CHAPTER 10

IT TAKES TWO TO TANGO: A PERSPECTIVE ON PUBLIC AND PRIVATE COVERAGE FOR LONG-TERM CARE*

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Introduction

Stakeholders hold divergent views regarding the potential role of private long-term care insurance in meeting the nation's future long-term care needs. For example, a recent treatise on long-term care reform released by the SCAN Foundation did not include options for promoting private insurance, stating "we do not consider promoting private long-term care insurance (LTCI) to be a priority for investment of public resources" (Komisar et al. 2009). In contrast, those with Medicaid budget responsibility express a different view. The National Governors Association position on long-term care reform states that "policies are needed to encourage greater reliance on long-term care insurance rather than Medicaid" (National Governors Association 2009).

The private long-term care insurance industry last year paid over $4.3 billion in claims (Conning Research and Consulting Inc. 2009), and one in six persons over age 65 with annual incomes over $20,000 have private long-term care insurance (Long-Term Care Financing Strategy Group 2005). Yet, the growth in the private market is largely regarded as disappointing; sales and market penetration have leveled off or declined since 2003, with new sales occurring in a narrowing market of upper income Americans. Even though the average price of insurance (about $2,000 per year, or $165 per month) could be considered within the reach of a large percentage of American households, long-term care insurance is not perceived by most to be a valued investment of discretionary income on par with automobile, homeowners, life, health, disability and other risk-pooling products.

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In this chapter, we review the current state of the private long-term care insurance market and explore factors underlying its relatively modest size. We address the affordability debate and why more Americans have not elected to secure insurance protection. We then review public policy options for promoting industry growth and discuss the intersection of private coverage and public policy with a focus on how public insurance (i.e., a program like the recently examined CLASS Program) and private insurance can work together to provide all Americans protection from catastrophic long-term care costs.

Why Insurance?

A starting point in discussing how to finance our country's long-term care needs is to emphasize the insurability of these services and supports. Most of us will have supportive service needs as we age, but there is tremendous variation across individuals in how extensive these needs will be and in the magnitude of spending for formal (paid) services. Upon turning 65, for instance, 42 percent of Americans can expect to have their long-term care needs addressed with non-paid sources and spend nothing on formal long-term care during their lifetimes while 16 percent can expect to spend more than $100,000 and paid caregivers (Kemper, Komisar and Alecxih 2005).

Although this distribution of financial risk implies an appropriate role for insurance as an efficient mechanism to spread risk, insurance currently plays a minor role in financing long-term care. Most of the almost 10 million individuals who need supportive services get by at home, receiving unpaid help from family and friends. For those who require paid supportive services, the vast majority lack coverage for these expenses. Neither Medicare nor private health insurance covers long-term care, and only a small portion of older people purchase long-term care insurance. Instead, the safety nets of family caregiving, out-of-pocket payments, and the means-tested Medicaid program support the bulk of long-term care in this country.

By all accounts, the current approach to financing our country's long-term care needs does not work well. In particular, the system does a poor job in spreading financial risk, in supporting access to high quality care in settings where people want to live, and in equitably sharing financial responsibility for care across individuals and their families. (For example, families that choose to try and support a disabled person to remain in a home setting tend to have less available public support for doing so compared to those who have an elderly relative receive care in a nursing home.)

