize the likelihood of potentially catastrophic expenditures later in life or may not be aware of the limitations in Medicare and Medicaid benefits. If people understood the risks, they say, the purchase of Long-Term Care Insurance might become a routine part of planning for retirement and old age. These two strategies are necessarily interrelated, but for the purposes of this paper, they are considered separately.

TAX SUBSIDIES FOR LONG-TERM CARE INSURANCE

The clarifications of the tax treatment of long-term care insurance in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were of benefit only to a few groups—those whose employers are contributing to long-term care insurance, rather than merely offering it to everyone; the self-employed; and those with medical expenses in excess of 7.5 percent of adjusted gross income (Wiener, et al., 2000).

There have been proposals at the national level to provide broader tax incentives for the purchase of long-term care insurance. For example, the tax bill passed by Congress in July 1999 would have phased in an "above-the-line" deduction for long-term care insurance premiums—that is, the deduction would have been available to taxpayers who did not itemize and would eliminate the current requirement that expenses exceed 7.5 percent of adjusted

gross income. In addition, the bill extended favorable tax treatment for long-term care insurance purchased as part of employee benefit plans. This would have permitted workers to pay their premiums with tax-free dollars and would presumably have encouraged the growth of employer-sponsored (but non-contributory) plans.

Both of these tax changes would have a greater effect on taxpayers in higher tax brackets. However, members of this group may already be more disposed to buy coverage or to accumulate assets sufficient to meet their own long-term care needs. In addition, it is difficult to justify a subsidy targeted at the highest income taxpayers.

An alternative that spreads the benefits more broadly is a tax credit, rather than a deduction, for the purchase of long-term care insurance. This reduces the taxpayer's actual tax bill, rather than taxable income, providing the same benefit to buyers at different income levels. Almost half of all states, including Ohio, have now enacted legislation to give tax deductions or credits to consumers who buy long-term care insurance for themselves, their spouse or parents (Wiener, et al., 2000)(see Table 3)(see Appendix). Tax incentives are likely to continue to expand. Each year, additional states propose legislation to establish or expand tax incentives for long-term care. Efforts continue at the federal level to expand the circumstances under which consumers can gain tax advantages for the private purchase of long-term care insurance.

Another option would be to provide an income-based subsidy for long term care insurance premiums, either through the tax system or through direct payment; this would target assistance to lower-income purchasers. For example, taxpayers with

adjusted gross income up to a specified amount might receive a credit equal to 25 percent of their long-term care insurance premiums; the credit would then be phased out for those with higher incomes, becoming unavailable when adjusted gross income exceeded some maximum threshold.

Subsidy options entail federal revenue losses that would eventually be partially offset by Medicaid savings. However, the revenue losses are immediate, whereas the Medicaid savings would come far in the future. A recent simulation of the long-range effects of four different possible tax subsidy schemes found that all resulted in sizable net federal losses on initiation. Furthermore, only one of the options approached break-even after 25 years, in 2018 (Mulvey & Stucki, 1998).

Leaving aside the potential cost of subsidies, it is not clear whether tax incentives makes the purchase of long term care insurance much more attractive than it already is (Wiener, et al., 2000). In 1995, the average federal taxpayer paid a marginal rate of 14.7 percent. An above-the-line deduction for the purchase of long-term care insurance in that year would have reduced a \$500 annual premium for a 40-year-old to \$427. Allowing purchase through flexible spending arrangements would also reduce the taxpayer's liability for Social Security and Medicare payroll taxes—a \$500 policy would then cost \$388. It is not clear whether such price reductions would be sufficient to induce many more middle-income persons to buy coverage during their working years.

The American Council of Life Insurance estimates that 58 percent of those aged 45 to 49 could afford a five-year policy without any subsidy, assuming that one can afford the policy if the premium is less than three percent of the buyer's income (Mulvey

& Stucki, 1998). Obviously the results would differ if some other criterion for affordability were used—for example, five percent of income, or ten. What matters is how much each person is actually willing to spend. Thus, the second component of the private long term care insurance strategy—education about the need for long term care insurance—may be more important than any subsidy scheme.

CONSUMER EDUCATION ABOUT LONG-TERM CARE INSURANCE

Consumers can make informed choices only if they have an understanding of the nature of the risk of needing long-term care and the potential for protection from that risk that is offered by insurance.

