

POLICY BRIEF 2015-06

## Strengthening Risk Protection through Private Long-Term Care Insurance

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# Strengthening Risk Protection through Private Long-Term Care Insurance

*The United States* spends more than \$300 billion on long-term services and supports (LTSS) every year through public programs, private out-of-pocket spending, and private long-term care (LTC) insurance. LTSS includes institutional care, community-based assistance, and home-based assistance with daily living activities. Elderly households' LTSS expenses in the event of cognitive or physical impairment present the largest source of out-of-pocket spending risk. The average 65-year-old couple can expect to spend \$65,000 on LTSS, and 5 percent of elderly couples can expect to pay in excess of \$260,000. However, the ability to insure against LTSS risks remains limited. The wealthiest Americans might be able to pay for these expenses through savings, but most Americans approaching retirement age will find paying for LTSS a daunting challenge.

The number of elderly Americans aged 80 and over is expected to more than double in the next 40 years, so the number of people using LTSS will grow considerably in the coming decades, reaching 27 million in 2050. With insufficient private resources, these aging Americans might reasonably expect to turn to public programs like Medicare (the federal government's health insurance program for individuals aged 65 or over, and for some younger individuals with disabilities) or Medicaid (a public health insurance program for those with low income and limited resources). But Medicare's coverage of LTSS is limited, offering only some post-acute care following qualified hospitalizations. Medicaid, on the other hand, does provide coverage of some LTSS, mostly institutional care, but does not typically cover home- and community-based services. In addition, Medicaid's program rules require that households essentially spend down all of their assets to qualify. Medicaid spending on LTSS is expected to grow at 6 percent per year over the next ten years. The pace of this spending is expected to increase after 2025, when baby boomers reach the ages at which LTSS needs are the greatest, leading to important fiscal challenges.

The financial risks facing middle-class Americans and the fiscal challenges facing Medicaid call for rethinking how households and the public sector finance LTSS needs. In a new Hamilton Project discussion paper, Wesley Yin of the University of California, Los Angeles presents a proposal aimed at two broad objectives: (1) improving the financial security of middle-class Americans facing uncertain but likely LTSS needs, and (2) fostering greater efficiency in both public and private LTSS delivery to better meet the needs of beneficiaries.

To achieve these broad objectives, Yin proposes changing how LTC insurance is financed in the private market so that individuals can have more-affordable and more-complete insurance against LTSS expenses, and so insurance firms can

manage their risks more efficiently. The three key pillars of his proposal follow:

1. A new LTC Advantage program would offer a progressive cost-sharing subsidy to help individuals purchase private LTC insurance. This subsidy would be paid directly to the insurer to offset future LTSS claims, thus lowering an individual's effective LTC insurance premium.
2. A shared-risk-corridor program (hereafter shared-risk program) would help insurers manage systematic and unavoidable financial risks in order to lower premiums, foster premium stability, and encourage insurer entry and competition. Qualifying losses and gains—from business cycles and changing market-wide disability and lapse rates—would be shared with the federal government and, in limited ways, with consumers. Losses from poor claims management and underpricing—risks controlled by the insurers themselves—would not be eligible for protection.
3. A range of policy options would boost access and demand for LTC Advantage coverage and improve the functioning of the private LTC insurance market. These options include plan standardization, modifications to the Employee Retirement Income Security Act (ERISA) to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, policies to encourage employers to offer private LTC insurance plans, and demonstration programs through the Centers for Medicare and Medicaid Services (CMS) to test models for efficient financing of LTSS, primary care, and acute care delivery through Medicare.

Yin emphasizes that undertaking this proposal does not necessarily require additional resources. Instead, this proposal would require a financing system that redirects much of what Americans now spend on out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance protection.

## The Challenge

As many health-care researchers have previously observed, Yin argues that the totality of LTC insurance coverage is both low and incomplete. In theory, the author observes, private LTC insurance could fill some of the gaps in coverage for Americans so that they could protect, rather than spend, their assets. However, few Americans buy private LTC policies, and coverage is imperfect as a result of institutional, supply-side, and demand-side barriers.