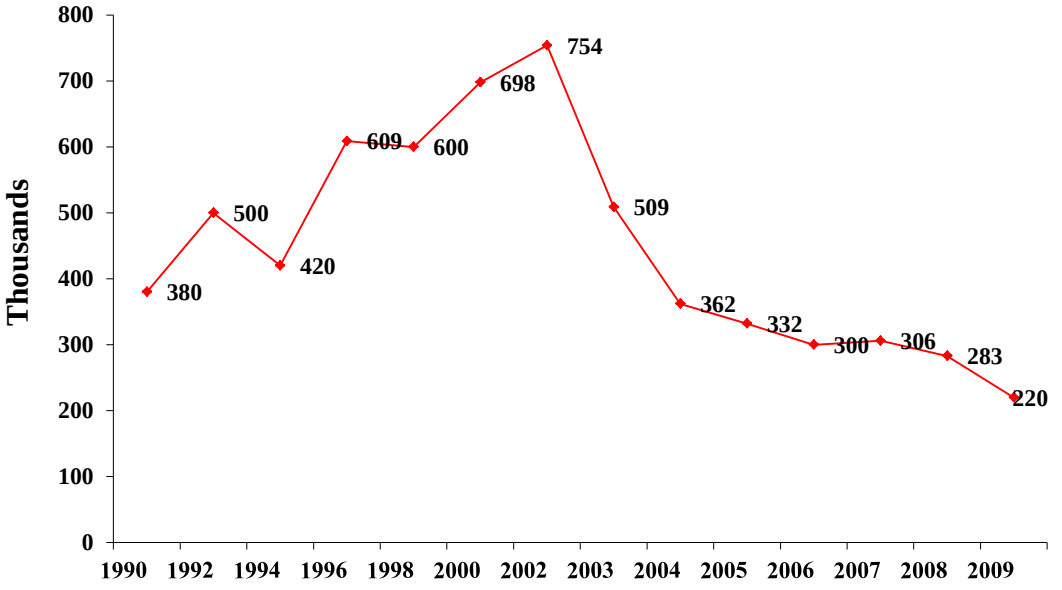
State of the LTCI Market

Today, there are around 8 million private long-term care insurance policies in force. While significant, the size and complexion of the market have not lived up to

optimistic trends and projections of a decade ago. The market grew by roughly 18 percent annually from 1987-2001, but sales growth has since slowed considerably. Specifically, while the group market grew at an annual rate of about 15 percent from 2000-2005, sales in the individual market—which account for more than 2/3 of this market—declined by 9 percent per year over the same time period (LIMRA International I 2000-2005). Much of the rapid growth in the group market was fueled by the Federal employees long-term insurance program which attracted upwards of 250,000 policyholders. Also, a growing number of employers began sponsoring plans for employees and given the small base of employer plans at the beginning of the decade, even modest increases in the number of insured translated into high rates of growth.

Figure 1 shows growth in the individual market over the past 20 years. Between 1990 and 2003 the market experienced steady growth, reaching its peak in 2003. Since that time, however, along with the decline in the stock market, sales have declined very rapidly so that by 2005, sales were below 1990 levels. By 2009, sales had declined to slightly more than half of 1990 levels.

Figure 1: Annual Sales of Individual LTC Insurance Policies (1990-2009)



Source: Authors Calculations based on Life Insurance Marketing and Research Association and LifePlans, Inc. data.

Although market penetration has remained relatively static in recent years, the attributes of policies sold have changed substantially from 1990-2005. This is shown in Table 1. In particular, policies sold now include significant innovations and enhancements such as expanded coverage for home and community-based care, increased parity in daily benefits for facility-based and home care, and greater inclusion of inflation protection. Consumers today have more choice with respect to the type and amount of coverage and can customize coverage to their specific needs, preferences, and pocketbook.

Table 1: Individual Long-Term Care Insurance Policy Designs, by Purchase Year

Policy Attribute	2005	2000	1995	1990
Policy Type (%)				
Comprehensive	90%	77%	61%	37%
Facility or Home Care Only	10%	25%	39%	63%
Policy Duration (%)				
2 years	11%	17%	24%	23%
3 years	22	23	20	12
4 years	17	14	18	15
5-8 years	27	16	8	17
Lifetime	23	30	30	33
NH Daily Benefit ($)	$142	$109	$85	$72
HHC Daily Benefit ($)	$135	$106	$78	$36
Choosing Inflation Protection (%)[a]	76%	41%	33%	40%
Average Annual Premium ($)	$1,918	$1,677	$1,505	$1,071

Source: Authors calculations based on data from AHIP (2006).

[a] Note that 6 percent of new policyholders had a guaranteed purchase option for benefit upgrades. This 6 percent is not included in the total percentage of individuals who purchased inflation protection.