Consumers can make informed choices only if they have an understanding of the nature of the risk of needing long-term care and the potential for protection from that risk that is offered by insurance (Lutzky & Alecxih, 1999). Consumers must first decide whether purchasing a product is appropriate given their personal circumstances (ODI, 1999). Many consumer groups and regulators argue that long-term care insurance is not appropriate for certain people and should not be sold to them, particularly those who would quickly qualify for Medicaid if they were to require long-term care services (Wiener, et al., 2000). However, industry representatives contend that the population for whom long-term care insurance is appropriate is unclear and that although some general suitability guidelines may help consumers make an informed choice, anyone should be able to purchase long-term care insurance if they choose to do so (NAIC, 2001). Purchasers of

long-term care insurance are on average in their late 60s, married, highly educated relative to the general population, and have substantial income and assets (LifePlans, 2001).

Once a decision on the suitability of purchase has been made, consumers are faced with difficult and confusing choices related to product features (Lutzky & Alecxih, 1999). The ability of consumers to compare policies and make informed choices is hampered by: 1) numerous policy options and features; 2) the complexity of the product; 3) the rapid changes occurring in products; and 4) a lack of easy-to-obtain, unbiased sources of information (ODI, 2001). Currently, insurance agents serve as the primary mechanism for translating arcane language and providing advice on which policy to buy and options to choose from (Lutzky & Alecxih, 1999). Consumer groups question whether agents always have the best interest of the purchaser in mind because they earn commissions.

The regulation of long-term care insurance often requires tradeoffs between protecting consumers and allowing them to make choices.

The regulation of long-term care insurance often requires tradeoffs between protecting consumers and allowing them to make choices (Lutzky & Alecxih, 1999). Consumer groups express concern that long-term care insurance is too complicated for the typical consumer to understand and efforts should be directed at making policies easier to compare, such as standardizing definitions and eligibility triggers for benefits. These groups also advocate that certain provisions, such as inflation protection, be included in all long-term care

policies. Industry representatives contend that the consumer should be permitted as much freedom as possible in tailoring the policy to his or her own circumstances.

ADEQUACY OF LONG-TERM CARE INSURANCE PROTECTION

In order for a policy to offer adequate protection against the cost of long-term care four conditions must be met: (1) the person must pay premiums and retain the policy (not lapse); (2) the policy must offer enough benefits to cover a reasonable portion of the costs of long-term care when the person needs it; (3) the person must qualify for benefits under the insurer's criteria when she or he is in need of care; and (4) the long-term care services the person needs must be covered by the policy (Alecxi & Lutzky, 1996).

While current long-term care insurance policies in Ohio appear to offer significantly better coverage than their predecessors, there is still reason to be concerned about the adequacy of the protection long-term care insurance offers.

While current long-term care insurance policies in Ohio appear to offer significantly better coverage than their predecessors, there is still reason to be concerned about the adequacy of the protection long-term care insurance offers (GAO/HRD, 1989; Lutzky & Alecxi, 1999). Many Ohioans will not have protection against the costs of long-term care because they will not have active policies when they need benefits. The limited data available suggests that 30 to 50 percent of all individual purchasers of long-

term care insurance lapse within five years (Wiener, et. al., 1994). Unfortunately, current data do not allow us to fully understand why people lapse and whether these lapses result mostly from mortality and people upgrading their policies, or whether they reflect people paying premiums for a time and dropping their policies (GAO/HRD, 1993; Alecxi & Lutzky, 1996;). There are a number of ways that regulatory mechanisms may reduce lapse rates, including consumer education, agent training, limits on commissions, suitability standards, and mandating nonforfeiture benefits (Lutzky & Alecxi). However, some of these mechanisms limit consumers' ability to choose which features they want and also can increase price (Meier, 1999).

To assure adequate protection from the financial risk associated with long-term care, a person must purchase a benefit that provides enough coverage for a long enough period of time to prevent erosion of assets. This level of coverage needs to account for increases in the cost of long-term care. "Adequate coverage" differs depending upon the individual's aversion to risk and willingness to self-insure. Whereas some people look for complete protection against all the costs of long-term care, others would rather keep premiums low by only insuring against catastrophic costs (e. g., an extended stay in a nursing home) (Lencsis, 1997).

Among those who keep their policies until they need benefits, some may experience substantial out-of-pocket payments because: 1) purchased benefit amounts are lower than typical nursing home costs; and 2) over one-seventh of policyholders who go into a nursing home could be in an institution longer than the duration of their policy (Lutzky & Alecxi, 1999). Those who do not purchase inflation

protection could have significantly greater out-of-pocket expenses.

The benefit triggers a company uses to assess whether an individual meets its criteria will strongly influence whether or when a person receives benefits (Meier, 1999). Companies using functional impairment triggers base them almost exclusively on impairment in activities of daily living (ADLs) and cognitive impairment and nearly all policies sold in Ohio comply with the HIPAA criteria to be a “qualified” plan (ODI, 1999). To be qualified, long-term care insurance benefits are only “triggered” when a person needs substantial assistance in performing at least two of six activities of daily living and the assistance is expected to last at least ninety days, or requires substantial supervision

resulting from a severe cognitive impairment.

