Time for Reform?
Three Opinions on the issue of the day
By Robert Eaton (moderator), John Cutler, John O'Leary and Bruce Stahl

For some time now, we have known about the demographic trends that will be facing our country over the coming decades. Driven primarily by 75 million baby boomers, America's aging population is facing a future long-term care (LTC) crisis of major proportions. The aging of the baby boomers, increasing pressure on state and federal budgets and the challenges being faced by private LTC insurance carriers, have piqued interest in reforming LTC financing.

Recently, the SCAN Foundation, AARP, LeadingAge, and the Department of Health and Human Services (HHS) funded an economic modeling study conducted by Milliman and the Urban Institute to provide further dimension on how much the need for LTC will increase over the coming decades, what the costs are likely to be, what the implications will be for the over-65 population, and for state and federal governments.[1]

That study was the first of a series of modeling papers that will likely continue into 2017. As the initial study, it set the stage by providing foundational data and a framework to look at a number of different policy options including voluntary and mandatory versions of a two-year "front-end" product, a "back-end" product with a two-year deductible that would provide coverage for catastrophic situations, and a comprehensive product that would include both front-end and catastrophic coverage.

Based on results from the economic modeling work, several groups, including the Bipartisan Policy Center (BPC), the LTC Financing Collaborative and LeadingAge released reports supporting, to one degree or another, the concept of a universal program to cover "long-duration" care needs.

The LTC industry has over the years generated ideas to address the on-coming expansion of LTC needs in the U.S. For example, the SOA sponsored LTC Think Tank (the Think Tank) published the "Land this Plane" study in 2014. That study generated and evaluated many ideas, including an LTC Savings plan, an LTC high deductible plan and a short-term care (STC) plan to help individuals plan for and afford their potential care needs. Moreover, the Think Tank recently published the results of a brainstorming session conducted in October 2015 that generated over 80 concepts for ways consumers can better afford the LTC that many will need. In addition, the SOA's Post-Retirement Needs and Risks committee also has focused attention on retirement security and LTC.

Regular readers of the *Long-Term Care News* saw many of these efforts outlined in Joe Wurzburger's "Up Front with the SOA Staff Fellow" column in the May issue. For this article, led by Editor Robert Eaton,

we have brought together three individuals who have long involvement with LTC financing to discuss some of the recent ideas and provide some perspectives on their pluses and minuses.

The terms long-term care (LTC) and long-term support and services (LTSS) are used interchangeably.

Robert Eaton: Tell us why you are so interested in this topic, beyond what we can read in your bio?

Bruce Stahl: My bio points to my interest as a reinsurer of LTC insurance. Before joining RGA in 2007, I spent several months considering what the LTC insurance industry needed, and one of the items I observed was access to reinsurance. Few reinsurers remained in the market, and insurance companies were looking for capital relief, access to broader expertise in setting assumptions and assistance with risk management in general. I joined RGA's effort to enter the LTC reinsurance market in order to be a part of a program that helps people plan for their future needs, and I wanted to be a part of helping people because I am a Christian. Being a Christian means that I want to trust Christ, follow Christ, and glorify God in all that I do. I believe Christ came to serve in a very big way (pardoning the guilty while satisfying divine justice). I can follow Him by trying to serve others in a small way, and I try by helping insurers help individuals and families plan for some of their future needs.

John O'Leary: My interest in LTC began with family experience. In the early 1990s my mom was diagnosed with Alzheimer's disease and following that, my mother in law also came down with the disease. As a family we lived with Alzheimer's disease for over 19 years. We experienced first-hand the difficult aspects that come from caregiving two very close family members with dementia.

Professionally, I am a consumer products marketer, with an MBA from Harvard University. For over two decades, I used that background and skill set to help organizations like John Hancock, CNA, and Genworth develop and market products that would better serve the needs of consumers as they encountered situations like those my family faced. Today I operate a consulting business—O'Leary Marketing Associates—that has a clientele of state and national organizations interested in LTC reform. In conjunction with that work I have been active with the SOA LTC Think Tank as author of the "Land this Plane" Delphi research study, and now as one of the co-chairs of the Think Tank. I am on the steering committee for the ILTCI (Intercompany Long Term Care Insurance) conference, co-chairing the alternative solutions track, and I speak, write, and advocate for reforming the way we fund and deliver LTC for our aging population.

