

GEORGETOWN UNIVERSITY  
Long-Term Care Financing Project  
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**“MEDI-LTC”**

**A New Medicare Long-Term Care Proposal**

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## Preface

At the same time we invest over \$200 billion in public and private resources in long-term care, dissatisfaction with our current public-private financing partnership is widespread. To promote a better partnership for the future, the Georgetown University Long-Term Care Financing Project examined options to move us from a partnership that consists primarily of out-of-pocket financing and last-resort public financing toward a partnership that spreads risk, supports access to quality care, and shares financial responsibility fairly among taxpayers and affected individuals and families.

To identify options, we invited experts to develop their own proposals for new ways to finance long-term care. We sought innovative ideas that varied in the nature of the partnership between the public and private sectors. This working paper is one of a set of eight proposals written for the project. These eight, plus an additional four proposals from other sources, are summarized and assessed in an overview paper, *Long-Term Care Financing: Options for the Future*, written by Judith Feder, Harriet L. Komisar, and Robert B. Friedland. The working papers and the overview can be found at: [ltc.georgetown.edu](http://ltc.georgetown.edu). The Georgetown University Long-Term Care Financing Project is funded by a grant from the Robert Wood Johnson Foundation.

Judith Feder and Sheila Burke

Project Directors

Georgetown University Long-Term Care Project

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# **“MEDI-LTC”**

## **A New Medicare Long-Term Care Proposal**

John Cutler  
Lisa M. Shulman  
Mark Litow

### **Goals of the Program**

- To increase the number of individuals with long-term care coverage.
- To offer long-term care benefits at an affordable, lower price.
- To establish a high quality, trustworthy package of long-term care benefits.
- To increase public awareness of the current gap in long-term care coverage.

### **Introduction**

This paper discusses an approach to creating a new Medicare “add-on” product, a voluntary, private, long-term care insurance program that is supplemental to Medicare. This approach is particularly well matched to current societal needs. The primary objective is to increase the number of Americans with long-term care insurance benefits. This is achieved by a combination of increasing awareness of the need for long-term care insurance coverage and improving the trustworthiness and affordability of the product.

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A recent study by Long Term Care Group, Inc. demonstrates that 30% of younger individuals and 62% of retirees believe that Medicare pays for long-term care<sup>1</sup>. Thirty-six percent of the younger group and 19% of the retired group report that they “don’t know” who pays for long-term care. Therefore, increased awareness of the Medicare program by seniors is accompanied by increased confusion about long-term care coverage. Linking public information about the acute care coverage of Medicare with information about the unmet long-term care needs of older Americans is a natural way to improve public understanding of long-term care issues. Therefore, one of the most important elements of this proposal is to fill a new educational niche for Medicare.

Increasing the number of insured persons also involves encouraging healthy people to enter early. By providing incentives for early entry into the program, the burden on social programs including Medicaid and Medicare will be reduced. These Medicare-authorized voluntary long-term care insurance plans will be offered starting at age 50, with new marketing materials sent every five years and the final enrollment mailing at age 65. These repeated government mailings will reinforce the educational message regarding the absence of long-term care coverage in the Medicare program, the cost and benefit options of authorized long-term care insurance plans, the rising cost of long-term care insurance with increasing age, and the risk of developing uninsurable medical conditions or disability with advancing age.

An individual could purchase this coverage at any age, between 50 and 65, if they satisfied underwriting/enrollment criteria. The mailings would be an educational effort to spur them to look closely at these policies and to understand the potential risk of not buying some form of private long-term care protection.

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<sup>1</sup> Long Term Care Group, “Public Attitudes on Planning for Long term Care”, December 2002.

Underwriting would be permissible on all products; therefore individuals could be rejected for coverage. For those individuals who are uninsurable, a useful exercise in the future would be to explore the creation of a high-risk pool<sup>2</sup> or other alternative.

A true open enrollment period (with guaranteed issue or modified guaranteed issue) once every five years, coordinated with the mailings, is also an option, but the potential for adverse selection would need to be considered. This idea is also not included in the current proposal.