LONG-TERM CARE INSURANCE FOR STATE EMPLOYEES

Over nineteen states-Alabama, Alaska, California, Colorado, Connecticut, Florida, Georgia, Kansas, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Washington, and Wisconsin offer long-term care insurance to their state employees (Wiener, Tilly, & Goldenson, 2000)(see Table 4).

Table 4
Long-Term Care Insurance for State Employees

	OHIO	CALIFORNIA	COLORADO	CONNECTICUT	WASHINGTON
Date Implemented	1999*	1995	1998	1997	1998
Eligibility	Employees, spouses, parents and parents-in-law, and adult children of employees	Employees, retirees and their spouses, parents and parents-in-law	Employees, retirees and their spouses, parents and parents-in-law	Employees, retirees and their spouses, parents and parents-in-law, grandparents and grandparents-in-law	Employees, retirees and their spouses, parents and parents-in-law
Underwriting	Short form underwriting at initial offering and for new hires. All others subject to standard underwriting.	Seven question underwriting on medical conditions and impairments; those age 65 or older who pass this test then undergo medical record review, telephone history, and possible face-to-face interview. Underwriting is necessary to keep premiums down and induce insurers to participate.	Active employees at time of initial offering and new hires receive two question underwriting; their spouses respond to six questions; retirees are subject to full underwriting. Modified guaranteed issue likely raised premiums, reducing sales.	Employees working 30 hours per month subject to no underwriting if they purchase insurance within four months of initial offering at their agency. Everyone else subject to standard underwriting. Connecticut wanted to set an example for employers and forgo underwriting for employees. Insurers would not have participated if Connecticut's group were small.	Short form underwriting at initial offering and for new hires. All others subject to standard underwriting. Underwriting is necessary to keep premiums down and induce insurers to participate.
Percentage of applicants denied purchase		155,000 applications since 1995. 24,000 denied = 15.5% denial rate. Of the 24,000, 21,000 were retirees.	One or two active employees have been denied. Retiree denial rates are much higher.	12% of applicants, most of whom are retirees.	2078 application forms completed correctly. 240 were denied coverage= denial rate of 11.5%. Of those denied coverage, four were employees.

	OHIO	CALIFORNIA	COLORADO	CONNECTICUT	WASHINGTON
Selection of insurers	Ohio issued a brief request for proposals and selected one insurer (Aetna Life Insurance Co.).	CalPERS is self-funded with a separate trust fund. California decided to self-fund because a feasibility study showed that there was very little value added by involving insurance companies and that premiums were projected to be 20-30% lower under a self-funded plan.	The “Public Employees Association,” (PERA) is the agency responsible for administering Colorado’s state employee long-term care employee long-term care insurance program. PERA conducted a competitive bidding process and selected a plan administrator. The plan administrator had another competitive bidding process and selected one insurer.	Connecticut issued a brief request for proposals and selected one insurer.	Selected one vendor
Inflation protection and nonforfeiture	Mandatory offer of both except for parents and parents-in-law.	Only mandatory offer of both. If an insured twice turns down optional purchase of additional benefits, they will not be offered the increases anymore; 45% of those offered benefit increases took them, 66% of purchasers chose compounded inflation protection. Only 63 people have purchased nonforfeiture protection.	Mandatory offer of inflation protection. Mandatory nonforfeiture	Mandatory inflation protection for those under age 65 and contingent nonforfeiture benefit (if policy lapses because of premium increases).	Mandatory offer of both.

	OHIO	CALIFORNIA	COLORADO	CONNECTICUT	WASHINGTON
Plan premiums	Less than equivalent individual policies.	20-30% less than equivalent individual policies.	PERA premiums are equivalent or higher than individual policies because of modified underwriting.	Connecticut premiums are equivalent or higher because of guaranteed issue.	Unknown
Marketing	The insurer does the marketing during open enrollment and participates in benefit fairs.	CalPERS uses direct mail, payroll stuffers, newsletter articles, videos, seminars, e-mail messages. Direct mail and newsletter articles generate the most leads.	90 meetings were held around the state during initial open enrollment. There also was direct mail and information in internal publications. There will be subsequent, periodic open enrollments.	The enrollment broker educated state employees agency by agency. The partnership program educates state employees about long-term care insurance in general.	The insurer does the marketing during open enrollment and participates in benefit fairs.
Enrollment	State of Ohio Plan has over 62,000 active spouses, members, and retirees are not eligible.	3-4% of active employees and 5-7% of retirees have purchased policies. There are 2.2 million active employees and retirees. Other related parties bring the number of potential buyers to 5 million. Sales figures are high because CalPERS has a good reputation, prices are competitive, and marketing is effective.	1277 people have enrolled half of whom were retirees and half active employees. Colorado has 158,000 current employees and 51,000 retirees. Sales have been low because of competition with other vendors. These vendors have lower premiums because PERA's policy is modified guaranteed issue and has a rich benefit package.	540 policies have been sold. The state has 50,000 employees and 20,000 retirees. The state's premiums are higher than those of the general market.	136,671 employees and retirees; 1838 people enrolled, of whom 1412 are current employees.