John Cutler: I have been involved in LTC reform since 1997. I was hired away from AARP (where I was basically in charge of compliance for their various products) to HHS. This was what I call Clinton 2 (his

second administration) where the focus was on targeted initiatives and not on universal reforms as in the first administration. We came up with four ideas the president moved forward: caregiver grants to the states, a caregiver tax credit, an education campaign, and LTC insurance for federal employees, retirees, and others in the federal family. Those last two were mine. The education campaign became “Own Your Future” and the insurance program became the Federal Long-Term Care Insurance Program. Since my retirement from OPM I’ve gotten clients in the reform space, including one with a concept based on using the death benefit in life insurance for LTC, and another that wants to add a home care benefit to Medicare Advantage and Medicare Supplement plans.

Robert: Could you go into a little more detail about your expectations for LTC reform this year and next?

John C: That is a tougher question than you think. We could have what happened during the Bush administration where all the LTC advocates were poised to make a charge only to have the president go for Part D prescription drug coverage. It’s hard for aging advocates to be against that! But it derailed reform until we got to the point where the CLASS Act was mature enough for legislative consideration. That, again, shut down other potential reform approaches. We are now in the “let a thousand flowers bloom” part of reform. The question going forward is whether one specific legislative approach is chosen—say catastrophic coverage or something for caregivers—versus a package of reforms more like what President Clinton moved forward in the late ‘90s.

Bruce: Informal caregivers carry the largest burden associated with financing LTC services. While I think it is reasonable to assume that family members will attempt to care for their own when they can, in many cases the caregiver is overwhelmed and needs respite. Furthermore, in cases where services are required for lengthy periods of time, caregivers may face making significant sacrifices to their careers and their ability to participate in society. I think reform should build upon the needs of these caregivers, recognizing the value of their contributions, yet also giving them regular respite and potential for knowing there is an end in sight to their services, should the recipient of care require it for a prolonged period of time. With this in view, in the next two years I hope to see some innovation in LTC insurance offerings so that more of the middle-income market can plan and benefit as well as those who have been able to afford insurance to date.

John O: With the most unusual and polarizing political situation we have faced in a national election since the sixties, it’s impossible to know what we will be facing come 2017. With that in mind I’m not optimistic

that we will see anything like a comprehensive national LTC solution over the next two or three years, despite the fact that it is sorely needed.

I do see the potential for incremental reform in a few places. First at the state level, where forward thinking states are seeing the need to plan for and test reform ideas now, to offset what they see as an imminent budget crisis looming in the future. Second, I see "disruptive innovation" opportunities on the private market side to begin to change the way LTC services are envisioned, delivered, and funded. Some of the ideas from the LTC Think Tank[5] brainstorming work of last fall are a start in that direction. Finally, I see incremental improvements in recent product trends such as combination products (making them simpler and more affordable for middle-income purchasers) and short-term care products (even if only a partial solution).

Regarding Bruce's point about caregivers, I think he is onto something when it comes to finding ways to develop products that recognize and support unpaid caregiving. Today some states are already seeing significant capacity shortages in caregivers, and that is only going to be exacerbated by the future demographic trends. The numbers point to a sizable reduction in the ratio of caregivers to those needing care from about seven to one today to less than three to one in 2040.[2] This suggests that while an increasingly important factor in the short-term, unpaid caregiving in the future will likely suffer from lack of supply and hence will need to be supplemented. One offsetting example might be innovative use of technologies that help provide more accessible and potentially more efficient care.

Robert: What do you see happening now in the way of innovations in marketing and product design?

Bruce: Given that the recent ILTCI conference had a session on reaching the middle market, I think insurers are already considering how they can target a broader part of the population. I also think that many are trying to introduce revised product designs toward the same end. But I will add that I think they need to design products and target their marketing toward the potential caregiver as well as toward the potential recipient of care. The design will need flexibility so that the caregiver and potential recipient of care can plan ahead according to their own expected needs and abilities. Today the focus tends to be on the needs of the applicant and perhaps the spouse. But the expected informal caregiver may be a child or friend, and the child or friend ought to be included in the planning. Insurance options designed with informal caregiver in mind may help facilitate this planning.

John C: I suspect the readers of this piece are way ahead of us on this. There is obviously the move to internet-based sales and more intelligent tools to work a client through the questions. What might be less

obvious is that this all occurs AFTER a product is developed. It would be interesting if the product was designed (built) after the person answered all the questions. For instance, they say they have poor health and lots of money—that sure sounds like an immediate annuity would work for them versus a traditional LTC policy they can't get due to underwriting.

