

GEORGETOWN UNIVERSITY
Long-Term Care Financing Project
ltc.georgetown.edu

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
*Watson Wyatt Worldwide
Arlington, Virginia*

Working Paper No. 2
*Georgetown University Long-Term Care Financing Project
June 2007*



Health Policy Institute
Georgetown University
3300 Whitehaven Street, Suite 5000
Washington, DC 20057
(202) 687-0880
hpi.georgetown.edu

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. 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

June 2007

Contents

Executive Summary.....	1
The Contingency Need for Long-Term Care Insurance	3
Crowding Out by Medicaid.....	4
The Current Market for Long-Term Care Insurance	6
Objectives of the Proposal for the Financing of Long-Term Care	9
Length of Life Uncertainty, Life Annuities, and Pension Plans	12
Objectives of the Proposal for the Distribution of Retirement Funds	13
Description of the Proposed Product Innovation.....	14
Potential Scope for the Product Innovation.....	18
Benefit Design Variations	20
Adaptation for Partnership Plans.....	22
Strengths of the Proposal.....	23
Limitations and Challenges of the Proposal and Possible Roles for Public Policy	24
Current Combined Insurance Products and their Impediments.....	28
Conclusion	29

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

Executive Summary

The proposal in this paper is meant to further the development of private insurance as a means for financing long-term care for most retired households, while simultaneously encouraging the use of voluntary immediate life annuities as a distribution mechanism for retirement plans and support for consumption during retirement. It does this through an insurance product innovation, the single-premium immediate disability-escalating annuity, "SPIDEA," which builds upon past product developments in the long-term care insurance (LTCI) and annuity markets. The SPIDEA, or as I would call it for marketing purposes, the life care ("TLC") annuity, integrates the life annuity and LTCI. In return for payment of a lump-sum premium to an insurance company upon retirement, steady periodic income payments, perhaps inflation-adjusted, are made for life to a household; the payments are increased substantially when a member of the household is disabled to an extent that would typically cause extra expenses for some long-term care to be incurred, and are increased even more when the household member is totally disabled. Past empirical research has shown that, compared to the two components of an immediate life annuity and LTCI sold separately, an integrated product can be offered somewhat more cheaply to a larger population that includes people in relatively poor health at the time of

Mark J. Warshawsky, Ph.D., is Director of Retirement Research at Watson Wyatt Worldwide in Arlington, Virginia. This paper was written in Fall 2001 while the author was a Visiting Researcher at the National Bureau of Economic Research offices in New York, New York, and was revised in 2003.

retirement — a substantial group of individuals who currently cannot now purchase any LTCI at any price. A key advantage of this particular approach, which is timed for those nearing retirement and actually retired, is that it does not demand that households make risky and unlikely purchase decisions regarding LTCI early in their life cycle — the alternative approach advocated by some to get around the significant underwriting problem of insurance offered at older ages.

It is admitted that the SPIDEA cannot serve the needs for LTCI coverage for all populations, especially poor retired households. Nevertheless, its potential scope is quite large, including households covered by pension plans, with all types of financial assets (both qualified and after-tax), owning small businesses, with owner-occupied housing (accessed through reverse mortgages), and, potentially in the future, with personal accounts available under a reformed Social Security program. Hence, it is claimed that this innovation could significantly improve the economic security of most retired households, substantially reduce dependence on the public means-tested Medicaid welfare and Medicare social insurance programs, provide competition to current offerings of LTCI and life annuities, and encourage appropriate product innovations to be available if and when Social Security personal accounts are created. Several variations are possible in product design, both in the provision of long-term care benefits and income annuity benefits, and in the level of benefits provided, for example, varying by geographic location. The product can also be designed to fit into state or national Medicaid partnership plans.

A few enterprising and imaginative insurance companies in the United States and United Kingdom have introduced products with some similarities to the SPIDEA, with varying degrees of success. Some or several changes in public policy could significantly increase the demand for the product, especially through pension plans, and, by reducing the risk to the issuing insurers,

increase the supply. These possible policy changes include the removal of regulatory impediments, the creation of tax accommodations (“level playing field”) or advantages, the encouragement of demonstration projects, and the collection of comprehensive nationally representative data sets on disability rates and costs among the elderly.

The Contingency Need for Long-Term Care Insurance

In a free market system, demand for insurance by a household or business and supply by an insurance company is a natural economic response to a contingency that is random to the potential insured, largely uncorrelated with other risks, has stable statistical properties, and is economically significant. For example, historically, as the need for, and the efficacy and cost of, health care increased at the beginning of the twentieth century, individual health insurance contracts were created. These contracts provided protection to households facing growing and significant risks to their financial and physical well-being arising from the statistically random need for expensive medical treatments and extended hospitalization. Owing to a sense of mutual concern, benefit, and responsibility at workplaces, as well as adverse selection problems (explained below) in individual contracts, employer-sponsored group health insurance plans for workers became widespread and the predominant form of coverage in the 1940s and 1950s. Finally, the federal and state governments stepped in, in the 1960s, to fill in the coverage gaps for the poor and elderly, who were left behind by the rapidly developing health care and insurance systems. Obviously, the benefit design, pricing, regulation, tax treatment, private/public mix, and so on, of health insurance have changed over time. These changes have occurred largely in response to changes in the nature, production, cost, and delivery of health care (sometimes induced by the general availability of insurance coverage), as well as in response to changes in social and economic conditions and preferences.