	OHIO	CALIFORNIA	COLORADO	CONNECTICUT	WASHINGTON
Lapse and claim rates	Not available	<p>Policies lapse at 2.5% per year. Policies lapse due to death and changes in individual circumstances. 115,000 policies remain in force.</p> <p>Since 1995, claims have cost \$8 million. CalPERS had 500 claimants in February, 1999. Claims activity is 40% less than actuaries had predicted.</p>	Not available	<p>Cumulative lapse rate is 4% after the 30 day free look period, compared to 11% for the general market. 472 policies remain in force. One claim is in process.</p> <p>Payroll deductions may discourage lapsing because people have to take affirmative action to stop deductions.</p>	Not available.

Note: From “Federal and State Initiative to Jump Start the Market for Private Long-Term Care Insurance.” By J. Weiner, J. Tilly, & S. Goldenson. 2000. *Elder Law Journal*, 8 (1). p. 57-102.

Employer sponsored long-term care insurance provides greater access to coverage than individual policies (Thompson, 1992; Pincus, 2000b). For example, Ohio’s State Teachers Retirement System (STRS) offers less restrictive underwriting and even guarantees issue policies (i.e., do not require health information) during initial offerings to employees. In addition, STRS offers coverage to at least one group in addition to full-time active employees (i.e., parents/in-laws, spouses, and retired employees), potentially extending the benefit well beyond the size of the employee population in the state of Ohio.

There are potential limitations of state-based private coverage, including: (1) insufficient numbers of individuals having any long-term care protection when they need it because of low enrollment rates and possibly high lapses, (2) insufficient protection for those who do retain their

coverage until they need benefits because of a failure to purchase inflation protection, (3) a lack of value for individuals who pay substantial premiums and then lapse, and (4) limitations in policies’ ability to adapt to changes in the long-term care delivery system.

Only five states, (California, Colorado, Connecticut, Washington, and Wisconsin) have over three years experience in offering long-term care insurance to their employees (Wiener, et al., 2000) (See Table 4).

Ohio has three long-term care insurance programs: the State of Ohio Plan, STRS, and Public Employees Retirement System (PERS). The state of Ohio Plan is designed for active employees and their spouses; retirees are not eligible for this program. The plan has around 62,000 members. The STRS is designed for state

teachers. The plan has around 400,000 members (350,00 active employees and 50,000 retirees and spouses. PERS has around 100,000 members. Only retirees and spouses are eligible for PERS.

PERS limits the number of benefit choices. PERS offers two to four benefit amount options and a set package rather than allowing the employee to select every option separately. Nearly all states use a single LTC insurer. The state of Ohio Plan, STRS, and PERS all use Aetna Life Insurance Co. These practices simplify the multiplicity of choices generally related to purchasing long-term care insurance.

Despite the limited choices of benefits, research suggests that the benefit features of group plans in Ohio generally resemble the most common individually purchased policies nationally (Pincus, 2000a). As an illustration, the state of Ohio plan, STRS, and PERS offer a full range of coverage for most recognized long-term care services, with most including a 60 or 90 day elimination period (the deductible period between qualification for benefits and the first day benefits can be received).

The state of Ohio plan, STRS, and PERS all offer inflation protection, with all three offering it immediately at a higher initial premium and half offering only the option to upgrade benefit levels in the future (future purchase option). Policies that increase benefits for inflation automatically may use simple or compound rates. Either way, the daily benefit increases each year by a fixed percentage, usually 5%, for the life of the policy or for a certain period, usually 10 or 20 years.

The dollar amount of the increase depends on whether the inflation adjustment is simple or compound. If the inflation

increase is simple, the benefit increases by the same dollar amount each year. If the inflation increase is compounded, the dollar amount of the benefit increase goes up each year.