Typically consumers are offered a number of choices regarding the nature of their coverage including a maximum daily reimbursement amount for service costs, the number of years of coverage, whether they want benefit payments to increase to keep pace of inflation, and how long they must wait once they are disabled to begin receiving insurance coverage for their costs—an elimination period. A typical policy may provide up to $150 a day in coverage for a period of three years, with a 90 day elimination period. Thus, the policy would make available to an individual roughly $165,000 in benefits to be spent on home and community-based care, assisted living, or nursing home care. If the individual chose to include an inflation option in their policy, then each year the average daily benefit would increase by the specified amount, say 5 percent compounded. Thus, if a person had a policy for 10 years and then required services, they would be eligible to receive $244 per day ($150*(1.05^{10})) for a total benefit pool of $267,545 ($244* 3 years). Given that most people tend to spend less than two years in a nursing home, the vast majority of policies provide durational coverage (see Table 1). In terms of total liabilities covered, that would depend on the value of the daily benefit chosen at time of policy purchase and the prices faced at the time of nursing home entry.

Concurrent with coverage changes, the profile of the typical long-term care insurance buyer has also changed (see Table 2). Today's buyers are younger, wealthier, and more educated. Since 1990, long-term care insurance buyers are drawn increasingly from the highest income and asset categories (America's Health Insurance Plans 1990-2005).

These trends are driven in part by substantial—and, one could argue, appropriate—declines in policies purchased by individuals at the lower end of wealth spectrum. More troubling, however, is that sales also eroded among middle-income individuals who ostensibly represent the market that companies and policymakers would most like to tap.

Why don't more middle-class Americans purchase long-term care insurance? Critics argue that the product is simply not "affordable" to a broad cross-section of Americans. Indeed, in a study of individuals who chose not to purchase long-term care insurance, 53 percent cited cost as the most important reason they did not buy coverage (AHIP 2007), a finding echoed in other analyses as well (Wiener, Tilly and Goldenson 2000). Nonetheless, the concept of affordability alone is not particularly useful because it implies that there is some definable level of cost relative to income that makes a product "affordable" to an individual. In fact, whether someone exercises a preference for a product is a function of the cost relative to its perceived value.

Clearly, the product is not viewed by consumers as providing sufficient value in light of its cost.

Table 2: Income and Asset Profile of Individual LTC Insurance Buyers

Socio-Demographic Characteristics of Buyers	2005	2000	1995	1990
Income Status				
Average Income	$62,825	$49,700	$36,600	$36,250
Less than $20,000	3%	9%	21%	29%
$20,000-$24,999	4	8	16	13
$25,000-$34,999	9	19	24	20
$35,000-$49,999	13	22	18	17
$50,000 and Over	71	42	20	21
Total Liquid Assets				
Average Assets	$95,475	$91,425	$68,750	$72,125
Less than $20,000	4%	6%	18%	16%
$20,000-$29,999	3	5	10	8
$30,000-$49,999	6	7	13	11
$50,000-$74,999	6	5	10	12
$75,000 and over	81	77	49	53

Source: Authors calculations based on data from AHIP, 2006

There are a number of potential reasons why a "perceived value gap" exists in the long-term care insurance market. First, research has shown that individuals who do not buy policies underestimate their risk. Roughly 70 percent of individuals who turn 65 will require long-term care support, either from family, friends, or paid caregivers at some point in their lives, and a sizeable minority of these individuals will face substantial financial liabilities and/or place large burdens on their families for

informal care (Kemper, Komisar and Alecxih 2005). Yet, only slightly more than half of non-buyers considered themselves to be at risk for needing significant long-term care services, and most believe that they would not be personally liable for the costs of care (i.e., the government or other health insurance would pay) (America's Health Insurance Plans 2007). At the same time, non-buyers overestimate premium costs and underestimate long-term care costs, reinforcing the barriers to purchase. Specifically, 70 percent of individuals considering a policy who chose not to purchase underestimated monthly costs of institutional care, compared to only 14 percent of people who bought policies (America's Health Insurance Plans 2007). We know this to be the case because in the referenced survey of buyers and non-buyers, each was asked to estimate the costs of nursing home care in their community and this estimate was compared to the actual costs of care in their community.