We believe that this program can be offered at lower cost than currently available forms of long-term care insurance. As the number of privately insured individuals increases and younger, healthier individuals join the beneficiary pool, premiums will be reduced. Economies of scale should also impact overhead and as more people become insured, the risk of insuring everyone will be spread across a larger population with enhanced predictability of results.

With regard to program design, we do not support product standardization, only minimum standards for coverage. In other words, we want to "standardize" the presentation rather than the product.

We believe that a simple "access" model such as we have presented will substantially increase long-term care insurance sales. It seems odd that Medigap is the private insurance product most closely associated with Medicare, when the gap that most needs coverage is long-term care. Our proposal would address this at the lowest cost and the highest chance of success.

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<sup>2</sup> Alternatively, options as to levels of underwriting, including a one-time to perhaps every five year open enrollment period, could be considered instead of the high risk pool concept. Yet another option would be something like the "service package" that is available in the Federal Long Term Care Insurance Program (FLTCIP) for persons that are declined insurance coverage.

The long-term care insurance market has also suffered due to poor business practices in the past. An air of insecurity and instability continues to hover over this product discouraging potential buyers. Purchasing a product that one hopes to not need for several decades requires a special sense of trust — a sense of trust that federal involvement and oversight can successfully confer.

## **Program Design**

What approaches will achieve the major goals of improved access, affordability and quality of long-term care insurance coverage? This approach proposes a Medicare Long-Term Care (Medi-LTC) benefit that is government regulated but provided by select private long-term care insurers.

Before going into these details, a key feature of this program should be spelled out. This proposal envisions using Medicare's skilled nursing facility (SNF) and home health benefit in a unique way. This will be done via an actuarial credit that will be discussed in greater detail later.

Currently, Medicare pays for claims as they come in, out of money dedicated to Medicare for that year. In contrast, private insurance pre-funds against such risks and costs, and has the ability to save significant sums of money in the long term.

## **Coordination Between Medicare and Medi-LTC**

### **Education and Marketing**

These policies will not fully supplant the current private long-term care insurance marketplace because they will not be as comprehensive in their benefit options as many private plans. If they wish, people may choose to pair private long-term care insurance with the new Medicare-authorized policies. This voluntary Medicare-authorized plan can be envisioned as a core package that can be augmented with supplemental private long-term care insurance as desired.

We propose offering a choice of 3 "simplified" (not standardized) packages, designed to provide a basic minimum standard of coverage. The daily benefit, benefit periods and waiting period will be similar to the packages offered in the Federal Long Term Care Insurance Program, however compound inflation protection will be required in all three packages.

We wish to strike a balance between simplification (for ease of purchase) and not stifling innovation in the marketplace (to encourage quality improvement). Therefore, the three packages represent sound minimum core benefits, however some customizing or tweaking of the benefits will be allowed. Recent experience from the Federal Long Term Care Insurance Program shows that two-thirds of purchasers choose a standard package, and even many "customizers" make only small adjustments.

Our overarching goal is to expand the private long-term care insurance marketplace. Just as a "rising tide raises all boats", the increased awareness of the need for long-term care insurance will increase interest in all long-term care policies. Private insurers outside our program may choose to design supplemental policies for people with specialized needs or more "high-end" benefits in mind. Private insurers would also be able to sell any policy they would like, competing with the plans advertised by Medicare.

For policies inside our program there would be:

- A comprehensive education, marketing and outreach effort will be developed for both new Medicare enrollees and individuals between 50 and 65 years of age.
- Benefit levels would automatically change as Medicare changed, so that total benefits never exceeded the amount purchased in the policy. Before Medicare eligibility, benefits would be paid in full. Benefits under these policies would offset any long-term care Medicaid benefits available.
- These policies are designed to pay before Medicaid and replace any Medicare benefit for long-term care. As Medicare changes its benefit

structure, the payment to the plan by Medicare in the case of selection of the Medi-LTC option would also change, similar to the annual changes that occur now to Medicare Part A.