Inflation protection is considered one of the most important additions to a long-term care insurance policy. Inflation protection increases the premium. As an illustration, a nursing home that costs \$162 a day (in 2000) will cost \$349 a day in 10 years, if inflation is 8% a year (the cost of nursing home care in Ohio has been rising at an annual rate of 8% for the past several years)(“Long-term care planning,” 1997).

All three plans offer a “non-forfeiture” benefit that would provide the purchaser some level of benefits if he or she lapses (i.e., if coverage is stopped because the individual stops paying premiums). This benefit allows a consumer to receive some value for the money one has paid into the policy. Without this type of benefit, one would get nothing even if one paid premiums for 10 or 20 years before dropping the policy. A nonforfeiture benefit can add roughly 10 to 100% to a policy’s cost. How much it adds depends on such things as the insured’s age at the time they bought the policy, the type of nonforfeiture benefit, and whether the policy has inflation protection.

The state of Ohio plan, STRS, and PERS also offer the “reduced paid up benefit,” which provides a reduced benefit amount over the same benefit period as defined in the policy. Reduced paid up benefits are much less likely to offer real protection against the costs associated with needing long-term care than other more expensive non-forfeiture provisions, most notably “shortened benefit period.”

STRS offers a "return of premium at death," benefit. This feature allows a portion of the premiums paid to be returned to the insured's estate upon his or her death. To get a refund at death, you must have paid premiums for a certain number of years. This benefit is only available to members and their spouses. It is not available to retirees or to parents and parents-in-law. This benefit is not available through the State of Ohio and PERS. Ten other states offer this benefit. In addition, all three plans require the employee to pay the entire premium. This is generally the most expensive type of benefit.

There is very little research on the employer sponsored long-term care insurance products in Ohio (Marlowe, 1996). The recent emergence of employer-based long-term care insurance and its small portion of sales may account for the lack of research (LifePlans, 2001). The Health Insurance Association of America (HIAA) periodically surveys the major long-term care insurers and publishes information about the number of employers offering long-term care insurance and size of those employers on a periodic basis (LifePlans, 2000). Unfortunately, these reports do not provide any further description of what employers are offering (McSweeney, 1995a).

Future Research Issues

While this section adds to the understanding of long-term care insurance

coverage offered by the state of Ohio, several issues need to be investigated to more fully assess the value of long-term care insurance for state employees (Pincus, 2000b). Future research could focus on addressing the following questions:

- *Should the tax treatment of long-term care insurance be enhanced?* Encouraging additional tax provisions for these products would reduce the cost long-term care insurance for many Ohioans and strengthen public confidence in this relatively new private insurance coverage. Research could look at the possible effects of enhanced tax provisions.
- *How does Ohio compare with other states in adopting and implementing the NAIC model regulations for long-term care insurance?* Currently, the state and NAIC do not keep comparative information on states implementation of the various long-term care insurance model regulations (NAIC, 2001a).
- *What is the effect of the OSHIIP program?* There has not been a program evaluation done on the OSHIIP program. As an illustration, one research area would be determining what impact the program has on consumer knowledge in the state. This information is critical because one of the findings of this report is that better consumer education is essential for helping Ohioans understand long-term care insurance.
- *What types of long-term care insurance are employees buying and are they retaining their coverage?* While this section describes the State of Ohio offerings (state of Ohio plan, PERS, and STRS), identifying actual policies that employees and retirees purchased was beyond the scope of the study. Assessing

lapse rates and the extent to which employees who purchase a policy protect their benefit from erosion caused by inflation either through built-in protection or choosing to purchase more coverage in the future (i.e., exercising the future purchase option) are key issues. Research that has been done in this area has, for the most part, been proprietary and focused on improving the marketing of employer LTC insurance (Pincus, 2000a).

- *What role does and should the State of Ohio play in managing long-term care insurance reserves and renegotiating LTC insurance contracts?* Findings from this study suggest that the state of Ohio currently plays a very limited role in designing policies and that changes to covered benefits and management of reserves is controlled by Aetna (the insurer). However, the research only addressed this item in a limited fashion. The creation of guidelines for the State of Ohio about roles it can play in managing reserves and updating benefits for the three plans may be useful to the State of Ohio.
- *To what extent do State of Ohio employees want long-term care insurance and what features would they most like to have included in a policy? What difference does the underwriting mechanism make in enrollment rates?* Research regarding the appeal of long-term care insurance to state employees and retirees is lacking. Research could assist the State of Ohio in making design decisions, especially if those decisions are contrary to the interests of Aetna (e.g., offering a self-funded policy).
- *What are the characteristics of the population purchasing long-term care insurance in Ohio? What types of*

employees and retirees are purchasing the plans and how many employees have enough assets to protect themselves with long-term care insurance? Would more people purchase long-term care insurance if the state contributed to the premiums?