Another theory for why individuals do not attach sufficient value to long-term care policies given their price is that the Medicaid program "crowds out" the purchase for many middle-income Americans. Although Medicaid is not considered a typical insurance product, since it offers little or no financial protection for long-term care costs—although it does guarantee services to the indigent—some have argued that the existence of a robust "Medicaid planning" industry attests to the fact that Medicaid can provide some degree of protection for those who are well-schooled in Medicaid eligibility policy (Moses 2005). Using simulation models, Brown and Finkelstein (2008) estimated that even if insurance markets were operating in a perfectly efficient manner, the implicit tax imposed by Medicaid would keep more than 60 percent of the wealth distribution from buying a policy (Brown and Finkelstein 2008), implying that the non-purchase of private long-term care insurance by middle-class Americans may reflect, to some degree, a rational decision. At the same time, however, it should be noted that reducing the implicit tax of Medicaid on long-term care insurance purchase would likely be an insufficient mechanism to expand the market (Brown and Finkelstein 2009). For example, related empirical analyses based on econometric modeling have shown that even if all states moved to the most stringent eligibility standards allowed by federal law, private long-term care insurance purchase would rise by only 2.7 percentage points (Brown, Coe, and Finkelstein 2007). More empirical work on these questions is needed.

Another issue relevant to perceived value concerns whether consumers trust that insurers will pay benefits when care is needed and keep premiums relatively stable over time. While data from NAIC-mandated claims denial reporting and independent research show low claims denial rates—more than 95 percent of claims are approved—there have been serious allegations that the claims practices of certain

companies are suspect and designed to make it difficult for people to access benefits (Duhigg 2007). These issues do not appear to be widespread however, as 94 percent of surveyed individuals who had filed claims said they were satisfied with their experience in claiming benefits (LifePlans Inc. 2006). These individuals were asked whether they had any disagreements with their insurance company at the time that they filed their claim and if they did, whether such disagreements were satisfactorily resolved. In addition, in the absence of insurance, claimants felt they would have needed to rely more on family support (53 percent), pursue institutional care options (48 percent), receive less care (57 percent) or simply not be able to afford their current level of care (61 percent) (LifePlans Inc. 2006). Thus, for those individuals accessing benefits, their claims experience appears to be a positive one. Even so, a general distrust of the health insurance industry in general among many people presents a further drag on market growth.

Rate increases are another important concern for consumers. Rate increases between 15 percent and 50 percent have been requested on some blocks of business and new products are typically priced 10 percent to 15 percent higher than just a few years ago.[1] These rate increases have, for the most part, had to do with imprecise lapse and interest rate assumptions; some companies also have failed to employ adequate risk management strategies to assure a stable risk pool. The challenge of keeping premiums stable has led to more stringent actuarial standards related to pricing policies. Moreover, carriers now have a broader experience base from which to draw for more accurate pricing, and there is widespread agreement as to the value of prudent underwriting and claims management approaches for assuring rate stability. Thus, one could expect greater premium stability in the future.

Finally, the purchase of insurance is complicated and requires a certain level of financial literacy and understanding of a variety of current and future contingencies. This is particularly true in the case of long-term care where services can be provided by family, friends and formal (paid) caregivers. Because there are a variety of ways that care can be provided, it is difficult for someone to know how much care they made need in the future, whether family members can provide financial or caregiving support, and what level of private coverage would be sufficient to cover future care needs. All these factors complicate the decision and therefore, the perceived value of the policy needs to be high to mitigate these confounding factors and lead to a purchase.

Potential for Expanding the Long-Term Care Insurance Market

While there is no consensus on the potential size of the private market, there is general agreement among private insurers, industry analysts, and many policymakers that

significant untapped market potential remains. Ultimately, the potential to expand the private market hinges on multiple supply and demand factors. Identifying public policy mechanisms to address all barriers is beyond the scope of this article; however, it is worth highlighting three such strategies: subsidizing the purchase of policies, fostering informed consumer choice, and bolstering consumer confidence.