Like health care historically, long-term care is now a significant and increasing expense that affects a statistically determinable, and growing, percent of the population, especially the aged, for some uncertain amount of time in their increasingly long lives. The nature of long-term care provision is becoming more varied, and, as families become more geographically dispersed, it is more difficult to obtain care through informal family networks. Logically, one would expect the same primacy of private sector insurance solutions supplemented by government programs to occur in the long-term care area, despite its logical connection to an older working and retired population. But, in fact, the reverse has happened: federal and state governments are the original and still primary providers of financing for long-term care, and the market for individual and employer-sponsored LTCI has begun to develop only recently with improved benefits and stable or slightly declining average premium rates. Government budgets for Medicaid and Medicare are growing rapidly and are forecast to consume larger and larger shares of public spending. This state of affairs has caused some frustration with both the current public and private sector solutions to financing long-term care, as explained immediately below.

Crowding Out by Medicaid

Medicaid, a welfare program jointly sponsored and financed by the federal and state governments, has been and is currently the primary payer for long-term care, especially nursing home care. Medicare, the federal health insurance program for the elderly, is a significant source of funding for many types of home care. Medicaid and Medicare, as government programs, are funded through income and payroll taxes, which may have dead-weight losses associated with them, and tend to be fairly stodgy in design and bureaucratic in administration.

In order to become eligible for Medicaid, according to the rules, a household must essentially have limited income and financial assets; that is, it

has to “spend down” to get benefits. The household is not required to sell its primary residence to qualify for Medicaid until the surviving member of the couple enters a nursing home for an extended period of time. Even if this survivor did not receive nursing home care funded by Medicaid, if her or his spouse had earlier received Medicaid benefits, after the survivor's death, the state government can collect the value of the Medicaid benefits from the estate including the value of the home. This seems to be a messy business and it is unclear how often the state invokes its rights. If the household has LTCI, it gets no “credit” for the resulting savings to the Medicaid and Medicare programs, except in those few states with "partnership" programs and then only if the LTCI policy is explicitly designed with a particular state partnership in mind. If the household moves to another state, the partnership provisions cannot be used.

The spend-down feature of Medicaid is arguably not consistent with the dignity and the financial security of the aged and their families, and discourages self-reliance, saving, and thrifty planning. It, as well as inadequate annuitization of retirement assets, may help explain the sharp increase in poverty rates among the oldest old, who are predominately women, compared to younger retired households. Spend-down also creates incentives for households' taking actions, legal and perhaps illegal, to hide assets or transfer them, despite the existence of rules and some enforcement mechanisms to control and police this type of activity. A recent attempt at federal action against estate transfer schemes was the so-called “granny goes to jail” law, now repealed. More broadly, means-tested welfare programs used by the majority middle-class population of this country may be thought to nurture a culture of disrespect for law and government.

Long-term care coverage by government programs, obviously, largely cancels the need for private insurance for most households, except for those with a strong desire and ability to avoid the restrictions of the Medicaid

program on the kind of care provided or on the amount of asset holdings allowed. Hence, the demand for LTCI is now currently logically limited to knowledgeable forward-looking upper middle-class households in good health, especially elderly female individuals, with significant asset holdings, but also with a desire to leave significant bequests to children or charities with some certainty. For example, let's suppose a retired couple getting Social Security and a modest pension income had \$150,000 in net worth (mainly the value of their home), and no special preferences for a bequest or any particular type of long-term care. Why should they purchase LTCI? If they are disabled before their financial net worth has been spent, they will use up their financial net worth to pay for long-term care and can then rely on Medicaid if their need for care is severe and lengthy. If they are disabled after their financial net worth has been spent, say when they are very old, they know that they can immediately rely on Medicaid. Indeed, even if the couple has a strong bequest motive, if they can manage to employ estate transfer techniques or they know the state will not go back to attach their house, Medicaid is still a good insurance coverage option.

The Current Market for Long-Term Care Insurance

As the financial situation of the retired elderly population has improved, especially with the run-up in financial asset values and housing prices in the last decade, the demand for LTCI has increased, and it has allowed the market to grow and develop, albeit initially slowly and cautiously. Also, federal legislation passed in 1996 gave LTCI an important clarification that policy benefits would not be taxed as income. It also led to the standardization of benefit design, in turn leading, according to many industry analysts, to more efficient competition in the marketplace. Despite these improved conditions, it is estimated that in 2001 only about 16 percent of elderly (above age 65) households with incomes above \$20,000 (the income suitability level

determined by the National Association of Insurance Commissioners) have private LTCI.

Primarily, agents representing commercial insurance companies sell LTCI mainly to individuals or couples. Some insurers sell policies through the mail or over the internet or through senior citizen organizations and fraternal societies. Also some employers make LTCI available to their employees and their families, although it is rare for the employer to pay any share of the premium cost and even rarer for the employer to self-fund the long-term care benefit, as is sometimes done in health benefits. The federal government has recently started offering its employees, retirees, and their families a menu of comprehensive long-term care policies, but with no government payments toward the premiums, issued by a consortium of two large insurance companies.

Most LTCI policies currently cover expenses incurred, up to (daily, weekly or monthly) dollar limits chosen in advance by the policyholder, for eligible services received in a nursing home or through assisted living or home care. Generally, home care provided by family members is not covered. Most policies base the insured's eligibility for benefits on his or her inability to perform at least two activities of daily living (ADLs) such as bathing, dressing, and so on, or on serious cognitive impairment. These are functional and measurable guidelines, unlike subjective criteria, such as medical necessity, which were sometimes used in the past. One or two companies offer policies where payments for disability are made, triggered solely by the insured's clinically proven disability and not dependent on actual long-term care expenses incurred.