Conclusion

The long-term care insurance market in the state of Ohio continues to grow at a steady pace. Its growth has been sustained largely through the consistent sales in the individual market. As the market continues to evolve, long-term care coverage likely will be more widely available through mechanisms other than the individual market. The state of Ohio is already seeing this in the employer sponsored market and recent efforts to reinvent long-term care coverage in life insurance policies. Additional proof of this trend is the emergence of new funding mechanisms such as tax-deferred plans, retirement vehicles, and even reverse mortgages.

The state government can play an important role in encouraging the growth of long-term care insurance. This could be achieved by enhancing the tax treatment of long-term care insurance. Encouraging additional tax provisions for these products would reduce the cost long-term care insurance for many Ohioans, while increasing the appeal of these policies to state employees and retirees, and strengthening public confidence in this relatively new private insurance coverage.

Further, enhanced tax incentives for the purchase of long-term care insurance would demonstrate the state's support for and commitment to the long-term care industry as a major means of helping Ohioans fund their future long-term care needs. These efforts might lead to an increase in the portion of the state's population using long-term care insurance to protect themselves against catastrophic long-term care expenses.

Tax incentives largely benefit two groups. They could help those who did not have the opportunity to purchase long-term care coverage when they were younger and the premiums were lower and who now face the greatest affordability problems because of their age. It could also help those younger adults: Ohio's baby boomers that need incentives or mechanisms in order to fit providing for their own long-term care protection into their current multiple priorities (for instance, mortgage payments, children's college tuition, and their own financial and retirement planning).

Regulatory activity is key to quality long-term care insurance.

Regulatory activity is key to quality long-term care insurance. In particular, current state efforts to develop standards on premium rate stability, standardization of policies, and mandating additional benefits could enhance the marketplace. If enacted, these proposed regulations could very well enhance growth in the market.

Better consumer education is essential.

Better consumer education is essential. People often believe they already have long-term care insurance or that they will never need it. Education should begin early, so that working age Ohioans understand their risks for long-term care and can plan for their potential while they have the income to do so.

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Appendix

Partnership for Long-Term Care

Beginning in 1988, The Robert Wood Johnson Foundation (RWJF) began funding the Partnership for Long-Term Care, a public/private alliance between state governments and insurance companies to create long-term care insurance programs. With a goal of solving a portion of the long-term care financing problem, the RWJF awarded grants to four states--California, Connecticut, Indiana, and New York--to work with private insurers to create insurance policies that were more affordable and provided better protection against impoverishment than those generally available. The resulting Partnership For Long-Term Care combines private long-term care insurance with special Medicaid eligibility standards. It was hoped that the program would stimulate market development of long-term care insurance policies in three key areas: quality, affordability, and coordination. The Partnerships provide an incentive for insurers to offer high quality products and for consumers to protect themselves from the high cost of long-term care.

Over the course of the development phase of the program two program models emerged. California, Connecticut and Indiana are using the Dollar for Dollar Model, while New York is using the Total Assets approach. Insurers participating in a partnership must meet a special set of criteria before selling these special long-term care insurance policies. To date, there are more than 20 insurers participating in the Partnership Programs in the four states. Two insurers, GE Capital and CNA, are filed in all four states.

Following the implementation of the Connecticut Partnership program in 1992, a number of states initiated efforts to replicate the partnership program. However, due to the impact of the passage of the Omnibus Reconciliation Act of 1993 (OBRA '93), most of the states simply ceased their efforts at implementation.

Mark Meiners, Ph.D., Director of the Partnership for Long-Term Care, notes that "we still have work to do to educate the public that long-term care is not somebody else's problem, but a reality that is likely to cost in the hundreds of thousands of dollars for many American families. It simply makes sense for people to purchase protection in the healthy years before long-term care devours a family's accumulated savings and forces them into destitution. It can provide peace of mind if and when the need arises."

Partnership for Long-Term Care Program Highlights

State Highlights

The PERS success in California continues to be dramatic, with over 40,000 applications received during the most recent offering. If past experience holds true, about 2,000 of these applications should be for Partnership policies. Broadly supported legislation is currently being considered that would require the inclusion of many of the consumer-friendly provisions championed by the California Partnership Program in all LTC insurance products issued in California. Many of these provisions have already been voluntarily adopted by insurers, both those participating and non-participating in the Partnership. At the same time that these improvements are being made in all LTC products, the California Partnership Program is being redesigned to keep current with trends in the LTC industry and reduce possible continuity of care issues related to movement from Partnership private coverage to Medi-Cal.