Subsidization of purchase

One of the most direct ways for policymakers to alter the value equation for long-term care insurance is to lower the effective price of policies. An approach implemented at the federal and state levels has been to subsidize the purchase of long-term care insurance through tax incentives. At the Federal level, the Health Insurance Portability and Accountability Act of 1996 offers limited tax advantages for long-term care insurance by clarifying the treatment of premiums for qualified plans as medical expenses for individuals deducting medical costs beyond 7.5 percent of their gross income and by not taxing benefits paid out up to certain limits. States have also used tax policy to encourage purchase, with more than half of all states currently offering a tax incentive for the purchase of long-term care insurance (Kaiser Family Foundation 2008). In lowering the price for insurance, government is trading off lost tax revenue against the possibility of reducing projected public (Medicaid) long-term care spending over the longer term. There has been surprisingly little empirical study of the topic, but existing analyses generally have concluded that these tax incentives have a modestly positive impact on take-up, but that tax incentives alone are unlikely to generate a substantial demand response (Cramer and Jensen 2006) (Johnson et al. 2008). One caveat to these analyses is that tax incentives implemented to date have been small. For example, if one is able to deduct a full $2,500 premium in a state with a 5 percent income tax rate, the value of the incentive is only $125. An example of a more substantial incentive would be to allow long-term care insurance premiums to be paid with pre-tax dollars by consumers and employers. Specifically, this would help sales in the group market, where price would also be reduced by the younger purchase age and lower marketing costs.

Product standardization

Although expanded choice has been an important sign of progress in the long-term care insurance market, consumer decision-making about whether to purchase and what type of coverage to buy can be difficult, with a wide array of options. Expanded public support for objective sources of information could aid potential buyers with their purchase decision. Product standardization, similar to the changes made in the Medicare supplemental insurance market in the early 1990s, has also been suggested by consumer advocates as well as some policymakers. In addition to instituting a

range of consumer protections, standardization of Medicare supplemental insurance products was aimed at reducing the variation and number of products on the market and stimulating competition on key product features. Insurers were limited to marketing one of ten standardized policies with precisely defined benefits. After standardization, sales increased considerably and consumer complaints declined (Hahn 2006). Although standardization of long-term care insurance products could simplify consumer choice, some argue that the market still needs continued product innovation to better meet consumer preferences and their evolving supportive service needs.

Consumer confidence

Strong regulatory oversight of private long-term care insurance is critical to its integrity and acceptance in the marketplace, particularly given the extended time that premiums are held in reserve. The federal government has some regulatory authority over tax-qualified long-term care policies, but states have primary oversight. State regulatory standards and enforcement vary considerably. Currently 19 states either have adopted or are in the process of adopting model policy and regulatory standards developed by the National Association of Insurance Commissioners (NAIC) (America's Health Insurance Plans 2009). NAIC standards include financial penalties to discourage companies from under-pricing policies, requirements that rates be actuarially-certified as reasonable and sufficient to ensure long-run solvency, as well as other provisions to protect consumers and ensure rate stability. NAIC standards require insurers to follow suitability standards to ensure appropriate sales and outline several policy-oriented consumer protection features, including mandatory offer of non-forfeiture benefits and inflation adjustment, protection against unintentional policy lapses, and a standardized outline of coverage. Despite the variation across states in adoption and enforcement of the most recent NAIC standards, most insurers offer a uniform product— with respect to consumer protection— in all states in which they offer coverage. While these protections are in place, consumers may not be aware of them, reinforcing the need for ongoing education. Another approach is federal legislation, which has been proposed to ensure uniform protections in the long-term care insurance market across the country (e.g., Confidence in Long-Term Care Insurance Act of 2009).

Integrating Public and Private Insurance for Long-Term Care

Medicaid

The interface between Medicaid policy and the private long-term care insurance market is complex. Designed as a safety net for low income individuals, Medicaid has

emerged as the leading third party payer for long-term care. Medicaid has paid for nearly half or more than 40 percent of all long-term care spending for the past few decades (Burwell and Crown 1994; O'Shaughnessy, Lyke, and Storey 2002).

Because of the prominent role of public coverage in the long-term care sector, there is inevitably some tension and uncertainty about the extent to which public coverage impedes the development of the private market. Public policy has been somewhat equivocal on the issue. On the one hand, Medicaid eligibility policies have become somewhat more generous over time (e.g., through increased spousal asset limits), arguably cutting expansion of the private market. At the same time, Congress has enacted a number of changes designed "close loopholes" in Medicaid eligibility policy, the most recent of which were contained in the Deficit Reduction Act of 2005. Such loopholes were being exploited by Medicaid planning attorneys and consumers who were able to shelter assets for heirs while accessing public coverage for long-term care costs.