Most LTCI policies have a total maximum benefit they will pay out over the length of the policy's duration; this amount is generally determined by multiplying the selected benefit period, say three years, by the, say, daily benefit level multiplied by 365. Most policies, however, offer the choice of

unlimited lifetime benefits in addition to specific benefit periods of various lengths. Logically, unlimited lifetime benefits are most protective of the risk of catastrophic cost of a low probability event, say, ten years in a nursing home, but this option is not usually chosen by insureds. Typically, insurers offer a choice of periodic benefit amounts or limits (usually \$50 to \$250 a day or \$1,500 to \$7,500 a month) for nursing home, and a half or some other significant percentage of that amount for assisted living and home care. (The cost of nursing homes and home care varies significantly by the geographic location of care, which explains the need for a wide range of choice in benefit levels.)

With most policies, benefits don't begin the first day of expense incurred; rather, a pre-selected elimination period, such as 30 or 90 days, must first pass. Most policies also offer the option of inflation protection, at a pre-set rate, generally 5 percent — the inflation rate thought to exist currently in the cost of nursing home and home health care. Also, most policies offer the option of a non-forfeiture benefit, whereby some of the investment (through the annual premiums paid) in the policy is returned if the policy is dropped years after beginning premium payments. All LTCI policies are guaranteed renewable, that is, the insured is guaranteed the right to renew his or her policy annually regardless of attained age, health status, or claim experience.

Obviously, the premium cost of the policy will depend on the benefit levels, elimination periods, and other options chosen, as well as on the age of the insured when the policy is purchased. Currently, premiums do not depend on the gender of the insured, despite some evidence that women have higher expected present values of claims. Premiums are paid periodically, generally every quarter, and are fixed with the initial age of the insured. The insurance company, however, is allowed to raise rates for a class of policies if the state insurance regulators determine that claims are being paid in greater amounts and frequency than initially expected and premiums are insufficient.

The right to raise premiums for a class of policies has been used in the past by some smaller and younger companies. Their larger and older competitors have expressed a concern that these companies were somewhat reckless in pricing, or intentionally underpriced their policies initially to gain market share with the expectation that prices could later be increased. Furthermore, the price increase action has caused some insureds to drop their coverage as too expensive, increasing the profitability of the line of business, as most policyholders do not select a non-forfeiture option. There has been a regulatory response by the states to this type of behavior by companies, but it is cumbersome and adds to the general cost of doing business. The trend recently, however, has been toward more stability in pricing and lower and lower lapse rates; in many cases, in fact, lapse rates are significantly below insurance companies' assumptions used in initial product pricing. A few companies are now issuing "limited pay" policies, where the policy is paid up after only a discrete number of years of premium payments, say the ten years between ages 55 and 65. This form of policy reduces the extent of strategic games through post hoc price changes that insurers may play, and provides better protection to the insured, but increases the risk to the insurance company of unexpected trends in disability. To my knowledge, no insurance company currently offers a single-premium LTCI policy.

Objectives of the Proposal for the Financing of Long-Term Care

In a voluntary individual insurance market, if coverage is not widespread, a significant problem can arise from adverse selection, that is, the natural tendency of those individuals most likely to need the benefits to purchase the insurance policies being offered. If the insurance company cannot, or is not allowed to, see the characteristics of the potential purchasers that would predict above average usage, then the following outcome is likely: only a policy with high premium rates will be available to those most likely to need care. To avoid this scenario, therefore, before issuing policies, insurance companies try

to collect relevant information through an underwriting process about the likelihood of individuals making claims. With this information, the insurer denies coverage to some, limits coverage for certain conditions to others, and charges higher premiums for full coverage to still others.

In the instance of LTCI, underwriting is taken quite seriously: detailed health and lifestyle information is gathered through an extensive and seemingly expensive and difficult process. Theoretically this information could allow the insurer to price policies at various levels to all groups in the population. In LTCI, however, the information is currently used to determine placement of the insured in one, two or at most three price categories, as well as complete rejection of the issuance of insurance for many individuals. In fact, in LTCI, reported evidence from industry experience indicates that about twenty percent of the population applying for insurance are actually rejected and cannot get any private LTCI coverage at any price. A simulation study, which also includes individuals in poor health who would not even bother applying for insurance, estimates that about a quarter of the population is uninsurable at age 65 and a third at age 75.

In response to the adverse selection/underwriting rejection problem, the insurance industry has recently been encouraging purchase of LTCI at younger ages, where health issues are not as likely to be present. A potential problem with this response, however, is that the nature of long-term care is constantly changing, and most policies, of necessity to protect the issuing insurer and the insured, must express their benefit terms in a fairly specific manner. Hence, older policies can become less valuable over time in the sense that they might not cover current forms and methods of care. Furthermore, the industry solution of early pre-retirement purchase represents a significant marketing challenge, as most young and even middle-aged people would prefer not to deal with issues surrounding long-term care, an admittedly depressing subject. And potential insureds must trust the issuing insurance company to survive several

decades into the future. Of course, early purchase does provide coverage in those cases, fairly rare, of working individuals where long-term care must suddenly be obtained at pre-retirement ages.

Another concern sometimes expressed about LTCI is that it is “expensive.” This expression sometimes is used simply to say that the insurance costs a lot of money. But if the policy is fairly priced, then the concern should not be with the insurance per se, but rather with the expected cost of the benefits, which is a broader structural and societal, not an insurance industry, issue. Sometimes, however, the concern is more nuanced — that the insurance is overpriced relative to the expected benefits to be provided by the policy, or stated another way, that the policy’s “money’s worth” is poor. There is no direct evidence on this latter concern, although there is currently no indication of substantial profitability in this line of business, as individual insurance companies enter and exit the business.