From an institutional standpoint, Medicaid offers LTC insurance and thus serves as a safety net for the most vulnerable Americans. However, Medicaid is a means-tested program: to

qualify for coverage, individuals must first spend down their assets so that they have sufficiently low levels of assets to meet eligibility requirements. Also, Medicaid offers incomplete coverage against LTSS risks: it does not cover all LTSS needs and it has a bias toward institutional care, often lacking coverage for home-based or informal caregiving. Even with incomplete coverage, Medicaid's LTSS expenditures are expected to grow with the continued aging of the baby boomers who, as discussed below, do not have adequate private insurance coverage for their LTSS needs.

The private market is also subject to many sources of market failure on the supply side. Notably, insurers face financial risks that are systematic because market-wide disability and lapse rates as well as business cycle conditions are not diversifiable across beneficiaries and are nearly impossible to forecast decades into the future. Also, there is adverse selection among beneficiaries (i.e., only those who have the highest LTSS needs purchase insurance), which makes the LTC market and premiums unstable.

On the demand side, a variety of behavioral factors deter consumers from demanding and purchasing private LTC insurance. Anticipating that an insurer might go insolvent, many seniors are deterred from buying insurance in the first place. Also, in part because myopia and limited financial literacy limit individuals' perception of the risk of needing LTSS and its costs, many Americans do not purchase LTC insurance. Perhaps most importantly, carriers charge consumers prohibitively high prices in order to remain solvent and to bear the financial risks mentioned above. They also deny coverage to those with the most elevated LTSS risks. High prices reinforce the adverse selection of relatively unhealthy individuals who need LTC insurance policies, thereby pushing prices up even higher.

Finally, important interactions between the private and public sector limit the availability of LTC insurance, reinforcing supply- and demand-side barriers to coverage. More specifically, the availability of free Medicaid LTC coverage crowds out (or reduces) the demand for private insurance, which in turn leads to higher federal outlays for LTSS spending than would be the case if more individuals had private insurance. In other words, households may sensibly choose to "spend down" their assets and pay for LTSS needs out of pocket in order to qualify for free Medicaid coverage rather than buy private insurance to protect their assets against LTSS spending risks but then not qualify for Medicaid. The "second-payer effect" also inhibits the purchase and take-up of private LTC insurance: For those eligible for Medicaid coverage, private policies have the legal responsibility of paying for claims. Only after the private plan has been exhausted does Medicaid step in. Consumers therefore face weak incentives to purchase private coverage ahead of Medicaid, since purchasing a plan simply delays the receipt of free Medicaid coverage.

## A New Approach

Yin calls for a new approach that will address the fragmented system of insurance coverage for LTSS. The author's proposed reforms of the LTC insurance market would establish a well-functioning LTSS financing system that increases risk protection through insurance expansion and would strengthen the efficiencies of LTSS spending and delivery.

### Long-Term Care Advantage Program

Yin proposes establishing a voluntary LTC Advantage program in which individuals would, in lieu of claiming future Medicaid LTSS benefits, be eligible to purchase a private LTC insurance plan for which the insurer has received a cost-sharing subsidy. By lowering future LTSS claims paid by insurers, the cost-sharing subsidy would lower premiums. In other words, the LTC Advantage program essentially converts some of the LTSS spending that Medicaid would have eventually paid into a cost-sharing benefit that lowers private LTC insurance premiums. This private insurance would be both more complete and more flexible in the services it covers than is Medicaid, and would not require individuals to spend down their assets.

With regard to eligibility, all individuals aged 55 or younger (except those with current or immediate LTSS needs) would be guaranteed coverage in the LTC Advantage program. Individuals aged 56–65 would receive a slightly reduced cost-sharing subsidy. All individuals aged 56 and older would face underwriting (i.e., the process by which insurers evaluate an individual's LTSS needs) and may be denied coverage if those needs are deemed too high. Allowing the terms of eligibility to vary by age in this way provides an incentive for individuals to enroll at younger ages and helps insurers protect themselves against age-specific risks.

The generosity of the cost-sharing subsidy would vary with an individual's wealth—as measured by projected lifetime Medicare earnings at age 65—and would be risk rated. Individuals with lower lifetime Medicare earnings or with higher expected LTSS spending would receive a larger cost-sharing subsidy, up to a daily benefit maximum. In exchange for this subsidy, individuals would not be eligible for Medicaid LTSS coverage. Any LTSS needs present after the private coverage period expires would continue to be covered by the cost-sharing subsidy, ensuring that the small fraction of individuals whose needs exceed the levels set by the private market would continue to have a safety net.