One innovation designed to marry Medicaid and support for the private market is the Long-Term Care Partnership Program. Under the Partnership Program, persons who purchase Partnership Qualified (PQ) policies receive guaranteed asset protection under Medicaid if they first buy and use private long-term care insurance. For every dollar of private insurance benefits used by the policyholder, the policyholder receives one dollar of increased asset protection from Medicaid after their private insurance is depleted. While not a direct subsidy of long-term care insurance premiums, the Partnership Program incents purchasers to buy "shorter and fatter" policies that are more aligned with their individual financial risk (i.e., the amount of their net worth they wish to protect). As of July 2009, 36 states had adopted Long-Term Care Partnership Programs and over 100,000 policies were in force (National Long-Term Care Partnership Data Repository 2009). At this stage, it is too early to evaluate the impact of these programs on market penetration or on Medicaid program costs.

Public Voluntary Insurance Programs: The CLASS Program

The Patient Protection and Affordable Care Act was signed into law by the President on March 23, 2010. Among other things, this act established a national voluntary insurance program, the CLASS Independence Benefit Plan. The purpose of the program—which was to be offered through employers—was to provide community living assistance services and supports to working individuals who have a functional limitation expected to last more than 90 days due to an inability to perform either 2 or 3 activities of daily living (ADLs), a cognitive impairment, or a level of similar limitation prescribed by the Secretary of DHHS. An eligible beneficiary of the program would have to pay premiums for at least 60 months before qualifying for

benefits, premiums would have to be set at a level consistent with program solvency for a 75-year period, and daily benefits would not be allowed to go lower than $50 per day. Public subsidies would be available to specified eligible population groups to assure the affordability of program premiums.

The Department of Health and Human Services (DHHS) was charged with the task of developing the mechanisms to implement the CLASS program and meet the objectives laid out in the law. On October 14, 2011, the Secretary of DHHS announced that after 19 months of planning and analysis efforts the Department did not "see a viable path forward for CLASS implementation at this time." Thus, there are no efforts being made to implement the program and it is not likely to become part of the fabric of long-term care financing for the foreseeable future.

Program supporters of CLASS had expressed a strong desire to see the current private insurance market work in concert with the new CLASS Program. Moreover, the program was not designed to replace Medicaid but to work in concert with the program; a certain percentage of CLASS benefits are to be designated to the program if an individual is receiving home and community-based care under Medicaid (for a more detailed discussion of the CLASS Act see Gleckman's chapter in this volume).

Based on the experience of the private market to date, one can point to several issues that would be important to address to assure better integration of the private the long-term care insurance market with a voluntary or even mandatory public insurance Program as well as with Medicaid. First, to meet the challenge of educating the public about the need to protect against long-term care costs through insurance mechanisms, the issue must be framed as one that is considered part of an overall strategy for retirement security and not simply as an extension of health reform. Similar to the manner in which Social Security payments, pensions, and personal savings combine to provide individuals retirement security, the public needs to understand that such is the case with long-term care needs; that is, that these needs must be met through a combination of resources, and that the distribution of risk suggests insurance as the most efficient mechanism for funding this risk. Reframing the challenge in this manner might help us move forward in debates about the roles of public and private resources, including insurance, and to devise innovative approaches to integrating public and private programs as well as new approaches that can work in a complementary manner across programs and markets.

Second, the first point presumes that there is a real effort at public education. Clearly, public education is vital to ensure that consumers and their families understand the long-term care risks they face, the importance of planning ahead for these needs, and

the planning options that they have. An important outcome of efforts such as the Federal government's "Own Your Future" campaign is to ensure that consumers have a clear understanding of where public coverage begins and ends -- something that would be particularly important in the context of the somewhat limited disability insurance benefit offered by the CLASS Program.[2] In other words, in the context of partial public coverage (whether through a public insurance program, Medicaid alone, or in combination with some supplemental benefit), individuals need to understand the limits of that coverage and, in turn, the value of any wrap-around protection.