John O: While short-term there are some noteworthy attempts to reach out to markets that heretofore have been underserved by LTC insurance, there is also a larger longer-term challenge that I believe needs to be addressed. The products we have been designing and marketing up to now, provide solutions that we logically think meet consumer's NEEDS—that is provide funding to pay for their care as they age. But more and more it appears, from looking at research like the RTI Awareness study that was published in mid-2015[3], that the current product offerings are not providing benefits that consumers WANT, or value very highly, in relation to the premiums we charge for them.

Consumers don't want to view themselves as NEEDING long-term care or as becoming physically and mentally less competent as they age. Rather they WANT to see themselves as healthy, vital, engaged, and competent for as long as possible (witness the shelf space devoted at your local CVS to vitamins and anti-aging remedies of all kinds). So there may be potential for product designs that go beyond paying for care, and incorporate, incent, and help people better manage their lives as they age. At a recent American Society of Aging (ASA) conference in Washington DC, there were several sessions devoted to behavioral programs that are designed to improve brain health and in so doing mitigate some of the chronic long-term conditions that make up large portions of LTC insurance claims (e.g., Alzheimer's disease). Also the LTC Think Tank brainstorming sessions identified a number of such concepts. While we have a long way to go before such ideas will be proven to help, they are definitely worthy of further exploration as we look to ways we can make long-term care funding options more relevant to our aging population.

Robert: Certainly when product design is contemplated, it is important to consider the management of risk. Any thoughts on risk management?

Bruce: I think the most important way to manage risk is to align the interests of the policyholder and the insurer. With life insurance, ordinarily both the policyholder and the insurance company would like the policyholder to live as long as possible. In contrast, LTCI policyholders today sometimes have incentives to remain on claim, while the insurer would obviously prefer to see the policyholder recover. For example: many assisted living facilities (ALFs) are so pleasant, that as long as the price is right, residents may like to stay after they recover enough to return to independent living. LTC benefits can make that price right. (A review of the most recent SOA LTC Experience Study claim termination models reveals that fewer

recoveries occurred in the first year of an ALF stay than in either nursing home (NH) or home health care (HHC) settings.) Similarly, benefits for services provided in the home or elsewhere can sometimes exceed the actual cost of the services if the benefit is on an indemnity rather than an expense reimbursement basis. A typical waiver of premium benefit may also give the policyholder a financial incentive to remain on claim.

John O: Actually, I look at the risk management situation a little differently. I think in order to manage the risk, it helps to understand the nature of the risk that is coming down the track as much as we can. I'm not sure as an industry that we are as proactive as we should be in reaching out to our insureds to understand their individual health situations and attempting to help them manage those situations even before they go on claim. One area where some state programs are making headway is with interventions to identify health issues early on, and with helping people manage them in advance to minimize costly crisis situations and ER visits. That is a trend the industry should look at to see if it could help bring down claim costs and at the same time provide the type of customer service that other industries use successfully.

I agree with the goal of aligning the interests of policyholders and carriers. And it is true that if our policies provided incentives for recovery that might be an approach worth analyzing, to see whether it might be both appealing to consumers and also help carriers mitigate some of their risks. That said, the consumer's primary expectation of this product is that it will be there to help them pay for care, when they are no longer able to care for themselves. I wonder how many of our purchasers were thinking of recovery as an option when they purchased the product. It certainly isn't an option for those with chronic conditions like Alzheimer's, Parkinson's, or MS. And those are the types of long duration expensive conditions that would seem to be among the most problematic for the industry. As we think about future product designs, I could envision products that incent people to remain at home as long as possible—with funding flexible enough to take full advantage of unpaid caregiving and emerging self-care technologies—and limited enough so that institutional care is attainable only as a last resort.

John C: Private insurers have been dealing with risk management a lot longer than government in the LTC arena. To me, that means it would behoove the social insurers to take note of what private insurers have already discovered. But, beyond that, part of the reason I'm a fan of a public/private solution is the desire to see the two systems talk to each other in spite of their different histories. Most LTC insurers, for instance, cut off the risk at the front end via underwriting. The public programs do it at the back end by requiring long delays (e.g., SSDI) or developing arbitrary rules (the Medicare homebound and improvement standards are just two among many that come to mind). In the fantasy world I sometimes reside, I think we could do better than either of those two approaches.

Robert: Let me follow up with another angle on risk management. You are talking about risk management from a private insurance company perspective. What would a social insurance kind of product have to do?

