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Short-Term Planning for Long-Term Care: Non-Traditional Solutions for Funding Care

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What options exist for people who don't pass underwriting for long-term care (LTC) insurance?

What about people who did not buy insurance when they could, but later find themselves facing an expensive care episode?

Given that only 2 percent of all LTC services in the United States are funded by private LTC insurance, and not everyone else goes on Medicaid, people are doing something else that is working, right?

I've spent the last year or so in discussions with insurance agents, financial planners, elder law attorneys, nursing home and assisted living executives, government policymakers, academics and insurance company executives on multiple continents piecing together answers to these questions. Much of this was motivated by my passion for much needed innovation in a long-term care insurance market, thinking that the answers might just lead to some new product concepts.

I'd like to share just a portion of what I've learned so far in this short article, which is based on a presentation I gave at a recent conference.

SUBSTANDARD LONG-TERM CARE PRODUCTS

The answer to the first question, "What options exist for people who don't pass underwriting for long-term care insurance?" is, at least currently, "not much." Today, people in this situation can't purchase traditional LTC products and must deal with financing their care if and when they are faced with a care episode.

Some life insurance products are sold in the workplace on a guaranteed simple issue basis, and LTC riders on such products are becoming more common. However, the availability of such an option is still limited and generally they have small face amounts, which means small LTC benefits.

Not long ago however, stand-alone substandard LTC products were available to persons that could not meet stringent underwriting criteria. These products disappeared at just about the same time that new sales in the traditional LTC market collapsed in the mid-2000s. The timing may be right for a come-back. I'll expand on my thoughts about this later. First, let's take a look at some key features of these products.

In spite of what you might think when you first encounter the concept of substandard products, these products are designed in such a way that many risks are more mitigated than their more selective counterparts. For example, many include the following risk limitations:

- Short benefit periods: 12 to 36 months
- Long elimination periods: 120 to 180 days
- Low daily benefit maximums: $70 to $120
- Covered services are limited to nursing home care
- No waiver of premium
- No restoration of benefits
- Low first year and no renewal commissions

These limitations reduce risk exposure in areas that have lead to unforeseen losses with other traditional LTC products.

Pricing of these products should take a release from risk posture, meaning that conservative pricing and reserving should be deployed, allowing bigger profits to emerge in the future if results occur as expected. Industry data that I have studied shows that incidence rates are, as one might expect, higher than those of traditional products in early durations. However, over time, these incidence rates do converge to ultimate incidence rates that are similar to those of traditional products. In a release from risk approach, an actuary could price a substandard product assuming that the early duration incidence differences are permanent.

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Policy termination assumptions can be another source of conservatism. Deployment of traditional product termination rates should be conservative, as substandard products should have higher mortality rates and terminations due to benefit exhaustions (resulting from shorter benefit periods and lack of restoration provisions). The actuary can also take into consideration the lack of minimum loss ratio requirements and the lack of competition in determining the level conservatism that is appropriate for such a product.

As for ongoing risk management, the actuary should consider that the critical experience occurs in the earlier durations, particularly just after the non-contestable period of the product. From there, the actuary should monitor incidence rates to confirm that they begin to grade down to ultimate levels. First principles monitoring is simpler than for traditional products due to the lack of certain product complexities (one level of care covered, and no restoration of benefits). Also, a shorter tail on claims results in earlier knowledge of claim sizes.

The potential market for such a product is large. Even in its shell of its former self, the traditional market still issues about 200,000 policies per year. According to some leading producers, about 15 to 25 percent of all applications submitted are declined coverage due to today's strict underwriting standards, and another 10 to 15 percent of applications are never submitted. This translates to a potential market of 65,000 to 135,000 of new substandard applications annually. Distribution could be greatly streamlined through automatic referral agreements with carriers that issue standard products.

POINT OF CARE ANNUITIES

Now for my second question: "What about people who did not buy insurance when they could, but later find themselves facing an expensive care episode?"