Moreover, subsidies and premiums would be risk rated to reduce adverse selection and the need for severe individual-level underwriting. In other words, by setting a higher premium for higher-risk beneficiaries, carriers would not need to raise the premiums for healthier beneficiaries. Since the subsidy and the premium would be risk rated using the same information about the beneficiary's risk characteristics, the larger individual-level subsidy would offset the higher premium for these higher-risk beneficiaries. As a result, individuals of the same age, region, and wealth would pay the same net-of-subsidy premium irrespective of their LTSS spending risk.

To acquire the subsidy, consumers would log on to an exchange Web site; provide basic personal information such as age, sex, marital status, and geographic area of residence; answer questions about their health; and enter their lifetime earnings based on their most recent Medicare earnings statement. Premiums on the exchange would depend only on lifetime Medicare earnings and where an individual lives, making it easier to compare plans. However, final premiums and coverage determination would be set only after the individual completes a formal application process through the insurer. Once approved, individuals would pay monthly premiums and would be insured as long as they continue paying premiums.

Finally, the LTC Advantage program would include a wide variety of plans to provide beneficiaries with flexibility in choosing their LTC coverage. Importantly, the program would include plans that offer only home- and community-based services (HCBS). To reflect the lower cost of care in HCBS settings, the dollar value of both the subsidy and net-of-subsidy premiums for HCBS-only plans would be proportionally less than the subsidy and premium for traditional LTC plans that include institutional settings. LTC Advantage would also allow subsidies for hybrid insurance products that combine LTC insurance with longevity annuities, which offer elderly individuals financial protection in the event they live past their savings. As such, LTC insurance would provide insurance against two of the primary risks faced in retirement.

### **Carrier Risk-Management and Premium-Stabilization Policies: The Shared-Risk-Corridor Program**

Currently, undiversifiable risks—such as unfavorable movements in key financial parameters like interest rates, disability rates, disability duration, and lapse rates—are already borne by Medicaid and by consumers through higher premiums, unexpected premium increases, and benefit reductions. To foster premium stability, improve certainty throughout the market, and spread risks among insurers, beneficiaries, and the government in transparent ways, Yin proposes a two-sided shared-risk-corridor program, similar to the successful market-stabilizing risk-corridor program in Medicare Part D. In short, the shared-risk program would provide downside protection for insurers that experience qualifying losses—that is, losses due to unfavorable movements in undiversifiable market-wide risk factors. In exchange for this protection, carriers would share the gains when favorable movements unexpectedly boost their profits. Importantly, the program would not cover insurer-specific losses (e.g., from underpricing premiums or claims mismanagement). This particular design is meant to deter insurers from irresponsibly underpricing premiums or engaging in risky investing behavior with the expectation of a bailout.

Yin proposes the creation of a new agency within the Department of Health and Human Services (HHS) to administer this shared-risk program; this agency's responsibilities would include determining assumptions about financial parameters such as interest rates, lapse rates, disability rates, and disability duration. Insurers participating in the LTC Advantage program

## **Roadmap**

- The federal government will implement a Long-Term Care (LTC) Advantage program that would provide a cost-sharing subsidy to LTC insurers in order to lower the cost of purchasing a private LTC plan. This subsidy would be larger for lower-wealth and higher-risk individuals and would reduce the effective premiums they pay for LTC insurance. The LTC Advantage program will in essence convert some of the LTSS spending that Medicaid would have eventually paid out into a voucher that individuals can use toward the purchase of private LTC insurance.
- The Department of Health and Human Services (HHS) will create a shared-risk-corridor program that provides protection for carriers that experience losses due to unfavorable movements in market-wide risk factors in exchange for carriers sharing the gains when favorable movements unexpectedly boost their profits. Importantly, the shared-risk program would not cover losses due to poor claims management, underpricing of premiums, or other decisions that insurers control.
- The federal government will consider a range of policies to promote additional purchases of private LTC insurance, including the standardization of plans, modifications to the Employee Retirement and Income Security Act (ERISA) to allow penalty-free withdrawals from tax-advantaged retirement accounts to purchase eligible LTC insurance plans, and incentives for employers to encourage employees to buy LTC insurance. Also, the Centers for Medicare and Medicaid Services (CMS) will conduct demonstration programs to test models that integrate the financing of LTC into Medicare. The LTC Advantage program would then be updated to reflect the findings of these demonstrations.