Bruce: I expect social insurance to face pretty much the same challenge of alignment of risk as private insurers. There may be differences in who can qualify for the program or how the benefits are managed when someone qualifies for benefits, yet a social insurance program will still do well to see that interests are aligned in the product design. A social insurance program that provides incentives for beneficiaries to linger on benefits will likely need to increase the funding of the benefits. If such incentives are in the program, the change in behavior of the beneficiaries would likely be viewed as adverse "unintended consequences."

John C: I want to answer this from the perspective of both private insurance as well as potential new public programs. Let's say there is legislation that creates a catastrophic backstop for individuals after three years of being on claim. We have been assuming that private insurers will just sell a three-year comprehensive policy. But I don't think we really appreciate this will be more difficult than that. Bruce is right to raise this concern. But, let's be clear, it is not a concern that says we should not go forward. It is a concern about how to construct the best COMBINATION product. The example that comes to mind of how *not* to do this is Medicare and Medicare Supplement. Those gap-filling products to Medicare came into being with no concern for how the two insurance systems would integrate their efforts. An example that may be better is the work now around integrating Medicare and Medicaid for those who are dually eligible. It has taken a long time to get to this point, but better late than never. So, for LTSS reform, it would be nice to see coordination of the private portion of any new public program at the start.

John O: Perhaps the biggest difference with a social insurance concept is the idea of universal or near universal coverage. While there are many arguments for and against the idea of whether a social insurance program is appropriate for long-term care in the U.S., it seems that universality for at least part of the coverage would go a long way toward mitigating the anti-selection issue which tends to be one of the larger risk problems faced by private long-term care insurance. As such whatever program is defined would be significantly more affordable for the average person. Results from the recent economic modeling project suggest that a voluntary approach would result in premiums that are as much as five or more times those with the same design that are universal.

That said, having a universal approach of some kind doesn't by itself eliminate the need to construct a product design that manages utilization, minimizes abuses, and incents appropriate consumer behavior. In fact, I would argue that it makes that activity significantly more crucial. The rule of large numbers cuts

both ways. In addition to spreading risk it also makes utilization, fraud, and less than optimal behavior both more likely and a potentially much more expensive when they do occur. As John Cutler suggests, learnings from the private insurance experience should form the cornerstone of what to include and what to avoid in any social insurance program for long-term care.

Robert: Why would a social program manage benefits differently than a private insurer?

John C: The only real difference to my mind is that the government can usually be tougher than a private insurer. Ask anyone who is trying to get on SSDI whether they think the government is a "softie" in this regard. Any time you have a universal benefit, the entity running it creates benefit (claims) controls to reduce utilization. Take a catastrophic kind of program. The goal for the reform efforts would be universal coverage. It would recognize that some people will have no private protection and can only get coverage via a government program (but after, say, three years). Others will have private insurance to cover certain things up front. But if the person is still in claim after three years we will then see the private insurer turn that person over to a government program. I worry that we'll see the government entity trying to restrict claims. (So much for "universal coverage"!) My suggestion would be that we set it up so the two programs follow the same rules. I'm not saying whether the rules are created by the insurer or the government. I'm saying they have to be the same so the person who is "handed off" is not treated differently by the two different insurance systems.

Bruce: I am not sure that a social program would manage benefits differently than a private program, but it could. The incentives of the governing board or managers may be different. A social program may face political pressures to address specific situations differently than under private insurance. Social programs that are managed or overseen by those looking for votes or to obtain endorsements may not look for the same types of improvements as private managers or boards who are interested in paying dividends to investors or policyholders.

Robert: Do you have an example of how any program might improve the management of a program's claims?

John C : There is a big debate between reimbursement and disability. The way the German model handles this is to give you cash if you like, but then discounts that benefit. By contrast, the U.S. "cash and counseling" Medicaid pilot gives you the same amount—no discount—but still allows for a better allocation. But the U.S. program requires intervention in the form of case management. All the fears surrounding the Medicaid pilot, about the woodwork effect and fraud, appear to be over-exaggerated. So

that is one approach. The other thought is that we enlarge what insurers do now with the alternative plan of care. Let the claimant make a case for managing their own claim better and cheaper (or at least not more expensively) but have the program manager (private insurer or governmental entity) sign off. But it can't be an exception to the rule. It has to be built in from the beginning. The expectation is that the claimants can structure the care best for themselves. The default is the traditional LTC insurance reimbursement model.