In response to the current state of affairs described above, my proposal’s two broad objectives for the financing of long-term care are as follows:

1. Reduce significantly the dependence on public welfare programs for long-term care by middle-class elderly households, reduce poverty rates among the older old, especially women, and increase significantly the use of private insurance products;
2. Improve the functioning of private LTCI markets, by making a viable and innovative insurance product available in many forms and venues, the pricing of policies more stable, the benefits continually relevant to changing conditions of care, the benefits more flexible to fit various family situations, all benefits essentially to be non-forfeitable for the insured’s lifetime, encourage purchase at or just somewhat before the relevant retirement ages, encourage and reward product innovation, and

most importantly, that insurance be made available to as many people as possible, despite their potential poor health status and adverse lifestyle.

Length of Life Uncertainty, Life Annuities, and Pension Plans

Another contingency facing retired households is how long they will live and whether their finite retirement funds will be sufficient to finance consumption needs over a possibly long remaining lifetime. The insurance product that has arisen in response to this contingency is the life annuity. Like the progression of health insurance coverage, insurance companies originally issued fixed life annuities to individual households, but then employers sponsored pension plans that provided life annuity income through a mandatory group mechanism to retired workers and their spouses. The adverse selection problem prevalent in voluntary annuity markets (described below) was thereby minimized; furthermore, the moral hazard of retired employees' quickly spending pension assets and being left impoverished was thereby avoided. At the same time that pension plans were becoming more common, the federal government created the Social Security program, which now provides an automatic inflation-indexed life annuity to nearly all retired workers and their spouses.

More recently, as the predominant type of pension plan has changed from the defined benefit to defined contribution form, and as asset markets have performed remarkably well, there has been a movement away from mandatory annuitization or even the offering of life annuities in pension plans. Similarly, current discussions and many prominent proposals for Social Security reform advocate the creation of personal accounts where voluntary annuitization would simply be one distribution option available among many options, including lump-sum payments. There are many good policy reasons for this shift, including increasing the ability of poor and middle-class households to pass on wealth to their children, and fairness to minority groups, which typically have shorter life expectancies. Nevertheless, this movement

should be tempered by a concern that as the average life expectancy of the population increases, the variance of life expectancy also increases and with it the risk of a lengthy and impoverishing retirement lifetime.

Objectives of the Proposal for the Distribution of Retirement Funds

Like other insurance products, the life annuity, sold in a small voluntary market to individuals and couples, is subject to adverse selection. In this particular instance, adverse selection occurs when only those with the longest life expectancies purchase life annuities, causing insurers, in equilibrium, to charge higher premiums than would be needed than if the "general" population were the average purchaser. Underwriting could theoretically solve this problem, with life annuities issued to individuals identified as being in poor health costing less. This does occur to a limited extent with "impaired life" annuities, but it is awkward and expensive to pursue on a large scale with many population groupings. Indeed, a substantial body of empirical research, much of which I have authored or co-authored, has demonstrated quite convincingly that adverse selection is present in the market for individual immediate life annuities.

Because of adverse selection, life annuities might be considered "expensive" for certain segments of the population, particularly those in poor health. This may explain, in part, why, outside of Social Security and many defined benefit pension plans, life annuities are not used widely as a distribution mechanism for retirement assets. In fact, most 401(k) plans do not even offer the life annuity as a distribution option. It is also thought that life annuities are not popular because they reduce considerably the financial flexibility of households to respond to emergencies and contingencies that might occur during retirement, including the need for costly long-term care, and reduce the amount of assets available as a bequest to children.

In response to the current state of affairs described above, my proposal's one broad objective for the distribution of retirement funds is as follows:

- Increase the popularity of immediate life annuities in various venues by improving their fairness to various populations and their flexibility, and to lower their price by reducing adverse selection, while still allowing for a bequest.

Description of the Proposed Product Innovation

The product design I propose here is a close variation on one that two co-investigators and I have examined empirically.¹ The new insurance product would be a life annuity with payments that increase upon the determination of severe chronic disability or cognitive impairment of a member of the insured retired household.

A special annuity issued to almost any recently retired individual or couple upon payment of a lump-sum premium could take the form of a "SPIDEA," that is, a single-premium immediate disability-escalating (life) annuity. For example, consider the following SPIDEA benefit levels. The insurance company pays \$1,000 a month for the life of the insured with a guaranteed ten-year minimum payout. This immediate life annuity is then combined with LTCI-like coverage. If the insured has been cognitively impaired or chronically disabled in at least two ADLs for at least 90 days, there is payment of an additional \$2,000 a month. If the insured has been chronically

¹ I first put forward the proposal in 1997; the empirical investigation was done jointly with Christopher Murtaugh and Brenda Spillman in 1999 and 2000, and is still ongoing. See Mark Warshawsky, "Annuity Redesign: Proposing Flexibilities in Payout Arrangements," in Dallas Salisbury, editor, *Retirement Prospects in a Defined Contribution World*, Washington, D.C.: EBRI, 1997, pp. 143-144. And see Christopher Murtaugh, Brenda Spillman, and Mark Warshawsky, "In Sickness and In Health: An Annuity Approach to Financing Long-Term Care and Retirement Income," *Journal of Risk and Insurance*, 68(2), June 2001, pp. 225-254. (The latter paper won a prize competition sponsored in 2001 by the British Institute of Actuaries.)

disabled in at least four ADLs for at least 90 days, \$2,000 more a month is paid. Thus, for example, a 65-year-old individual would receive \$1,000 a month (\$12,000 a year) in income benefits for life; if she died before ten years had passed, her heirs would receive those monthly payments until the insured would have turned age 75. If the individual became chronically disabled, she would receive \$3,000 a month (\$36,000 a year) for as long as her disabilities were severe (and therefore likely to need home care or assisted living). She would receive \$5,000 a month (\$60,000 a year) for as long as her disabilities were extremely severe (and therefore likely to need to live in a nursing home).