- One option we would like to explore in this context is a mechanism to reduce the premium and save Medicare money through coordination between the new voluntary long-term care insurance plan and Medicare, by replacing Medicare long-term care benefits by a set amount (to be described later). If dually eligible for Medicaid and Medicare a similar option could be explored but the credit would be much greater. This possibility for the dually eligible population is not explored further in this paper, but can be examined if desired.
- At the age of eligibility for Medicare (age 65) or prior to being Medicare eligible (beginning at age 50), a person may purchase these Medicare long-term care policies — even though Medicare is not covering their acute care. We believe it is inappropriate to encourage people to wait until they are 65. Educational and marketing materials will encourage enrollment during this pre-Medicare period, with incentives of lower cost, level premium policies and avoidance of the risk of onset of costly, potentially uninsurable medical conditions. These purchasers would not receive Medicare coverage before 65, unless they became eligible for Medicare by reason of disability or End-Stage Renal Disease.

Elaborating on this, we propose four distinct enrollment periods at age 50, 55, 60 and 65. Individuals under age 50 and over age 65 will not be eligible with the exception of late retirees with delayed entry into the Medicare program. The goal is to encourage early enrollment. The rationale for limited enrollment periods is that it would:

- maximize the incentive to enroll.

- provide four defined time points for education and advertising the product.
  - foster a younger, healthier beneficiary pool and offset costs of the program.
  - encourage purchasing when policies are more affordable and prior to the development of exclusionary co-morbidities.
- At least initially, persons on Medicare by reason of disability or ESRD would not be included because the underwriting would likely be too tight. In the future, however, it might be useful to explore how these populations might be given access (though an additional subsidy might be necessary in order to do this).
  - Public education and enrollment should be enhanced by marketing of these policies through both authorized carriers and Medicare. Medicare will distribute several supporting publications. One such publication can be analogous to the “Guide to Health Insurance for People with Medicare” (also known as the Medigap Guide) to generally inform the public about long-term care and long-term care insurance. Another publication can be similar to the Federal Employees Health Benefit Program (FEHBP) guide for its health enrollees, with information on approved carriers. Product options may also be included. This will involve some basic formatting of products as well as serving as “validation” of the approved carriers (a “Good Housekeeping seal of approval”).
  - For the most part we envision that insurers will supply materials describing their own products and compliance items (e.g., the National Association of Insurance Commissioners (NAIC) Shopper’s Guide), though these materials would be sanctioned and reviewed by the Centers for Medicare and Medicaid Services (CMS). In this regard it is similar to what the Office of Personnel Management (OPM) does with its carriers (as opposed to how Medicare operates with its carriers), paid for with a small

(in the range of 1%-2 %) administration fee (“load”) to pay for costs. This will allow Medicare to supply information (print materials, website and their toll free number, and so forth). It also means that, in essence, the cost is nominal to the government.

We would also expect that not only would we see increases in sales of long-term care insurance within the program, but the experience of the Federal Long Term Care Insurance Program shows that insurers, and especially agents, were able to use the existence and advertising of the Federal Program as a way to increase their own presence and sales. Given the limitations of our program to persons ages 50-65 there is no reason to assume that we will not see vigorous private market activity above and below that age range, as well as competing policies inside that age interval.

### **An “Actuarial Trade”**

Coordination between Medicare and private long-term care insurance presents opportunities for cost savings. Savings may be possible in part due to an under-appreciated feature of private long-term care insurance; private carriers collect money and invest it over time, whereas Medicare takes current dollars to pay for current claims.

One significant opportunity is establishing a trade between the carriers and Medicare where over the long term both come out ahead. Under this concept, the insurers would pay for all SNF and home health explicitly rather than Medicare paying a portion. But rather than have Medicare recognize this via MSP (Medicare as a Secondary Payor), the savings to Medicare could result in a lower cost for long-term care insurance coverage. Perhaps it would be best to leave the actuarial value to be negotiated between CMS and long-term care insurance carriers or an actuarial formula could be prescribed. A cursory review of long-term care costs under Medicare indicates an annual average of perhaps \$600-\$700 per person per year (in 2002 dollars) for those eligible for the program. The value of these benefits over time would need to be equated with

the present value of necessary risk premiums, with investment income, expense issues and inflation considered, with some allowance for margins for both Medicare and the carriers.