During the first six months of 1997, the Connecticut Partnership Program has experienced considerable growth with policy sales more than doubling over the previous six-month period. First-time purchasers represent 90% of the sales. Of the 3,229 policies in force, the average policyholder's age is 61 years. Connecticut also recently began offering a partnership long-term care insurance policy to state employees. Information on the Connecticut Partnership can now be obtained from its web site at <http://www.opm.state.ct.us/pdp4/ltc/home.htm>.

The Indiana Partnership Program, which has been marketing its program since 1993, has hit several milestones. Of the more than 2,500 policies sold, more than 2,100 are in force. Although the average age of policyholders remains 68 years, Indiana saw a 13.5% increase from the last quarter in the number of purchasers aged 60 years or less. Currently, marketing tools have been put in place to assist the partnership insurance agents in Indiana.

The New York Partnership Program is using the Total Assets Model, which requires insurers to meet a somewhat different set of criteria before they are certified to issue policies by the state insurance department. New York's Governor Pataki signed into law Chapter 42 of the Laws of 1997 which provides a first dollar state tax deduction for LTC insurance premiums in accordance with the limitations set forth in HIPAA. The Partnership Program is now under the administration of the New York State Department of Health, Office of Medicaid Management. Information about the Partnership can be accessed on the Internet at: www.nyspltc.org.

Uniform Data Set Undergoes Major Revisions

Since 1993, partnership states required insurers to report program activity on a regular basis. The four participating states developed a Uniform Data Set to ease the reporting burden on insurers participating in more than one state.

Recently, the participating states proposed major revisions to the data set. Several files have been dropped and others have been consolidated or streamlined. These changes should make it easier for insurers to report program activity and for states to track partnership progress. If approved by participating insurers, the changes will take effect over the next six months.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The passage of HIPAA brought a number of changes to partnership programs. In general, the tax advantages granted to individuals and employers who have or will purchase long-term care insurance policies should significantly stimulate the market.

Partnership staff in each state have worked hard both to comment on the overall regulations and to alter their individual programs to recognize the new requirements imposed by HIPAA and enacted by state insurance divisions. This activity is nearly complete in some states and ongoing in others.

Summary of Partnership Policy Sales

Policy sales to date indicate steadily growing interest in public/private long-term care insurance policies. Sales also indicate that, when given the opportunity, consumers are willing to protect themselves against the costs of long-term care. The following are highlights from Partnership policy sales in the four funded states.

- Of the more than 26,000 applications received for the purchase of partnership long-term care insurance policies in the four participating states, there are currently more than 21,000 policies in force.
- Three states allow the sale of one- and two-year partnership policies. The percentage of policyholders purchasing these policies remains high: California at 93%, Connecticut at 33%, and Indiana at 35%.
- The majority of partnership policy purchasers are first-time buyers. They range from a high of 96% in California to a low of 82% in Indiana.
- The percentage of policyholders under the age of 65 continues to grow. For example, in Connecticut, the average age of the group policyholder is 53 years old, while the average age for the individual policyholder is 63 years old.
- The vast majority are married (almost 70%) and female (60%).

For more information on the Partnership for Long-Term Care program contact:

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State Statutes for Tax Incentives Concerning Long-Term Care Insurance

Alabama (Deduction)

Allows a state income tax deduction for premiums paid for a qualifying long-term care policy. Policies must be guaranteed renewable and coverage must be equal to or greater than three years of Medicaid coverage.

California (Deduction)

The deduction applies only to tax-qualified LTC policies for taxable years beginning in 1997. The maximum deductible amount is based on a sliding scale which is increased each year to account for inflation. Also, beginning with this tax year California residents who need long-term care services for at least 180 days can qualify for a \$500 tax credit. This is not available if adjusted gross income exceeds \$100,000.

Colorado (Credit)

For tax years beginning on or after January 1, 2000, H.B. 1246 allows a nonrefundable state income tax credit. The amount of the credit is 25% of the cost of the policy, up to a maximum of \$150 for each policy. The credit is available to individual filers with federal taxable income of less than \$50,000; joint filers with federal taxable income of less than \$50,000 if the credit is claimed for one policy; or joint filers with federal taxable income of less than \$100,000 if the credit is claimed for two policies.

Hawaii (Credit/Deduction)

If adopted, proposed legislation in Hawaii would allow individual taxpayers to take either a credit or a deduction for expenses relating to long-term care insurance. Among the most recent pieces of legislation, S.B. 3144 would allow individual taxpayers meeting a threshold adjusted gross income level to take a personal income tax credit equaling a percentage of the costs paid for long-term care insurance premiums, whereas H.B. 170 would allow a deduction commensurate with that provided under federal law.