These disability benefit levels (that is, \$2,000 and \$4,000 monthly for the two levels of disability, respectively) are patterned after the provisions and benefit levels of many LTCI policies issued in urban areas, with home care typically covered at half the daily benefit amount selected for nursing home care. A daily nursing home rate of \$133, a reasonable and empirically relevant amount for a LTCI policy, would therefore broadly match our basic SPIDEA policy. (Currently, the average daily benefit amount selected in newly issued LTCI policies is about \$115 a day.) The SPIDEA's lifetime disability benefit design, however, is considerably more flexible and protective than most current LTCI policies. It is also natural to envision an inflation adjustment option to the SPIDEA, whereby income benefits would increase by, say, 3 percent a year, and disability benefits would increase by 5 percent a year. Inflation-adjusted Social Security benefits typical for middle-class individuals or couples are currently just below \$1,000 monthly. Combined with Social Security, SPIDEA benefits at the levels described above should be sufficient and appropriate to cover basic consumption needs in retirement for most middle-class households whose home mortgages are paid off. The SPIDEA benefits described above should also be enough to cover contingent home care and nursing home care costs in many regions of the country.

I envision that this product could be made available to almost anyone near or beginning retirement, regardless of his or her health status and lifestyle. Indeed, the product will be more successful if individuals in poor health or with adverse lifestyles purchase it. Individuals who upon purchasing the SPIDEA would immediately claim disability benefits, however, would have to be excluded from the possible purchase groups through some minimal underwriting; otherwise, the SPIDEA would be too costly and adverse selection could result. But, according to our empirical simulations, at age 65, only 2 percent of the population would be excluded, and at age 75, only 5.5 percent would be excluded, compared to more than 20 percent under current LTCI underwriting practice. Because disability rates increase rapidly beyond age 80, it probably makes sense to limit issuance of the SPIDEA to those households whose members are under 80 years of age. Those individuals who would immediately claim disability benefits could still be issued SPIDEAs if the minimum elimination period of their policies was long, about three years.

In empirical work, we priced the SPIDEA on a unisex basis because we thought that employer-sponsored pension plans would be among the primary venues for this product, and federal law prohibits gender-distinct pricing of employee benefits. Unisex pricing could conceivably lead to some adverse selection in a voluntary SPIDEA market, as women live longer and have more severe and longer disabilities. Because most households enter retirement as married couples, however, most SPIDEAs presumably would be issued as joint-and-full-benefit-to-survivor annuities, and therefore adverse selection arising from unisex pricing might be limited in extent. Furthermore, lengthy guarantee periods for the income annuity benefit would improve the fairness of SPIDEAs to male individuals.

The empirical work we have conducted shows that an integrated product like the one proposed above could be offered at a total premium of about 3.5 percent less than a single-premium immediate life annuity and single-premium

long-term care disability-based insurance policy sold in separate markets. This savings arises from the availability of LTCI-like benefits with only minimal underwriting attracting individuals in poor health who otherwise could not purchase stand-alone LTCI, but whose participation in the SPIDEA market lowers the cost of the income annuity portion of the SPIDEA benefits to everyone, including the healthy groups. Furthermore, the empirical work shows that individuals with most types of health and lifestyle conditions would find the value of a SPIDEA in the proportions modeled superior to the immediate life annuity and LTCI policy sold separately (assuming they could purchase LTCI). In particular, the empirical results indicate quite firmly that individuals with impaired life expectancies (excluding those who are already severely disabled) are likely to have a more immediate need for long-term care, but not necessarily of a greater extent than long-lived individuals. But because LTCI is paid for by a steady stream of premiums, however, it cannot be made available to individuals in poor health with short life expectancies except when combined with a life annuity.

Based on prior empirical work, I estimate that the price of a SPIDEA (with no inflation adjustment) for a 65-year-old individual with the benefits described above would be \$159,103 (with no inflation adjustment) or \$225,988 (with automatic inflation adjustment). In particular, the life annuity component costs \$139,827 or \$178,426 and the LTCI-like component costs \$19,276 or \$47,562, without or with the inflation adjustments discussed above, respectively. These price estimates include what we believe to be reasonable assumptions for the costs of administration of the contract and benefit provision, and the profitability of the issuing insurer; 6 percent interest earnings were assumed. The price estimates do not include, however, extra marketing costs that would depend uniquely on the venue of the product, for example, commissions to an agent selling an individual policy or corporate image marketing incurred in the employer-provided group line of business. Furthermore, the estimates, based on a government survey in 1986 of mortality and disability among the

population, may be thought to be on the low side. Owing to the natural tendency in an actual money-paying insurance product for disability to be claimed at higher rates than reported in an impersonal and “academic” government-sponsored survey, I estimate, also based on our empirical work, that it might be necessary to add another 50 or so percent to the costs for disability cash form of payments. This addition, for example, would bring the SPIDEA premium for a 65-year-old individual, without inflation adjustment, to \$169,066.

Although we have not done the calculations, the premium for a SPIDEA offered to a couple will be less, likely significantly so, than double the premium for a SPIDEA offered to two separate and unrelated individuals. Regarding the retirement income portion, a joint-and-survivor immediate life annuity generally costs only about 20 percent more than an individual life annuity at typical retirement ages and current interest rates. Regarding the LTCI portion, insurance policies sold to couples generally receive a 10 percent or so discount compared to two policies sold to two unrelated individuals, apparently because married couples are generally in better health and less at risk of long-term care needs than individuals.

