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Immigration Reform and What It Could Mean for the Long-Term Care Insurance Industry

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Long-term care insurance (LTCI) provides financial protection to individuals facing debilitating health issues and requiring assistance with activities of daily living. That assistance relies heavily on a human workforce. Not enough has been accomplished in terms of automating the long-term support and services (LTSS) industry, and there are limits on how much those services could be automated.

We have all seen estimates of future demand for long-term support and services, and we are aware of the supply challenges in meeting those demands. This is a labor-intensive industry with generally inadequate pay. As a nation, we struggle to incent enough individuals to adequately staff the industry as we brace for a dramatic growth rate in demand. The nation's immigrant population is a considerable source for LTSS workers.

The news is full of stories about the increased focus on deportation, removal or return of unauthorized immigrants from the country. In January of 2017, an executive order was signed significantly broadening categories of unauthorized immigrants who are priorities for removal. And in September of 2017, the rescission of DACA (Deferred Action for Childhood Arrivals) was announced with a six-month wind-down.

These actions to increase enforcement of immigration and customs laws could directly impact the LTSS industry. This has sparked conversations regarding the potential financial consequences for LTCI carriers.

The demand for LTSS is projected to increase significantly over the next several decades. If the number of unauthorized immigrants begins declining at an escalated pace, more of those jobs will need to be filled by native U.S. citizens and authorized immigrants, both of whom earn higher wages on average.

Through several scenarios, this article is a study of what these changes could mean for those carriers managing large blocks of in-force long-term care insurance.

BACKGROUND ON UNAUTHORIZED IMMIGRANTS AND DIRECT CARE WORKERS

Reports indicate that there were almost 44 million immigrants living in the United States in 2016; 11 million of those were unauthorized. More than half of those live in four states (CA, FL, NY, and TX). There were 450,000 documented removals of unauthorized immigrants in each of 2015 and 2016. Conversely, new immigrants have been entering the country at a rate of almost 1.5 million per year.[1]

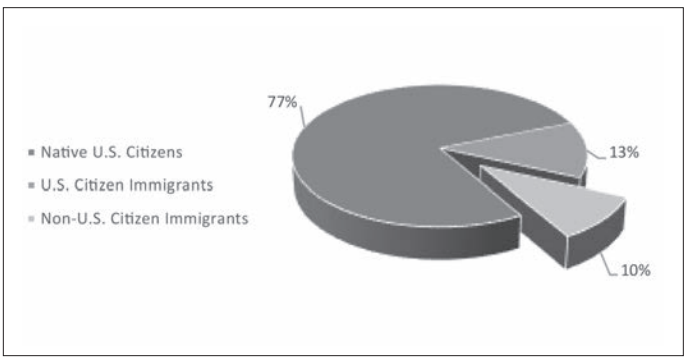
There are 4.4 million workers in the direct care industry (certified nursing assistants, home care and personal care aides). This number is projected to grow by 41 percent over the next ten years.[2] This article focuses on home care and personal care aides, as Certified Nursing Assistants are assumed to be either native U.S. citizens or authorized immigrants.

Immigrants comprise almost one million of those direct care workers (nearly 25 percent). Of those immigrants providing direct care, 44 percent are non-U.S. citizens. In other words, 10 percent of direct care workers are estimated to be non-U.S. citizen immigrants.[3] Some portion of these non-U.S. citizens is authorized to work in the country. However, as 25 percent of all immigrants living in the United States are unauthorized, many of these non-U.S. citizens providing direct care are likely to be unauthorized. Furthermore, this number is likely significantly understated as there is a "gray area" in which much of the work provided by unauthorized workers goes undocumented.

For purposes of this article, I assumed that half of the non-U.S. citizen immigrants providing direct care are unauthorized. Sensitivity tests provided later show the impact of assuming only 25 percent or as much as 75 percent are unauthorized. Those tests show that the financial implications for long-term care insurers are relatively insensitive to this assumption.

While there are generally more safeguards in place to be an approved provider for qualified benefits from an LTCI policy, many policies have provisions through which the cost of services provided by unauthorized immigrants are currently being reimbursed. Examples of such provisions include an informal caregiver benefit or a cash benefit. Furthermore, services currently provided by unauthorized immigrants, but not reimbursable by long-term care insurance policies could become services provided by qualified providers and thus become reimbursable benefits if the cost of those services were to increase.

Figure 1
Direct Care Workers by Legal Status



While immigrant workers in total make up 23 percent of the direct care workforce, they provide 28 percent of the care. Again, this number is most likely underestimated due to unreported care provided by those unauthorized immigrants.

The annual median direct care wage in 2016 was $22,192.[4] This assumes that 60 percent of direct care is personal care and the remainder is provided by home health aides. The median for all immigrant direct care workers was $19,000.[5] Unauthorized immigrants earn less than authorized immigrants. Estimates put this differential at 20 percent when adjusted for similar functions. This puts the median direct care wage for authorized immigrants at $20,833 and unauthorized immigrants at $16,667.