As a general example, assume the average annual long-term care benefit that Medicare will pay averages \$650 over a person's lifetime. Further, assume this is consistent with a 5% inflation rate in long-term care costs, 10% annual decrement rate (mostly deaths), and the value of \$1 decreases by 3.5% per year. Then the present value of future benefits is \$8,362.

In pricing an insurance product, the insurer may use different assumptions but in general, morbidity, cost inflation and decrement rates should be reasonably consistent between insurers. In any case, the insurer would now take the risk on these items if transferred, not Medicare. Relative to the time value of money, the insurer would recognize additional revenue through investment income. The accumulation of investment income and the time value of money would allow Medicare, the insurer, and the consumer to all "win."

In our example, if the insurer made 6.5% investment income on assisted cash flow, then the present value of benefits becomes \$6,267. The difference of \$2,095 (\$8,362 minus \$6,267) is more than sufficient for Medicare to provide an upfront credit of about \$8,000 in order to lower the long range cost. The insurer would need part of this excess amount in exchange for taking the increased risk on the assumptions, which may turn into profit, and whatever additional administrative cost is associated with this coverage. Assuming an 85% loss ratio on this piece, that would produce a cost of \$7,373 (\$6,367 divided by 0.85), leaving the remaining \$627 (\$8,000-\$7,373) for a premium reduction. Obviously, this is only an illustration using hypothetical numbers (pre-tax/with inflation), but we believe this example demonstrates the potential of this concept.

An advantage of this option is that it will encourage people to purchase long-term care coverage since the investment income margin created will result

in lower cost. In the long run, this will mean more savings for Medicare, and perhaps dramatic savings for Medicaid. A drawback to this concept is the short-term cash cost to Medicare. We have not performed any analysis estimating the aggregate cost just as we have not estimated the long-term savings, but clearly the savings by definition will exceed the cost. Please note that the above calculation assumes charges paid by an insurer are at the same level as Medicare or Medicaid.

The fact that insurers have higher charges (in order to make a profit) than Medicare is true based on accounting as done today. Under this assumption, only a social insurance system that had Medicare paying all the SNF and home health costs would zero this out and produce a societal savings. This statement also ignores any difference in quality of care issues. Absent such a solution, we assume savings in that insurer costs ("charges") in our program will be less than in current market private policies since we should achieve the economies of scale targeted by Medicare.

That is to say if one looks at how charges allowed under Medicare compare with charges paid under our program for the same service, the answer will be found in the prescribed daily and other benefit limitations in the policy. What is important here is that insurers will not be required (or even expected) to limit their payments to Medicare fee schedules. On the other hand, we expect if Medicare were to expand coverage then policies would keep up with this.

Alternatively, the actual payments from Medicare to the insurers could be delayed until a future date, such as the earlier date of Medicare eligibility or the date at which a claim occurs, but obviously never before the policy is issued. This would reduce the initial short-term strain on Medicare, but the credit against insurance premiums would be reduced.

Regardless of which way the payment mechanism is constructed, Medicare pays the insurer an amount that is intended to be slightly lower than the amount they pay on average for long-term care benefits as provided by

Medicare today. With this payment, plus a premium paid by the insured, an insurer provides coverage for long-term care services, with cost sharing and other provisions as may be stated in the particular policy.

Medicare coverage for non-long term care events (i.e., less than the HIPAA 90 day rule) would not be effected by the purchase of Medi-LTC. (We should note that not all services are covered by long-term care insurance. For instance, under HIPAA, coverage for a physical disability is provided only when the person is certified as needing help with 2 or more Activities of Daily Living (ADLs) AND this is expected to continue 90 days or more. BUT if the health care provider does certify this, it means long-term care payments could start at day 1 rather than after the three day prior hospitalization rule Medicare would otherwise employ. And in the case of cognitive impairment, this 90 day certification rule does not even apply.)

The program is designed so that the government is not providing an additional subsidy on average (as compared to today); the intent is to save the government a little money. However, the government is still subsidizing coverage. This program is intended to operate more like a Medicare Risk Contract, except that additional long-term care benefits would be provided, in addition to what Medicare provides, since Medicare provides limited long-term care benefits. Payments to the insurer would be made monthly.