Potential Scope for the Product Innovation

As mentioned above, the most natural venue and largest likely market for the SPIDEA is the qualified pension plan, where the immediate life annuity was traditionally the only distribution method available for spending during retirement, and still represents a dominant (although declining) method. This asset base covers ten of millions of active and retired workers and their families in both the private and public sectors and contains expected benefits and assets worth trillions of dollars. It originates in all types of plans: single-employer defined benefit plans sponsored by private corporations and governmental employers, multiemployer defined benefit plans organized with unions, and defined contribution plans sponsored by all types of employers,

especially smaller ones, either as the sole pension plan or to supplement a primary defined benefit plan. Defined contribution plans include 401(k), 403(b), money purchase, employer stock option, simplified employee plans, and so on. All these plans can be funded solely by the employer, jointly with the employees, or, more rarely, solely by employees. Qualified retirement assets residing in individual retirement accounts could also fund a life care annuity; assets in these accounts result from roll-overs from employer-sponsored pension plans upon employee separation and retirement, as well as small discretionary employee contributions made during the working years.

In most qualified retirement plans and accounts, contributions, when made, are not included in the taxable income of the worker, investment earnings are also not taxed, and distributions are taxed at the income tax rates of the retired household. Distributions generally need not be made until retirement or age 70-1/2, whichever is later. Qualified assets are "protected" for retirement purposes in various senses: protected from creditors if the household or plan sponsor declares bankruptcy, from the plan sponsor for diversion to other corporate or government uses, and from the household itself for all, or most, pre-retirement distributions, except the early death or disability of the worker. It seems reasonable for funding for long-term care disability needs to be considered a bona fide retirement purpose as part of a qualified plan (say through a 401(h) account), and still, at the same time, for disability payments to be exempt from income taxation in the same manner as traditional stand-alone LTCI. That is, the taxation of disability payments in this integrated manner should be treated on a level-playing field with stand-alone LTCI purchased by the employer on the current tax-advantaged basis, or, if an above-the-line individual deduction were allowed, purchased by individuals.

Another tax-favored source of retirement and long-term care finance is owner-occupied housing. Indeed, the home can be, and sometimes is, used as a type of nursing home insurance, while still avoiding the stigma of, and lack of

choice in, Medicaid. When the last surviving member of the retired household (generally the wife) becomes severely disabled, the residence, no longer needed or desired, is sold to pay for nursing home expenses. This behavior could be made explicit and rationalized even before the onset of disability if reverse mortgages with SPIDEAs were commonly used. Moreover, utilization of the reverse mortgage-SPIDEA combination would unlock trillions of dollars in asset value of owner-occupied housing for the majority of households, encompassing even those in relatively low socio-economic groupings; their retirement years would thereby be insured against the risk of lengthy lives and expensive disabilities.

As mentioned above, personal accounts, arising through any one of several Social Security reform proposals, could also be transformed into SPIDEAs at retirement; this would have the added advantage of spreading the availability and affordability of SPIDEAs among poorer households. Finally, after-tax financial assets or the value of small businesses naturally could be funneled to SPIDEAs sold on an individual basis. In all these venues, the payments from the LTCI portion of the SPIDEA should be exempt from income taxation, consistent with the current treatment of stand-alone LTCI.

Benefit Design Variations

I have described a fairly basic fixed SPIDEA with few bells and whistles, except perhaps for an optional inflation adjustment feature. Moreover, the benefit levels, and proportions and disability and income benefits, chosen were meant to provide adequate coverage for most, but not all, households, and to ensure fairness among groups with various health conditions. In this section of the paper, I describe some of the possible variations in benefit design. Although their introduction does enhance the comprehensiveness of the product and expand its scope, design variations also complicate the decision-making of the retired household, as well as the administration costs of the issuing insurer.

The simplest, and most trivial, design variation is to allow the benefit levels in the SPIDEA to increase or decrease by a scalable factor. This would equally accommodate households living in urban centers in the Northeast, where the general cost of living as well as the cost of long-term care is high, and households living in the rural South, where costs are much lower. The proportions of income annuity and disability benefits could also vary somewhat, for example, to please those households with modest budgets and standards of living but a perceived need for extra levels of long-term care. The allowable proportions would have to remain within a broad pre-set range, however, to avoid adverse selection and unfairness to certain population groups.

I have already mentioned that the joint-and-survivor benefit form would be the natural, perhaps even default, option for married couples. In addition, guaranteed periods of ten to twenty years would improve the fairness of the SPIDEA to males, and to those relatively few individuals with impaired life expectancies but without increased immediate risk of needing long-term care, as well as to accommodate a bequest motive. It is possible to imagine that variable income annuity payments could be chosen, whereby periodic income payments are fixed in units, not dollars, and depend on the value of an underlying asset portfolio, generally equities. This choice could allow for better diversification of asset risk, as well as allow for benefit increases over time. Unless the asset portfolio carefully matched the primary cost drivers of long-term care, primarily nursing and other types of skilled and unskilled labor, however, it might not be wise for the disability-escalating portion of the SPIDEA to be made variable with asset values.

I have stated earlier that a concern about moral hazard could exist in a SPIDEA arising from the tendency of insured individuals or their relatives to claim severe disability in order to receive cash payments. Although this issue could be addressed through a strict definition and measurement of disability,

sometimes it is preferable, even if only for public relations purposes, but equivalent in expected value, to give incentives to insureds to delay SPIDEA claims for as long as possible. This can be accomplished by not issuing policies with short elimination periods. Appropriate incentives can also be given by installing an actuarially fair benefit schedule in the SPIDEA where the (inflation-adjusted) level of disability benefits increases with age. For example, 80 percent of the selected benefit level is paid if disability is claimed between the ages of 65 and 70, 100 percent between the ages of 70 and 80, and 120 percent of the benefit level is paid if disability is claimed after age 80. One small insurance company has used this structure of disability benefits in its deferred annuity policies for several years.