John O: I've spoken earlier in this paper with some thoughts that I think could improve claims management through earlier interventions with insureds prior to their going on claim and potentially building incentives for healthier behaviors into the plan designs.

Regarding alternate plan of care, it would be interesting to know the extent to which claimants are currently using that benefit. Anecdotally, I have heard that the number is small. If that is the case, perhaps it needs to be redesigned or re-named if we can prove that is an effective way to actually reduce claim costs in the long-term by providing more benefit flexibility.

Regarding Bruce's point on face to face interviews with claimants, I like the idea of reaching out to claimants periodically to determine both whether they are in fact still eligible for benefits (which is mandated) and whether they might be better served in another site of care than where they are. Some states have had some positive experiences moving people from institutional settings back to home and community settings when it was feasible and in their best interests. By doing so they have seen savings for those individuals. Under the heading of public/private joint learning, it might be worth evaluating those state experiences to see if they are worth emulating.

With that said, I would be very interested in understanding the percent of claims that LTC insurers expect to recover. My sense (see earlier comments) is that recoveries are the exception for LTC situations, not the rule.

Bruce: I agree with John's idea about a well-managed Alternative Plan of Care provision in LTC policies that is built into the claim from the beginning. The benefit provision needs to be structured so that the incidence of claim is not increased due to its presence. I have a couple of other thoughts as well. Many times over the past nine years working at RGA, I have suggested to insurers that they perform a face to face assessment on claimants in advance of the date of their expected recovery. I don't know that any ever actually followed that advice because their systems are often set up to work with average expected recovery time. Yet averages often have a wide range, and perhaps half of the claimants might recover from a particular diagnosis sooner than average. While the managers of the programs did not find financial savings, or at least did not demonstrate financial savings in order to induce change, I expect that

with advanced technology, we will see improvements in monitoring real levels of care needs even while someone is not physically present. For claims that are not expected to be permanent, technology may help to close the margin for concern over misalignment of interests in the timing of coming off of claim.

Robert: Are you aware of any technology existing today that may help?

John O: Yes there are several technologies that are either available today, or just on the horizon that have the potential to be adapted to provide personalized long-term care help for seniors, albeit few have yet made it into the caregiving mainstream. Personal technologies like fit-bits and apple watches certainly hold out promise, as does the explosion in personal medical sensing devices and computerized and mobile applications that provide remote in-home care. At the recent SOA Think Tank brainstorming session several technology related ideas emerged including a "Healthy Longevity App" which would encourage and incent lifestyle behaviors that could potentially mitigate the effects of brain related diseases like Alzheimer's; A "Care Uberfication" concept which would use Uber-like technologies to enable seniors to quickly access trained and vetted help when they needed it; and a "care exchange" that would use technology driven database to match seniors with care needs with providers who could provide that care to address that need. I'm encouraged by the opportunities to improve effectiveness and efficiency of care via technology that is readily available today or will be within the next few years.

Bruce: I assume wearables such as wristbands to monitor the wearer's activity levels can be used for both the recipient of care and the caregiver alike. But I also expect that a variety of robotics will be useful in the caregiving arena in the future, including "smart home" concepts and machines that give instructions of routine activities to the cognitively impaired. Apparently out of necessity, Europe and Japan are already developing this type of technology.

Robert: I suppose when we think about technology, we must also think how it can help alleviate fraud. Do you have any thoughts on managing fraud?

Bruce: Based on what I hear at conferences and what I have observed from a reinsurer's perspective, insurance companies often fear taking legal action against policyholders who commit fraud even when they have the evidence. Juries tend to favor the policyholder even when the case seems "cut and dried," and insurance companies fear sizable awards against them, not to mention the high cost of going to

court. I think insurance companies need to find a way to address real fraud without fear of financial consequences or harmed reputations. As an actuary who must consider the impact of the claims adjudication process on the claim costs, I expect that rewarding fraudulent behavior tends to breed more fraudulent behavior, and increase claim costs. Additional LTC insurance losses may hurt the many honest policyholders in the form of premium rate increases.

John C: The insurers out there reading this are thinking fraud against the company. But most of the advocacy community is thinking more like provider fraud. And even, gasp, insurer fraud (think about all those claim filings that get lost in the mail and never get to the insurer). What might work is to get the government involved along with the private insurer. I'm thinking how a Medicare Supplement carrier denies claims. It is based on the government declining a Medicare claim. No Medicare claim; no Medicare Supplement claim. But, more than that, having an integration between the private insurer and the governmental insurer creates a checks and balance system. It is harder for a fraudulent enrollee to make a case against that combination.