From the 2017 Genworth Cost of Care Survey, the average hourly rate for direct care was $23.28. Using the differences in median wages above along with the distribution of work among the three categories, one can estimate the average hourly rates for direct care by legal status. For native U.S. citizens, an average hourly rate of $25.33 is implied. The rate for authorized immigrants is $21.85. For unauthorized immigrants, the rate is $17.48. Unauthorized immigrants earn an estimated 31 percent lower hourly wage than that earned by native U.S. citizens.

WHAT THE FUTURE DIRECT CARE WORKFORCE MIGHT LOOK LIKE

Today, 77 percent of direct care is provided by native U.S. citizens, at an average hourly rate of $25.33. Only 10 percent is reported to be provided by unauthorized immigrants at an hourly rate of $17.48.

Assuming enforcement of immigration and customs laws continues and increases, it is conceivable that in ten years 86 percent of direct care would be provided by native U.S. citizens at an average hourly rate of $34.04 or higher. This assumes a continuing 3 percent average annual increase in the overall cost of home health care. However, as the demand increases for more native U.S. citizens in this workforce, it is plausible that the annual increase in the cost of care will be higher for those services. If it is only 1 percent higher, the average hourly rate in ten years would be $37.50. If there is a 2 percent additional annual premium, the average hourly rate could be $41.26. Further, if there is a 3 percent additional annual premium, the hourly rate could be $45.37

All the same, ten years from now, 4 percent of direct care could be provided by unauthorized immigrants, at an hourly rate of approximately $23.50.

In twenty years, 88 percent of direct care would be projected to be provided by native U.S. citizens, and only 3 percent would

be projected to be provided by unauthorized immigrants. At that point, the average hourly rate earned by native U.S. citizens could be as much as two and a half times that earned by unauthorized immigrants.

Figure 2
Projected Mix of Direct Care Workforce

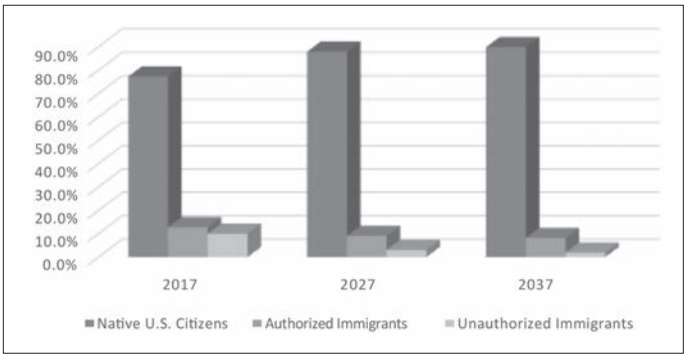
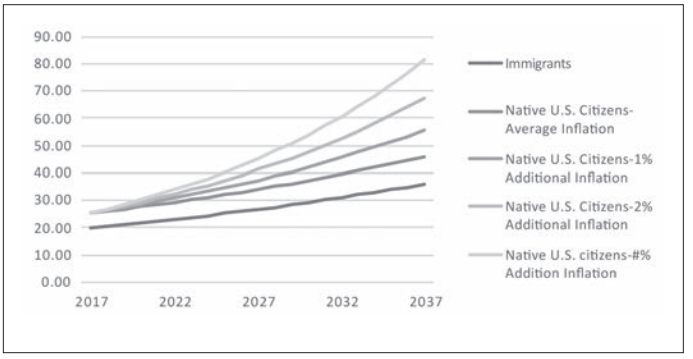


Figure 3 demonstrates the potential growth in hourly rates over the next twenty years.

Figure 3
Projected Hourly Cost of Direct Care



The increasing disparity in the average cost of services provided by native U.S. citizens versus those provided by unauthorized immigrants coupled with a decrease in the population of unauthorized immigrants and the corresponding increase in demand for native U.S. citizen direct care workers poses an interesting scenario for long-term care insurers. To understand the potential implications, I developed projections of future liabilities.

WHAT COULD THIS MEAN FOR LTCI CLAIMS?

In short, higher costs for long-term support and services will lead to higher claims. How much higher could claims be? To address this, I used a simple model based on a block of business with an average attained age of 80 and in force for 15 years, which is typical for the industry.

Using assumptions representative of experience with an average block of LTCI, the model projects nursing home, assisted living facility and home health care claims separately, assuming the direct care workforce continues as it has been. I then used the same model but reflected shifts in the future demographic makeup of the direct care workforce. The demographic shifts are a function of increased deportation and removal of unauthorized immigrants coupled with a slower future rate of overall immigration into the country. Furthermore, several scenarios were projected reflecting additional increases in the cost of services provided by native U.S. citizens to address potential increases in demand versus supply.

Benefits were assumed to be reimbursement, with an equal mix of inflation protection and no inflation. Utilization was adjusted to reflect the projected future benefits.