### **Other Potential Savings**

One potential area of savings is that all of these policies will automatically be integrated with Medicare so that no overlapping coverage exists, at least as far as SNF and home health are concerned. This provision is consistent with qualified long-term care policies, but non-qualified policies do allow for overlapping coverage. To the extent people make use of these Medi-LTC policies instead of non-qualified coverage, some savings should be realized, since utilization with overlapping coverage is generally higher and higher premiums are required.

We also expect savings to Medicare to some extent due to the design of long-term care insurance. For instance, a recent Alzheimer's Association report on care coordination illustrates why we believe long-term care insurance would save Medicare (especially the fee-for-service part) money. Their analysis shows that nearly 10 percent of elderly Medicare beneficiaries have dementia and this costs Medicare three times more than other elderly beneficiaries (\$13,207 versus \$4,454 annually). The largest part of this cost is for hospital care that could have been avoided had care coordination (a feature in long-term care insurance but not Medicare) been employed.<sup>3</sup>

For Medi-LTC policies, it is estimated that overhead will be substantially reduced - perhaps in the range of 15%-20% — due to a reduction of insurance agent compensation, marketing and profit margins. Overhead will likely be reduced since marketing efforts by Medicare should allow carriers to reduce their marketing and commission (compensation) costs for these products.

Another potential area of Medicare savings is the possibility of this program resulting in lower Medigap sales, as people allocate more dollars to long-term care insurance and less to Medicare supplements with the result of lower Medicare utilization. We believe this is a reasonable outcome of an aggressive education and marketing effort given that people are paying somewhere in the range of \$1,200-\$1,500 a year on Medigap policies. In other words, it is likely that additional Medicare “savings” would be realized when people give up Medigap coverage for long-term care insurance. Of course, some of these savings will be needed to cover any additional Medicare costs associated with this program.

One reason for believing the Medicare supplement experience is relevant is the preponderance of persons over age 65 who have coverage in addition to Medicare. Roughly two-thirds of the age 65 plus population have some form of

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<sup>3</sup> Alzheimer's Association, "Alzheimer's Disease and Chronic Health Conditions: The Real Challenge for 21st Century Medicare," June 2003.

coverage that supplements Medicare. Yet the risk represented by the cost of claims emanating from this additional coverage is modest compared to the risk represented by the long-term care gap.

Recent data shows average Medigap premiums are \$1,562 per year. New policies run \$1,248 per year.<sup>4</sup> Since policyholder switching is not a feature in the market, these lower premiums are likely to reflect age 65 purchasers (the first time they can buy if not on Medicare for reason of disability). Because Medi-LTC marketing will begin long before age 65, it is likely that sizable amounts of this Medigap premium flow (\$2.3 billion) would be diverted to long-term care insurance. This is especially true of the population that has purchased individual Medigap coverage (at least a quarter of the total Medicare population).

We believe that better access to long-term care services, particularly home health services, will in the long term reduce the need for hospital services by seniors to a degree. We are simply pointing this out, but not expecting any recognized cost savings as part of estimates of long-term care costs.

Work done for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in U.S. Department of Health and Human Services shows Medicare savings due to the use of private long-term care insurance.<sup>5</sup> Their report shows that individuals who are receiving private long-term care insurance payments:

- are less likely to access Medicare financed home health aide services; and
- have fewer visits and lower expenditures (i.e. \$2,400 lower) for home health aide services.

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<sup>4</sup> Life Insurance Marketing and Research Association (LIMRA), "2001 Group and Individual Medicare Supplement Premiums."

<sup>5</sup> Miller, Dimitrova and Cohen, "The Impact of Private Long-Term Care Insurance Benefits on Selected Medicare Services" (March 12, 2002).

(On the other hand, the study showed that persons using private insurance are just as likely to use Medicare skilled nursing services and have roughly similar expenditures; and use similar levels of facility-based skilled nursing services and inpatient hospital care.)

## **Highlights of the Program**

We believe a major strength and advantage of this proposal is its potential to result in a dramatic expansion in the long-term care insurance market over a relatively short period of time. Increased enrollment is anticipated to result from a combination of education, marketing and enhanced affordability. In particular, we anticipate not only expanded enrollment, but also enrollment by younger and healthier purchasers. Lower costs are anticipated due to a larger single pool of policyholders, reduced overhead, and potential savings due to investment income and better integration of various forms of long-term care coverage.