Most of the moral hazard problem described above arises by designing the SPIDEA as a disability policy. It is possible, however, to design the long-term care part of the SPIDEA more conventionally as an indemnity or expense reimbursement policy, as is mostly done in LTCI currently. Because most individuals will not enter a nursing home or even receive home health care unless they really need it, there is little scope for moral hazard and these types of policies are cheaper than cash disability policies. They also, however, are less flexible; for example, family members or unskilled service employees providing care generally are not paid by a LTCI. By contrast, an individual insured by a SPIDEA could choose to reimburse, out of his disability payments, family members, neighbors, or unskilled workers for their caring time and effort. Family and community ties are thereby strengthened, and the retired household is given maximum flexibility in designing a program of care to its liking.

Adaptation for Partnership Plans

As mentioned above, in a few states, partnership plans exist. That is, if an individual or couple purchases a LTCI policy with certain required features, all or some of its assets will be protected from Medicaid spend-down asset

rules; after the benefits of the LTCI policy run out, the individual becomes eligible for Medicaid. It would be easy to adapt the life care annuity to a partnership plan, by simply having all annuity payments (both income and disability) to the disabled individual stop after a certain number of years, and thereafter to become eligible for Medicaid, without penalty. Such an approach would obviously lower the cost of the life care annuity.

Strengths of the Proposal

As designed and if utilized widely, the SPIDEA would achieve all of the objectives we set forth earlier. It would reduce significantly dependence on a public welfare program, Medicaid, for the financing and provision of long-term care by middle-class elderly households, thereby avoiding the problems associated with large-scale welfare programs — high taxes, large government budgets and deficits, avoidance of planning and saving, scope for fraud, bureaucratic rules and strong enforcement. The SPIDEA would reduce poverty rates among the older old, especially women, and, by definition, it would increase significantly the use of private insurance products, likely leading, in turn, to more innovation, efficiency, and competition in the annuity and traditional LTCI markets.

The SPIDEA would improve the functioning of private LTCI markets. It is a viable and innovative insurance product potentially available in many forms and venues for the retirement market — the natural market for LTCI and life annuities. As outlined above, the number of households and dollar amounts of assets in this market should be quite large, when all pensions, housing, other financial assets, and Social Security personal accounts are considered together. SPIDEA average single-premiums of \$170,000 to \$250,000 presumably are not beyond the reach of most retired middle-class households when these asset sources are added together. Equivalently, if the SPIDEA is purchased out of an accumulation funded beginning at, say age 45, and annuity income begins at age 65, annual inflation-adjusted SPIDEA premiums of \$6,500 (including

through pensions and other retirement saving vehicles) should be affordable to provide retirement income security and adequacy, and LTCI coverage, for the average household.

If SPIDEAs were to become widespread, the pricing of LTCI coverage would become more stable, as the single-premium structure of a SPIDEA prevents the insurer from post hoc price increases. SPIDEA benefits would be continually relevant to changing conditions of care, and the benefits are more flexible to fit various family situations, because benefits are cash disability payments, not dependent on specific conditions of care, as currently specified in LTCI policies. All SPIDEA benefits are non-forfeitable and unlimited for the insured's lifetime (except with partnership plans), thus providing optimum insurance coverage and protection. Most importantly, the SPIDEA avoids the adverse selection problem that always seems to burden markets for individual insurance contracts. LTCI would be made available to as many people as possible, despite their potential poor health status and adverse lifestyles. And the life annuity would increase in popularity by improving its fairness to various populations and its flexibility, and lowering its price, thereby providing longevity insurance urgently needed as the population ages, pension forms evolve, and asset markets do not continually produce double-digit returns.

Limitations and Challenges of the Proposal and Possible Roles for Public Policy

As designed, my proposal does not address the financing of long-term care needs for poor populations. Presumably these households would continue to use the programs and products currently available to them, mainly Medicaid and Medicare. Of course, as explained above, the continued existence of Medicaid and Medicare for long-term care needs poses a challenge to private LTCI of any sort, including the SPIDEA. The challenge is particularly great with those retiree groups on the "border," that is, households with retirement assets just sufficient to buy a SPIDEA.

There are at least three possible broad approaches for dealing with the crowding-out issue — one, negative, and two, positive. The negative approach would change Medicaid eligibility to a pure asset test imposed at the time of retirement, defined, say, as the time Social Security benefits are claimed. If the household did not purchase a SPIDEA and its retirement resources were determined to be sufficient to purchase a SPIDEA judged to be minimally adequate for the cost of care in that particular region of the country, then all members of the household would be declared ineligible for long-term care benefits from Medicaid forever. If, however, its assets were insufficient, the household would be eligible for Medicaid. Similarly, if the household purchased a SPIDEA, and long-term care benefits were not paid for some reason, saying owing to the bankruptcy of the insurer or skyrocketing costs of care, Medicaid could serve as the insurer of last resort.

A positive approach to the “Medicaid-crowding-out” problem would be to offer households a voucher good only toward the purchase of a qualified SPIDEA. The value of the voucher would decline smoothly as the level of retirement assets of the household increased. Governments would finance the vouchers from the savings in the Medicaid and Medicare programs realized by the hopefully widespread utilization of SPIDEAs, although acceptance of the voucher would not be mandatory.