Figure 4
Projected Increase in Paid Claims

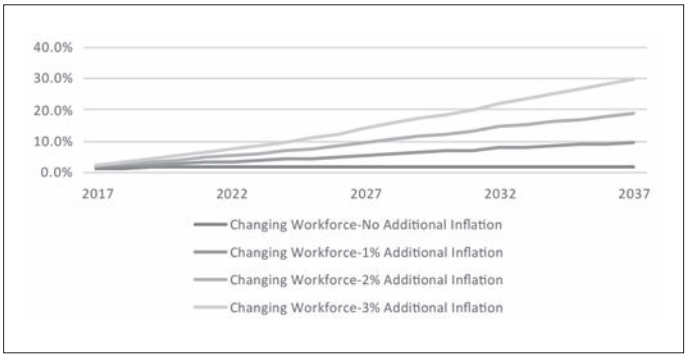


Figure 4 demonstrates the increase in projected paid claims for four future scenarios.

As can be seen in the chart in Figure 4, additional inflation in the average hourly cost of direct care services provided by native U.S citizens has a significant impact on projected increases in future claims. If no additional wage inflation were to emerge, the increase in future claims remains relatively steady (approximately 2 percent). However, if the potential supply and demand imbalance were to add 3 percent annual inflation for wages of native U.S. citizen direct care workers, future claims could ultimately be more than 30 percent higher.

I studied the present value of future liabilities under each scenario over the next twenty years as well as over the remaining lifetime for the book of business that was modeled. Given the block has an average attained age of 80, the difference between the two results is minimal. The potential percentage increase in liabilities is presented in Figure 5.

Figure 5
Percentage Increase in Liabilities

Additional Wage Inflation	20 Year Increase	Lifetime Increase
None	2.0%	2.0%
1%	5.1%	5.2%
2%	8.6%	8.9%
3%	12.5%	13.0%

POTENTIAL LONG-TERM CARE INSURANCE MARKET IMPACT

In reviewing 2016 long-term care experience reporting for the just over 100 carriers who comprise the majority of the in-force business, the total reported reserves were $117 billion. 74 percent of the total reserves, or $86 billion, were reported by ten carriers.

Using reported reserves and earned premiums, I approximated the total industry anticipated future claims from $150 to $175 billion. For the top ten carriers, the estimated future claims are from $110 to $125 billion.

We could certainly debate as to the reasonableness or adequacy of these reported numbers, and recent industry news articles suggest that best estimate liabilities could be substantially greater. Nonetheless, the impact of increased enforcement of immigration and customs laws discussed in this article could easily add at least another $3.4 billion to total industry claims under a more optimistic scenario, where there is no supply-and-demand influence on additional wage inflation. In worse scenarios, these actions could add $22.6 billion or more. Figure 6 shows the potential industry impact by inflation scenario, using the upper bound of estimated liabilities based on reported reserves and earned premium.

Figure 6a
Potential Additional Liabilities (m)

Additional Wage Inflation	Total Industry	Top 10 Carriers
None	3,433	2,502
1%	9,075	6,613
2%	15,424	11,239
3%	22,578	16,452

Using the same approximations, and based on reported values, the average future anticipated claims are about $12.6 billion per carrier for the top ten carriers. Given this, the scenarios discussed could consume from 3 percent to 20 percent of capital and surplus per carrier. Even the lower end of this range would be a significant challenge to a less capitalized carrier. The upper end of the range could be catastrophic.

Again, these numbers all assume that half of the non-U.S. citizens providing direct care are unauthorized. The following tables summarize sensitivities around that assumption.

Figure 6b
Total Industry Unauthorized Sensitivities

Additional Wage Inflation	25%	50% (Base)	75%
None	3,181	3,433	3,683
1%	8,728	9,075	9,419
2%	14,969	15,424	15,874
3%	22,002	22,578	23,150

Figure 6c
Top 10 Unauthorized Sensitivities

Additional Wage Inflation	25%	50% (Base)	75%
None	2,318	2,502	2,684
1%	6,360	6,613	6,863
2%	10,908	11,239	11,567
3%	16,032	16,452	16,868

CONCLUSION

The long-term care insurance industry is certainly not without challenges. The introduction of the topic of this article into future claims projections is something that most have not yet considered. Whether these changes materialize or not remains to be seen. Nonetheless, with all the media attention the topic is receiving, this is one more interesting factor for our industry to consider. ■

Disclaimer: The views expressed in this article are those of the author and are not necessarily those of the Society of Actuaries or the Long Term Care Insurance Section.

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ENDNOTES

1 Source: The Migration Policy Institute
2 Source: Bureau of Labor Statistics Occupational Outlook Handbook
3 Source: P.H.I. Research Brief – Immigrants and the Direct Care Workforce
4 Source: Bureau of Labor Statistics Occupational Outlook Handbook
5 Source: P.H.I. Research Brief – Immigrants and the Direct Care Workforce