Robert: Let's return to your expectations for the next couple of years. What is the greatest obstacle or concern you face in achieving these expectations?

John C: Good question! My worry is that some people try to kill suggested solutions because they are not close enough to their desired way of doing things. Any government program should start small, take a serious look at what the private sector already knows and, last but not least, assume it will need mid-course corrections.

Bruce: In general, market innovation tends to flourish when all the potential stakeholders in new transactions know their planning will have the potential to help in the future. If any of the stakeholders think there is a material likelihood that the "game will change," such as the state or federal government mandating benefits, market innovation will likely be stifled. Government mandates may initiate a whole different set of innovations, yet those new innovations will not be focused on individually designed plan options, but rather on compliance with government requirements on individuals whose situations may or may not fit well into the mandate. For more on this, see Luke A. Stewart's research, "The Impact of Regulation on Innovation in the United States: A Cross-Industry Literature Review."[4]

Furthermore, private and social programs normally have unforeseen consequences. In the case of private programs, the investors and other participants in the general market either lose or profit from the unforeseen consequences. In the case of government programs, the public as a whole takes notice because they all will pay for unforeseen but consequential financial burdens. For example, Medicaid was

and is explicitly intended to be a welfare program. Yet based upon comments made by members of Congress from both political parties during an early 2016 hearing regarding LTC reforms, many people attempt to plan their finances such that when they need LTC, Medicaid or other government program will cover it. Some, if not many, people get the false impression that they can count on the government to cover their own needs and fail to purchase insurance.

It is reasonable to assume that LTC reforms will have unintended consequences. Some recent proposals included a universal "catastrophic" insurance program (presumably government mandated). If such were to be implemented with the expectation that private insurance policies would cover costs of care up to the point the universal program begins, policyholders will likely view the coverage as a package and behave as if they have unlimited or relatively high levels of benefits. Private insurers have learned that policyholders with unlimited benefits behave differently than those with more limited benefits. If the continuance models from the most recent SOA LTC Experience Study are representative of this behavior, the difference to a private insurance plan's benefits with and without such a government plan could average two or three months of services on a two-year or three-year maximum. These extra services can be priced into the private plan, but the price will increase. The increase in benefits would likely include existing private plans that were issued before such a hypothetical government program was even a thought, inviting the likelihood of premium rate increases on in-force policies.

Turning to the total program from onset of disability to recovery or death, we can consider why private insurers over the past few years have for the most part stopped selling the unlimited maximum option with their LTC policies. The insurer and policyholder behavior is different. One might expect that the incidence rate for unlimited benefits might be substantially smaller than policies with maximum limits because underwriters would presumably be more cautious in issuing unlimited benefits. In fact, the 2015 SOA experience study's predictive models identified a 2 percent to 6 percent smaller incidence in such plans. That is significant, but not as substantial as one might expect. The greater difference is found in policyholder behavior once they enter claim: insureds with unlimited benefit periods remain on claim longer. Applying two sets of claim termination rates from an SOA model in the same SOA study, one designed for policies with a three-year lifetime maximum and one designed for an unlimited maximum, to claimants with unlimited maximums, we find the unlimited claim termination set to identify an average claim life that is more than 125 percent of that using the three-year benefit claim termination set.

John O: Once again, I come at this a little bit differently. With regard to Bruce's point about Medicaid it has been a long-held industry assumption that the presence of Medicaid "crowds out" LTC insurance. I think that may be an element of truth to this, but probably not to the extent many of us in the industry would like to believe. I don't disagree that people may have a "perception" that somehow a government program may be there to help, but study after study has indicated that consumers are woefully

uneducated about ALL aspects of LTC, including how likely they will be to need care, how much that will care cost, and what they would need to do to avail themselves of the government safety net, if they wanted to. I have no doubt that some do plan this out, but thinking that "many" are logically thinking this issue through may be giving consumers too much credit on this issue.