## Learn More about This Proposal

This policy brief is based on The Hamilton Project discussion paper, “Strengthening Risk Protection through Private Long-Term Care Insurance,” which was authored by

WESLEY YIN  
University of California, Los Angeles

would agree to the industry standards and the determination of benchmark financial parameters and premiums. At predetermined time intervals (e.g., every five years), the newly formed agency within HHS would assess the carriers’ performance and determine how much, if any, of the losses are attributable to departures from forecasted market conditions. Immediate qualifying losses would be borne solely by the insurer. Moderate qualifying losses (e.g., 3–5 percent) would be shared by beneficiaries and insurers, who would be allowed to adjust premiums or benefits in limited and transparent ways. When losses exceed moderate levels, the federal government would bear some of the losses. Yin notes that moderate losses are already being borne by consumers through unexpected premium increases, and that larger losses are already borne by the government through Medicaid. This program would only make consumer risk-bearing and government backing more explicit, and would be limited to qualifying losses. Overall, the presence of this program is meant to lower risk for insurers, resulting in lower premiums, greater consumer confidence in LTC products, and therefore higher consumer demand for coverage.

### Boosting Access and Demand for Long-Term Care Advantage Coverage

Higher take-up of private LTC insurance is critical to achieving broad-based premium and load reductions, enabling carriers to efficiently diversify idiosyncratic risks, and aggressively confronting the fiscal challenges that arise from individuals’ shortfalls in protection against LTSS risks. To address these challenges, Yin offers a menu of four policies for consideration, but stops short of offering highly prescriptive proposals. Broadly speaking, some of these policies are ambitious and would require coordination among legislators, government agencies, employers, and regulatory bodies.

First, to make plan comparison easier for consumers and to promote competition among carriers, Yin proposes that plans be standardized and vary along only a few key dimensions. Ideally, individuals shopping for plans would do so on well-designed exchanges. Second, to provide individuals with a

way of paying for LTC insurance premiums, Yin proposes modifying ERISA to permit penalty-free distributions for all LTC Advantage program products, including any HCBS-only or hybrid insurance products. Current regulatory barriers make it difficult for individuals under age 59½ to use a portion of their retirement savings to purchase LTC insurance, even though allowing withdrawals at an earlier date would have only a minimal impact on the federal budget. Third, Yin contemplates ways to encourage employers to offer the LTC Advantage program, such as through employer mandates.

Finally, Yin proposes that CMS sponsor and evaluate demonstration programs to test models for coordinating care across the proposed LTC Advantage program and Medicare, which only provides limited coverage of LTSS for most beneficiaries. Specifically, CMS would sponsor and evaluate demonstration programs that integrate the financing of LTSS into Medicare, either through a private Medicare Advantage insurer or through an Accountable Care Organization mechanism. The structure and application of the federal subsidy program would then be updated or reformed to reflect the research findings of these demonstrations.

### Budget Implications

Yin contends that much of the spending on the LTC Advantage program would be paid for by future savings from Medicaid. The proposed LTC Advantage program initially requires little spending, but this amount of spending grows as more individuals enroll in the program and begin needing LTC. By about 2036 estimated spending on new enrollees would roughly offset the reduction in spending due to the oldest participants leaving the program. At this point, net spending on the LTC Advantage program is estimated to be approximately \$800 million per year. However, if LTC premiums fell substantially—for example, as a result of a greater number of individuals purchasing LTC insurance or due to the success of premium-stabilizing policies—the estimated cost for the program could be even lower. The author suggests that one way for the subsidy to be funded would be to cap the tax deduction available to federal workers paying for federal LTC insurance premiums, which, in the aggregate, costs \$2 billion per year.

## Conclusion

As life expectancy rises and the population ages, demand for LTSS will continue to increase in this country, placing great financial pressures on households as well as on the Medicaid program. In his Hamilton Project discussion paper, Wesley Yin puts forth an LTC finance reform proposal to improve the financial well-being of Americans and foster greater efficiency in both public and private LTSS financing and delivery. The author argues that if these proposals were undertaken, the LTC market would achieve a meaningful increase in risk protection for middle-class American families, better meet the needs of beneficiaries, and mitigate the fiscal pressures that Medicaid currently faces.