Indiana (Deduction)

Beginning January 1, 2000, a deduction is allowed in an amount equal to the portion of any premiums paid during the taxable year by the taxpayer for a qualified long-term care policy for the taxpayer or the taxpayer's spouse, or both.

Iowa (Deduction)

Long-term care insurance premiums for nursing home coverage are eligible for a deduction to the extent premiums are eligible for the federal itemized deduction for medical and dental expenses.

Kentucky (Deduction)

One hundred percent of premiums paid for LTC policies can be deducted from the state income tax.

Maine (Deduction/Credit)

Individuals can deduct premiums from their state income tax for policies that cover both nursing home and home care services and that are certified by the state insurance department.

Maryland (Credit)

S.B. 171 allows individuals to offset their state tax liability by a one-time credit equaling up to one hundred percent of eligible long-term care insurance premiums. The credit may not exceed \$500 for each insured for which premiums are paid for those over age 50. For those aged 41-50 the credit is \$410. For those under 41, the credit is \$220. Those individuals covered by Long-Term Care Insurance at any time before July 1, 2000 are not eligible to claim the credit.

Minnesota (Credit)

A tax deduction is allowed for long-term care policies with lifetime maximum benefits of \$100,000 or more with benefits that adjust for inflation. It is in the form of a tax credit that is the lower of \$100 or 25 percent of premiums paid, to the extent they are not deducted in determining federal taxable income. Minnesota is considering an increase in its tax credit.

Missouri (Deduction)

Beginning after January 1, 2000, a Missouri resident may deduct 50% of his or her unreimbursed payments for qualified long-term care insurance premiums to the extent such amounts are not already included in itemized deductions claimed by the individual.

Montana (Deduction)

All premium payments for policies covering both facility care and home care may be deducted retroactively to the 1995 tax year. Premium payments made by a person for parents or grandparents can also be deducted starting in the 1997 tax year. In addition, for taxable years beginning after 1998, a state income tax credit is allowed for "qualified elderly care expenses" paid by an individual for the care of a "qualified family member" during the taxable year. Premiums paid for long-term care insurance coverage for a qualifying family member are included in "qualified elderly care expenses." The amount of the elderly care expense credit that may be claimed by the taxpayer depends on his or her adjusted gross income. Taxpayers claiming this credit are prohibited from taking an additional income tax deduction for premium payments on the same policy for which the credit is taken.

New York (Deduction)

A tax deduction is allowed beginning in 1996 for policies that meet minimum loss ratio standards and are federally tax qualified.

North Carolina (Credit)

A nonrefundable state income tax credit equal to 15% of premiums paid is allowed for tax qualified long-term care policies, up to a maximum of \$350 per policy. This credit expires for taxable years beginning on or after January 1, 2004.

North Dakota (Credit)

A state income tax deduction is allowed for 25% of the amount paid for long-term care policies for a taxpayer, taxpayer's spouse, parent, stepparent or child. The deduction may not exceed \$100 for each insured individual.

Ohio (Deduction)

For taxable years beginning on or after January 1, 1999, a deduction is allowed for amounts paid by a taxpayer for qualified long-term care insurance for the taxpayer and the taxpayer's spouse and dependents.

Oregon (Credit)

Taxpayers may claim a nonrefundable credit for long-term care insurance premiums for policies on behalf of the taxpayer, the taxpayer's dependents or parents. The credit is available in tax years beginning after December 31, 1999, for policies first issued after December 31, 1999. The amount of the credit is equal to the lesser of 15% of the total amount of long-term care insurance premiums paid or incurred by the taxpayer during the tax year or \$500 for the taxpayer and the dependents or parents of the taxpayer.

Utah (Deduction)

After January 1, 2000, individuals may deduct long-term care insurance premiums for their state personal incomes taxes for the purpose of determining Utah taxable income. This deduction is limited to the extent that these expenses were deducted for federal tax purposes.

Virginia (Deduction)

Provided the individual has not claimed a deduction for federal tax purposes, long-term care insurance premiums may be deducted from federal adjusted gross income in calculating Virginia taxable income. This deduction is effective for taxable years beginning on or after January 1, 2000.

West Virginia (Deduction)

For tax years beginning after December 31, 1999, premiums for qualified long-term care insurance policies are fully deductible for West Virginia income tax purposes to the extent that they are not allowable as a deduction in arriving at the taxpayer's federal adjusted gross income.

Wisconsin (Deduction)

All premiums paid by individuals and their spouses can be deducted from gross income when figuring the amount that qualifies as federal adjusted gross income for state income taxes.