That said, I think Bruce raises a very valid question regarding the concept of a universal catastrophic program, and what impact such a program would have on pricing of potential "front-end" private market products. The data he cites confirm what we have been hearing for several years, that purchasers of policies with larger lifetime benefits, especially unlimited lifetime benefits, behave differently than those with smaller capped benefits. His argument raises a couple of questions for me. First, do we know what is causing the behavioral differences? Are they a function of just the size of the benefit or could they relate to the characteristics of the voluntary buyers—who for the private policies in question would likely be at the very high end of LTC insurance purchasers? What impact does the size of the premiums they paid have on their behavior? You could argue that the more you pay for any consumer product, the more you will expect from it, and with LTC insurance that would mean a higher likelihood of trying to use the benefits to the fullest. Lastly, if the catastrophic plan is universal, would there be incentives to encourage higher participation for front-end products, up to and including making it universal as well? And would the lower price of broader coverage offset the kinds of increases Bruce points out?

I'm not suggesting that there may not be an impact on the pricing of private front end policies if a universal catastrophic program is instituted. What I am saying is this is a great question that needs more study and investigation as to whether the behavior seen on private policies with higher lifetime benefits translates to broader based universal programs.

15 percent of all seniors and 20 percent of females over 65 will have catastrophic LTC needs. Finding a viable solution to this issue is at the heart of the LTC financing dilemma.

Robert: Do you ever envision LTC insurance products becoming standardized and simple for the consumer to understand and purchase?

John O: Often we confuse the idea of standardization with "simple to understand and purchase." I would contend they are not the same. I would agree with a point made earlier that the regulations surrounding long-term care, which came out of well-meaning attempts to protect consumers from unscrupulous practices, neither protected them (certainly not from price increases) nor provided an environment for carriers to develop innovative solutions to the consumer's problems. Sometimes in our zest to be prescriptive, we end up with a system that doesn't work for either carriers or consumers.

John C: If you talk to LTC insurers in the group market they love standardized/streamlined products. Agents by contrast love flexibility. The difference is that you have to be able to talk to the person for flexibility to be valuable. Until such time as we have agents in every home or internet sales (or another avenue) to give that flexibility, in my view we are likely better off with stripped down policies. It might not quite be one size fits all, but three sizes might do it. The way I'd handle this is to set up the system so you can exit out to an agent or otherwise more complex product if your needs require it. But if plain vanilla does it, then go for it. We know that complexity here is the enemy of action. If people "freeze up" at the point of sale we have not done any good. In other words, get them covered first. Then move them to something better if there is something else for them.

Bruce: Each and every individual and family has their own needs and abilities, and standardized plans fail to address that fact. My wife's grandmother remained healthy and independent until she was about 92. Then she moved in with my in-laws where she only needed occasional attention, and still walked with a walker for about five miles on sunny days. But around the age of 95 she needed much more attention, and my in-laws were considering placing her in a nursing home. My wife and I did not want to see that happen, and we made arrangements for her to live in our house where someone could be home with her at all hours (a college student in her twenties, several teen-agers, a pre-teen, and my wife and me). She lived until age 101. In hindsight, had we planned for the need when my wife's grandmother was in her fifties or sixties, we likely would have concluded that her grandchildren would expect to help in some way, and that the insurance benefits would not need to be as comprehensive as many others might expect to need.

My family was in a unique situation, and that is my point. Every individual and family has a unique situation, and every individual and family will want to plan differently. They need to plan, but the specific plan may look different among different individuals and families. Allowing flexibility in benefit options is important.

Robert: Informal or unpaid care by family and friends is a cornerstone of long-term care today. What are your thoughts on its importance going forward?

John C: I'd say that today, caregiver issues are the most salient ones from the standpoint of getting policymakers to focus on long-term care issues. (It's also important for employers, given how many people have to take time off work or even quit to take care of a family member.) With the number of dependents for seniors declining it will become an even greater problem over time. My crystal ball says to

look for caregiver legislation in the next Congress and administration. The key issue then is whether it's a stand-alone proposal or other ideas can ride along with it. But anything the government can do to support the unpaid caregiver system helps divert people from greater use of Medicare and Medicaid.

John O: As a former caregiver for my mom and mother-in-law, who both had extended care needs due to Alzheimer's disease, I applaud thinking that more needs to be done to account for and accommodate caregivers. I'm not sure I would replace products targeted to the actual care recipients, but including other family members and other potential caregivers in planning, and perhaps payment and coverage, is an interesting direction that deserves more thought. One idea that emerged from the latest LTC Think Tank session was the concept of "family long-term care" where multiple family members could be covered under one policy. Bruce's caregiver support product approach certainly would fit in with that thinking, and may be a good standalone approach as well, from both a product and marketing point of view.