# Questions and Concerns

## 1. Will maintaining the cost-sharing for LTSS claims after private coverage is exhausted lead to greater public spending?

No. Spending on the small fraction of high-need cases—that is, in which an individual needs LTSS for longer than five years—is largely covered by Medicaid now, so this safety net feature of LTC Advantage would have little impact on the budget. More generally, the level of the LTC Advantage cost-sharing subsidy would be scaled to meet budget objectives.

## 2. Will LTC care be affordable for low-wealth and low-income individuals?

Private plans might not be able to negotiate reimbursement rates achieved by Medicaid. As a result, there may be concerns that costs to individuals would increase such that lower-wealth and lower-income individuals would not be able to afford the premiums. Several options could be considered to address those concerns: First, the subsidy could be made more progressive—for example, by boosting the maximum cost-share subsidy at lower-wealth levels and by phasing out the subsidy more steeply at higher-wealth levels.

A more ambitious option would be to allow flexibility for states to set rates actively with providers on behalf of all insurers, particularly where negotiated rates may be significantly higher than Medicaid rates. Such states could stipulate that all LTC plans and contracted providers doing business in the state must accept rates set by the state. This option would be no different from how prices are currently determined within Medicaid LTC coverage.

## 3. Won't the shared-risk program just lead to moral hazard?

No. The most obvious sources of moral hazard would be insurers engaging in riskier investments, poor claims management, and underpricing of premiums to gain market share. The risk corridor does not insure carriers from losses due to these behaviors. Only losses associated with unanticipated movements in market-wide disability rates, duration, and lapse and interest rates would be covered. And even then, only a portion of those losses above some trigger rate would be covered. Losses from both of these behaviors would not be covered by the shared-risk program. Also, losses beyond the attachment point are held by the carrier, ensuring that carriers retain incentives to manage claims efficiently, even in the shared-risk program.

## Highlights

Wesley Yin of the University of California, Los Angeles proposes changes to the financing of long-term care (LTC) insurance so that individuals can have more-affordable and more-complete insurance against long-term services and supports (LTSS) expenses, and so insurance firms can manage their risks more efficiently.

## The Proposal

**Long-Term Care Advantage Program.** This program would offer a progressive cost-sharing subsidy to help individuals purchase private LTC insurance. This subsidy would be paid directly to the insurer to offset future LTSS claims, thus lowering an individual's effective LTC insurance premium.

**Shared-Risk-Corridor Program to Manage Risk and Stabilize Premiums.** This program would help insurers manage systematic and unavoidable financial risks. Qualifying losses and gains—from business cycles and changing market-wide disability and lapse rates—would be shared with the federal government and, in limited ways, with consumers.

**Additional Opportunities to Boost Access and Demand for the Long-Term Care Advantage Program.** A range of policy options would improve the functioning of the private LTC insurance market. These options include plan standardization, modifications to the Employee Retirement Income Security Act to allow penalty-free withdrawals from tax-advantaged retirement accounts for the purchase of subsidy-eligible LTC plans, policies to encourage employers to offer private LTC insurance plans, and demonstration programs through the Centers for Medicare and Medicaid Services to test models for efficient financing of LTSS, primary care, and acute care delivery through Medicare.

## Benefits

This proposal aims to improve the financial security of middle-class Americans facing uncertain but likely LTSS needs as well as to foster greater efficiency in both public and private LTSS delivery to better meet the needs of beneficiaries. First, the cost-sharing subsidy would increase LTC coverage rates, thereby achieving a meaningful increase in risk protection. Structuring the LTC Advantage program as a cost-sharing subsidy would eliminate the dampening effect that Medicaid's current design has on demand for private LTC insurance. Second, the risk-corridor program would lower premiums, foster premium stability, and encourage insurer entry into and competition within the market. And third, the menu of supporting policy options would improve the functioning of the private LTC insurance market in addition to improving consumer choice, plan competition, and coordination in health-care and LTSS delivery. Overall, this proposal would redirect much of what is currently spent on out-of-pocket expenditures, informal care, and public programs toward the cost of more-complete insurance protection.



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