Both of these approaches continue a negative characteristic of the current system for financing long-term care — discouragement of long-range planning and saving. They would also both necessitate introduction of a cumbersome and intrusive process to investigate the resources of millions of households at the time of retirement. Hence, another, perhaps superior, positive approach is simply to leave the current Medicaid system in place exactly as it currently exists, but to also offer substantial incentives, or least remove disincentives, to the purchase of SPIDEAs. These incentives probably would originate in the individual income tax system. For example, premiums for SPIDEA disability

coverage could be excluded from all or part of the taxable income of the household (consistent with a current tax proposal for stand-alone LTCI), or, alternatively, all of the SPIDEA premium could be deducted from taxable income for those households with income below certain levels. Or, somewhat less generously, but equivalent to the current treatment of LTCI, the entire cash disability payment from the SPIDEA would be exempt from income taxation. Also, if, as proposed by some, life annuity income were to be given advantaged tax treatment, that favored treatment should also apply to the annuity income portion of the SPIDEA. Again the savings in direct government expenditures on long-term care through Medicaid and Medicare presumably would at least make up for the loss in tax revenues arising from the creation of incentives. Under all three approaches, the social insurance benefits for home care in Medicare could be pared back significantly, with Medicaid picking up the slack for poor households, and SPIDEAs covering households in the middle-classes and above; this would, obviously, have a positive long-term effect on Medicare finances.

Although insurance companies have been moving to a limited pay approach for charging premiums for LTCI, none, as yet, has embraced a single premium approach. It admittedly puts some additional risk on, and creates a business and intellectual challenge for, the insurer issuing such a policy (or its reinsurer) to “get it right.” That is, the insurer must charge a premium sufficient to cover claims over an extended period of time and not risk company bankruptcy, but not so high as to be unfair or not competitive. It is unknown how large (and therefore expensive) these risks and challenges are, and whether direct external assistance or intervention, beyond the creation of incentives and tight product design and oversight, is needed. It is also possible, but currently unknown, that disability and mortality risks are negatively correlated in a dynamic sense, that is, over time, and therefore the risk to an insurance company with a significant book of business in the life care annuity may be lower than if it issued a lot of life annuity or LTCI policies.

If necessary, there are at least three ways, not mutually exclusive, of addressing the problem of insurance company risk in issuing a SPIDEA. First, some organization better able than a commercial insurer to bear and manage the risk could take the plunge first; the experience gained, whether positive or negative, could then be shared and evaluated by everyone to improve subsequent pricing and product design. Such an organization might be a large non-profit insurer issuing coverage on a participating basis, such as TIAA-CREF or Mutual of America, or a retirement system for government workers, such as the California Public Employees' Retirement System (CalPERS) or the Federal Employees Retirement Systems (FERS). (CalPERS itself is actually currently issuing LTCI for California government employees.) A second approach could involve either commercial or non-profit insurers, but would depend on a benevolent third party, perhaps a senior citizen organization or large foundation, to serve as a reinsurer to insure against extreme claims experience that would threaten the solvency of the issuers of the SPIDEA. To avoid moral hazard issues in the industry with this product, this reinsurance would have to be limited both as to duration and to amount.

Finally, better and more complete information on disability incidence and trends might enable even commercial insurers to issue SPIDEAs on a highly competitive, but single premium, basis. It is difficult to design and price accurately insurance contracts on contingencies where statistical information is scarce; furthermore, the competitive nature of the insurance industry sometimes makes it difficult for commercial insurers to share information in a complete and timely manner. Researchers from academic institutions, professional organizations, and the government could be encouraged to collect relevant statistics on disability rates and trends and relationships with mortality rates and trends in the retired population and to create models forecasting likely future experience. It might also be helpful if independent and objective third parties, such as senior citizen organizations, academics, government officials, and financial advisors, provide education and information

about the disability and longevity risks facing households, and the appropriate role of various insurance products, including SPIDEAs, and government programs in providing adequate coverage.

One of the challenges facing an integrated product such as the SPIDEA is that it crosses regulatory boundaries. In the case of the SPIDEA, it is both a life insurance and a health/disability product. This can cause difficulties when state insurance commissions are divided into separate departments for different lines of business; it may be difficult to get regulatory approvals for product issuance and pricing because of a lack of coordination and mismatched policy agendas among the departments. It is possible that the SPIDEA disability payments would fall into this problem area, and hence some regulatory or legislative clarification might be needed to provide reassurance to nervous potential issuers. Also, all retirement plans must meet the federal regulatory requirement that distributions must be made at minimum levels and in a generally non-increasing pattern as the household ages; apparently the SPIDEAs would not meet the technical requirements of this regulation, and therefore a change might be needed.

Current Combined Insurance Products and their Impediments

Some insurance companies have attempted to bring or even achieved bringing combined long-term care and annuity products to the market. The annuity product subject to combination, however, has been a deferred annuity, and hence it is not clear that these combined products capture the reduction in adverse selection and increase in LTCI availability aspects of the SPIDEA, as I have proposed them.

I have been sometimes asked, if the particular approach you have advocated is so promising, why has it not yet been offered? The possible answers, aside from status quo behavior, cautionary business practices, and lack of understanding, include tax and regulatory treatment. Under current tax

law, an after-tax SPIDEA would be treated as a life annuity, and hence any disability payments would be subject to income taxation — a distinct disadvantage compared to stand-alone LTCI and an annuity. Furthermore, official permission, under current law, to offer a SPIDEA in a qualified retirement plan, whether defined benefit or defined contribution, is unclear, indeed, unlikely. Finally, as mentioned above, state regulatory treatment of a combined product straddling different product lines is likely to be drawn out and involved, and hence the insurance company first to introduce the SPIDEA will likely incur significant legal and other costs.

Conclusion

I have put forward in this paper 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. I believe I have demonstrated that it achieves the ambitious, but still somewhat circumscribed, objectives put forward, namely to improve the lifelong economic security of most retired households through the private sector, minimizing the need to rely on public welfare programs. Although the proposed product represents a natural evolution from products currently being sold in the LTCI and annuity markets, it represents a significant marketing and design challenge for the insurance industry. Despite its private sector focus, the proposal therefore also addresses the possible public policy changes that would be helpful to the product's success and widespread utilization.



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>.