I researched the financial situation the average person over age 80 finds himself in. His net worth is $275,000, of which $135,000 is home equity. His average annual income is $22,000. Currently, the average annual cost of a nursing home stay is $81,000, which results in an average income shortfall of about $60,000. The fear of outliving assets becomes very real at this point, as it will take only four years for this to happen for the average person. This fear is often shared with the adult children of the person needing care, who commonly make or heavily influence the tough financial decisions in these cases. Many people panic and initiate Medicaid planning.

In this average situation, the incidence risk has been decoupled from the longevity risk. The person is now faced with a care episode. The time for insuring against the chance of that occurring has now passed. If we look closely however, the person has the means to pay for an average stay in a nursing home (just under two years), but surely cannot afford to pay for a stay that lasts more than four years, which is a real risk. So, we are left with a need to protect against the longevity risk. This is nothing new. Isn't this what immediate annuities are for?

Traditional immediate annuities are priced assuming that the annuitant is anti-selecting. That is, that the person is very healthy and is expecting to live longer than others the same age. For example, let's assume that the premium for a healthy person buying an annuity at age 82 is 10 times the annual payment he will receive. So, a $120,000 single premium will purchase an annual income stream of $12,000. However, someone beginning a nursing home stay typically has health conditions that will shorten his life expectancy to, let's assume 20 months. This makes the purchase of a traditional immediate annuity to protect against longevity uneconomical.

Enter the underwritten annuity. Particularly, one aimed at people entering a nursing home. Here, underwriting is counter to what we think of in life and health insurance. The more conditions a person has that shortens life expectancy, the more leverage that person has. An underwriter could discern, based on health conditions, that a particular person is expected to live 20 months. Allowing for profit margin, the insurer might assume a two year life expectancy for pricing purposes. In this case, the $120,000 could purchase an annual income stream of $60,000 for the life of the annuitant. That is enough to fill the average income gap during a nursing home stay while the annuitant lives. This could be purchased from just a portion of the average person's net worth at age 80+. This would eliminate the fear of outliv-

ing assets and the panic that leads to the initiation of Medicaid planning.

Does such a product exist? Yes. As of the date of this article, there is at least one on the street in the United States. We can see proven success elsewhere. This is the predominant form of LTC insurance in the United Kingdom, where the traditional product as we know it in the United States is not sold. Is there a market for it here? I think so. The target market comprises people that are entering or are currently in care episodes with income shortfalls, but enough net worth to fund that income shortfall for an average remaining impaired life expectancy. You might be surprised to learn that this is the case for about half of the U.S. population over age 80.

OTHER OPTIONS

Other point-of-need funding solutions have emerged for those that did not previously purchase LTC insurance. I've learned that there is a budding financial advisory space that focuses on these cases and that is not pushing a Medicaid solution.

The approach taken is to first determine if there is an income shortage and, if so, to quantify it. Then, steps are taken to convert net worth into income streams that help to fill that gap. The most common ways of doing that are:

- Home equity can create income via reverse mortgages.
- A life insurance death benefit can be assigned in exchange for a lifetime income payment (life settlements).
- A series of loans against a life insurance policy can be taken, but only while principle lasts.

At least one "financial concierge" company has emerged on this scene. This company receives referrals from nursing home and assisted living facility admissions offices. It acts as an advocate for new entrants in finding ways to finance care. It can provide bridge loans as solutions are put in place, which can take months in many cases. They also receive real estate brokerage or referral fees in cases where a home is sold and referral fees for other transition services (such as moving and storage services). Is it possible that we are seeing the beginning of a new distribution point for financial products at this critical point in people's lives?

CONCLUSIONS

As stated earlier, this is just a portion of what I've learned about this topic so far, and I continue to learn more as I research the answers to the questions at the beginning of this article both in the United States and around the world. I hope that what I have shared here has provided some useful information to the reader and to our industry. ■