Regardless of whether it is the CLASS program or any other voluntary public insurance program, it is critical that policymakers, consumer advocates, and providers emphasize the point that no single program is likely to be designed to address all long-term care needs for all people and that it is only likely to be one piece of the necessary financing solution. The risk is that without doing so clearly and forcefully, individuals will falsely assume that a public insurance program like would have represented the solution to all of their long-term care needs. Hence, the need to examine supplemental or even primary coverage such as long-term care insurance will significantly diminish and individuals will still be at risk for facing catastrophic costs.

Third, in thinking about the design of public voluntary insurance programs, policymakers should take note of lessons learned in the private market, several of which have relevance to the program. First, due to such program's voluntary nature there will have to be a balance between concerns about adverse selection (i.e., attracting only those at higher risk of needing services) against broad goals pertaining to covered populations. This presents a very real regulatory challenge to policymakers since program premiums must be sustainable over a very long period. A related point is that the program must be implemented in a manner consistent with assuring that premiums are no more costly than for similar plans that can be purchased privately. If not, additional selection issues could threaten the solvency of public voluntary insurance programs, if no underwriting is allowed.

Moreover, employer-based voluntary programs covering long-term care in the private sector have achieved relatively low participation rates— typically well less than 10%. Thus, a sophisticated education and marketing campaign will be necessary to convince employers to invest in the effort needed to put the program in place and to convince employees to participate.

Second, in all programs a well-defined risk management approach is needed to verify initial and ongoing eligibility for benefits so as to ensure premium stability. Because the structure of such programs is likely to be based on a cash disability benefit, there is a substantially increased risk of significant moral hazard, a fact reflected in

substantially higher private market premiums for similar structured policies. Clear regulatory guidelines relating to benefit eligibility triggers need to be established to protect program solvency and rate stability, make any wrap-around private insurance policies feasible, and provide confidence to consumers that they understand the circumstances under which they will qualify for benefits. If in the implementation of a public voluntary insurance plan the benefit eligibility triggers differ from those that are the basis for payment of private insurance benefits it is going to be difficult for the two markets to work in tandem. Confusion in the marketplace regarding the precise eligibility triggers will stifle growth in the private market and depress participation in the public program. Finally, even with a cash benefit, there is a need for assistance to help consumers navigate a fragmented long-term care system. Research in both the private and public Medicaid market suggests that without assistance to navigate the complex provider system, even in the presence of insurance unmet and undermet needs will persist.

Conclusion

As the baby boom generation ages, policymakers continue to struggle with the challenge of designing effective policies for encouraging long-term care risk protection. This complex problem is exacerbated by the fact that long-term care presents a risk both in terms of unpaid or family care burdens and the costs associated with paid care. Insurance pools can help reduce catastrophic risk and offer the most efficient way to protect against this liability. To date, private risk pools have demonstrated an ability to provide adequate coverage for long-term care but at a price that many Americans believe to be too high relative to their perceived value of the coverage. At the same time, publicly financed long-term care through the Medicaid program has exhibited important deficiencies of its own, including recurring quality of care problems, a bias toward institutional care and insufficient funding of home- and community-based care options, and costs that impose a sizeable constraint on state budgets. The CLASS Program represented a new strategy for making available a public risk-pooling program for long-term care, but the details around implementation.

Clearly neither a public or private financing approach on its own can meet the long-term care needs of all Americans, and no one has yet argued that a voluntary public insurance program and Medicaid represent a comprehensive solution to the long-term care financing challenge. In all likelihood, both public and private insurance models will need to work together to mitigate the catastrophic risks of long-term care. The CLASS program might have provided an opportunity to test if and how well these markets can work together, but at this point, we can only conjecture, since the

program is no longer on the policy agenda. Even so, policymakers still need to focus not on whether a public or private insurance model works best, but rather on how public programs can be structured and implemented to assure that in conjunction with an evolving and supported private market, efficient and equitable outcomes for taxpayers and consumers can be achieved.

Notes

[1]These figures are based on information derived from personal communications with state insurance departments. There is no reliable aggregate information on all rate increase findings across the country.

[2] The program has reached over 20 million households and based on results to date, response rates greatly exceeded expectations and individuals who received the education were significantly more likely to take some type of planning (Long-Term Care Group and LifePlans, Inc. 2006).

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