## **Potential Features of a Coordinated Advertising/Marketing Campaign**

- Our goal is to offer this program at a monthly cost that is targeted for middle class purchasers who are ineligible for Medicaid unless they deplete their assets, but do not have adequate assets to cover the average costs of long-term care. Educational materials should specifically address the income/asset range that is at greatest risk, as well as the issue of asset protection for Americans with abundant assets.
- Government mailings will be sent from CMS (and perhaps Social Security as part of their retirement mailings) to people approaching ages 50, 55, 60 and 65 years to educate this segment of the public and alert them to their eligibility to buy into the program. Repeated mailings every five years will reinforce the educational concepts and alert the potential buyer to the impact of advancing age on both the cost of the policy and the risk of chronic medical conditions. The final offering will be at the age-65

enrollment period in order to incentivize demand at what is still a relatively younger and healthier age for this sort of product.

- Even though there is underwriting, an alternative that might be considered is to have a limited open enrollment period every five or so years to further encourage enrollment. However, adverse selection considerations must be evaluated before this alternative is used, due to the potential for higher costs. Access restrictions also reduce conflict with the market outside the Medi-LTC Program.
- Medicare’s “seal of approval” coupled with a coordinated public education program regarding the risk of long-term care would provide further incentives.
- The “carrots” to attract purchasers include low cost and anticipated level premiums not increasing with age, but with solid underwriting. However, insurers could be encouraged to offer a policy that guarantees rates for some period of time, or even permanently, though this feature would add significant cost to the product and should not be necessary if sound actuarial rules are employed in the first place.
- Participation in the Medi-LTC program will be voluntary, both for insurers and for the public.
- Mailings and other educational initiatives will inform people of Medicare’s lack of coverage for long-term care so even those who choose not to buy insurance are more aware that they need to plan for this risk.
- While the federal government would play an important role in public education and marketing, there are advantages to capitalizing on the experiences of the private sector in these areas. Therefore, the approved insurance carriers in the program will also engage in a coordinated marketing effort.

## Other Program Specifics

In terms of product design, our broad objective is to develop a core group of high-quality, dependable policies that meet basic needs rather than providing “bells and whistles.” These provisions include:

- Guaranteed renewable/fully portable — individuals may retain all insurance coverage they have bought even if they exit the program or it ends, as well as use it in any state, or overseas.
- Lower premiums — affordability is enhanced by leveraging the value of current long-term care benefits, thus creating incentives for enrollment, and expanding the long-term care insurance market.
- Inflation Protection — the program we envision will have compound inflation protection, but an indexed inflation option might be considered instead of a fixed option such as 5% or perhaps a graded inflation option.
- “Pool of Money” — the total maximum benefit of the policy can be used for nursing home, assisted living facility, home care, adult day care, or other similar long-term care services as needed.
- Other important options that may be considered include spousal discounts that encourage both spouses to buy protection. Married couples have lower costs over their lifetime due to a number of factors including the ability of a healthy spouse to care for the one that would otherwise be in claim earlier or more often.<sup>6</sup>

The cost of the policy is based upon the age at enrollment and choice of plan level. Underwriting should be at the discretion of the insurer. The beginning benefit package will be spelled out, but the pilot will have the flexibility to allow

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<sup>6</sup> We envision these sorts of options would be subject to minimum standards established by the program. An option such as a spousal discount is one we would certainly like to encourage, since differences in morbidity between married couples and single individuals is very significant. (In this context, morbidity would include “utilization,” with utilization being the change in the intensity of the service or number of visits or length of stay, but not the incidence per se.)

modernized packages in the future without requiring Congressional intervention. Modernization may be required to accommodate changes in health care delivery or changes in the Medicare or Medicaid programs. Such changes could occur as often as CMS and the insurers believe necessary, perhaps annually. If so, premiums may also have to change if the change in coverage was substantial; this is what happens with Medicare Supplemental insurance. We would encourage updating of policies as appropriate to reflect changes in the environment; failure to do so will eventually create serious equity situations. However, existing policyholders – since they hold guaranteed contracts – may simply be offered the choice of updating their coverage or staying with their original plan.