The one caveat I want to bring up is that reliance on informal caregiving in the future is potentially problematic in terms of supply—there are going to be fewer people available to provide informal (unpaid) care than there are today. An AARP analysis suggests that the ratio of caregivers to care recipients will go from about 7 to 1 today to 4 to 1 by 2030, and less than 3 to 1 by 2050.[2] Couple that with the increasing family geographic dispersion that we already see, and the changing nature of the traditional nuclear family and we can begin to see issues with too much reliance on informal care in the future.

Bruce: I mentioned earlier that I think products ought to be oriented as much to the informal caregiver as the recipient of care. I think that informal caregivers will continue to be needed, yet products that help to alleviate the need for breaks in providing care and the disruption to careers or other personal objectives will serve to enhance the caregiving experience for both the care giver and the recipient of care.

Robert: One curious thought that comes to mind as a final question is where people fit into all this. By that I mean, we all develop our products and ideas and then trot them out as if we really know what will work or what people will buy. Reaction?

John C: Good question again. I will poke both the private guys here and the public solution advocates. LTC insurers do all this testing and get feedback from the buying public so, in theory, are light years ahead of public advocates. Yet, private LTC insurance really hasn't done as well as we all hoped. So that is a big disconnect for any private insurance fan trying to explain how wonderful the private sector is when it comes to LTC insurance. On the other hand, private insurers frequently run focus groups and field other consumer research on their product ideas. Their feedback loop is better and nimbler. Public program

advocates often don't do any of this. So how do they know people want what they are trying to sell? I don't have a cosmic solution but suggest the best way to avoid problems with the buying public is coordination between the public and private sector when they develop and test any reform proposals.

Bruce: People are often opting not to purchase LTC insurance. People are individuals who each have different expectations, financial capabilities, and needs. Yet the private insurance market has been forced to market within tight boundaries. For example, the federal government imposes a floor on the qualifications for benefits that it considers long-term enough for premiums to be tax qualified—that is, no fewer than two ADLs—whereas most states do not currently permit insurance policies with more than two ADLs to be sold. Presumably and hypothetically, policies with tighter requirements such as requiring deficiencies in at least three ADLs would be less expensive and therefore more affordable. The American Academy of Actuaries published an issue brief in 2015 on the subject of flexibility in policy design that addresses this point.

Insurance products are intended to help people plan who otherwise would face risks that make planning difficult. Individuals' expected risks may change over time, and insurance programs need the flexibility to adjust with those expectations. For example, many people will likely be able to use genomics not long from now, allowing them to determine their individual expectations for future LTC needs. Insurers will need to be nimble and turn this knowledge into a flexible product structure that helps satisfy the particular financing of each individual's expected needs.

John O: So a couple of points in closing. I know it is often assumed that insurance companies spend enormous amounts of money researching and understanding consumer's needs and wants, in depth, through expansive consumer research. From my experience in LTC marketing, that hasn't been and isn't the case, especially relative to other consumer facing industries, and specifically over the past 10 years when the industry has been in precipitous decline. Looking at actual product designs that have been brought to market, they typically have been the result of what distribution thought they could sell, coupled with what was allowed by regulation, as opposed to what consumer's actually want. If we are to be successful, that needs to change. There are some excellent research techniques to get below the surface of the typical focus groups and understand the behaviors that are motivating, or not motivating, the consumer to act. And those motivations need to be balanced by whether companies can develop viable and profitable businesses around them. I'm optimistic that they can, but this means the private industry needs to work together with regulators and the public sector to re-envision and re-create the way LTC is provided, delivered, and funded in this country, and that needs to happen now, before it is too late.

Robert: Thanks to you all for this eclectic and informative discussion!

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Endnotes:

1. (Microsimulation Analysis of Financing Options for Long-Term Services and Supports, Urban Institute, Nov 2015). See also the *Health Affairs* issue dedicated to this "Financing Long-Term Services And Supports: Options Reflect Trade-Offs For Older Americans And Federal Spending," November 2015, accessed at http://content.healthaffairs.org/content/early/2015/11/24/hlthaff.2015.1226
2. AARP Public Policy Institute, *Valuing the Invaluable: 2011 Update*
3. *Long-Term Care Awareness and Planning: What do American's Want?* RTI International, July 2015
4. "The Impact of Regulation on Innovation in the United States: A Cross-Industry Literature Review" (www.iom.edu/hitsafety)
5. Long Term Care Think Tank: Exploring the Possibilities for Helping The American Public Manage The Financial Burden Of Long Term Care. https://www.soa.org/Files/Sections/2016-03-long-term-care-think-tank.pdf