Other important aspects standing behind the program:

- Tax qualified based on HIPAA — providing for triggering of the policy when a person has either a severe cognitive impairment or inability to perform two out of six ADLs for a period of at least 90 days.
- NAIC standards — we follow the NAIC’s latest model that includes rate stabilization language and contingent nonforfeiture. This means prices will be set according to NAIC rules as to insurers pricing using “moderately adverse assumptions.” Not only does this mean better pricing on the front end, but with the NAIC provision for contingent nonforfeiture if a price increase occurs over a certain amount it also provides some back-end protection.

## **Strengths and Weaknesses of this Proposal**

### **Major Strengths**

- An educational program to substantially raise awareness about long-term care risks and costs that will increase public debate on these issues.
- The capacity to dramatically increase the number of Americans with long-term care insurance.

- The ability to reduce pressure on long-term care costs under Medicare and Medicaid.
- Providing a needed boost to the private long-term care insurance marketplace.
- Establishing significant savings accounts over time that will create an accumulation of investment capital.

### **Weaknesses**

- The possible short-term cost of funding optional benefits, i.e., whether a supplemental market might grow up around the Medi-LTC product just as Medigap has around Medicare.
- The administration of a new system, including new federal involvement.
- Undercutting the Medigap marketplace.

### **Conclusion**

This “Medi-LTC” proposal achieves several important objectives:

- Offers long-term care benefits at a more affordable price.
- Establishes a high quality and trustworthy package of long-term care benefits.
- Substantially increases the number of Americans with long-term care benefits.
- Reduces reliance on Medicaid, Medicare and other social programs for long-term care needs.
- Launches a comprehensive public educational program regarding the current gap in long-term care insurance coverage, the high cost of long-term care services, and the significant risk of the onset of disability requiring long-term care in the future.

The Medi-LTC program relies on a different paradigm for long-term care insurance. The program we have designed capitalizes on the success and trust engendered by the Medicare program, but is a private long-term care insurance program. It recognizes that the answer to today's problem of long-term care requires both public and private solutions. In contrast to Medicare, this program leverages the time value of money. One of the significant deficiencies of social insurance as we know it today is that it is designed only for acute care needs, not chronic care or long-term care needs. To meet the needs of long-term care, we must collectively invest early and aggregate the investment income to be prepared when the need arises.

The growing numbers of elderly related to population demographics and increased life expectancy place us at a critical point in time. If we do not fundamentally expand long-term care insurance access and affordability now we will miss the chance to create a solution that uses the time value of money. We cannot afford to wait.



Georgetown University Long-Term Care Financing Project  
*Working Papers*

- No. 1 **Medi-LTC: A New Medicare Long-Term Care Proposal**  
John Cutler, Lisa M. Shulman, and Mark Litow
- No. 2 **The Life Care Annuity: A Proposal for an Insurance Product Innovation to Simultaneously Improve Financing and Benefit Provision for Long-Term Care and to Insure the Risk of Outliving Assets in Retirement**  
Mark J. Warshawsky
- No. 3 **Forced Savings as an Option to Improve Financing of Long-Term Care**  
James Knickman
- No. 4 **Long-Term Care Policy Option Proposal: Consumer Controlled Chronic, Home, and Community Care for the Elderly and Disabled**  
Marty Lynch, Carroll Estes, and Mauro Hernandez
- No. 5 **A Federal Catastrophic Long-Term Care Insurance Program**  
Christine E. Bishop
- No. 6 **Linking Medicare and Private Health Insurance for Long-Term Care**  
Anne Tumlinson and Jeanne Lambrew
- No. 7 **A Trade-Off Proposal for Funding Long-Term Care**  
Yung-Ping Chen
- No. 8 **A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge**  
Leonard E. Burman and Richard W. Johnson

**About the Project**

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is funded by a grant from The Robert Wood Johnson Foundation. More information about the project and other publications can be found at <http://ltc.georgetown.edu>.