



Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress

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Summary

As the 80 million baby boomers approach retirement, many are concerned they will not have sufficient savings to sustain their standard of living in retirement. Few, however, may be focused on another risk to their retirement security—the potential cost of financing often expensive long-term care services and supports (LTSS). LTSS include help with either functional or cognitive impairment and generally include assistance with activities such as bathing, eating, and dressing. For the majority of older Americans, the cost of obtaining paid help for these services may far exceed their financial resources in the future.

Private long-term care insurance (LTCI) is available to provide some financial protection for persons against the risk of the potentially high cost of LTSS. In 2010, about 6% of LTSS spending was paid by LTCI. This low rate of financing reflects relatively low demand for LTCI over the past few decades. Moreover, most policy owners have not yet reached the age where they may need services.

In 2010, between 7 million to 9 million Americans owned a private LTCI policy, with about 11% of the population aged 55 and older covered by a policy. A number of factors have adversely affected the demand for LTCI. The cost and complexity of LTCI policies have been cited as major deterrents to purchasing LTCI. In addition, increased concerns have arisen about the adequacy of consumer protections for LTCI as a result of inconsistencies in LTCI laws and regulations across the states. More recently, adverse publicity about premium increases and heightened concerns about the future solvency of LTCI insurers in the current economic environment have further dampened demand, prompting state regulators to re-evaluate current regulations and laws governing LTCI.

The private LTCI market has undergone significant changes in the past three decades. The employer-sponsored market has grown as a share of total LTCI sales and the overall market has become more concentrated in terms of the number of companies selling the product. A number of newer product lines have been introduced that combine LTCI with other products, such as retirement annuities and life-insurance products.

To address these issues, the 113th Congress may consider a number of legislative options to increase participation in the voluntary LTCI market. These may include proposals to

- increase tax incentives to lower the after-tax cost of policies,
- improve consumer protections to boost consumer confidence in the product, and
- expand consumer education.

This report discusses the role of LTCI in financing LTSS and current trends in the LTCI industry; factors affecting the demand for LTCI, including cost and complexity of the product and adequacy of consumer protections; and legislative options available to address these issues.

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Introduction

As the 80 million baby boomers approach retirement, many are concerned they will not have sufficient savings to sustain their standard of living throughout retirement. Few, however, have focused on another risk to their retirement security—the potential cost of financing often expensive long-term care services. The cost of long-term services and supports (LTSS) for the majority of older Americans may far exceed their financial resources in the future. Private long-term care insurance (LTCI) is available to provide some financial protection for persons against the risk of the potentially high cost of LTSS. To date, however, only about 1 in 10 individuals aged 55 and older own a LTCI policy.

This report discusses

- the role of LTCI in financing LTSS and current trends in the LTCI industry;
- factors affecting the demand for LTCI, including cost and complexity of the product and adequacy of consumer protections; and
- legislative options available to improve affordability, strengthen consumer protections, and expand consumer education.

Private Long-Term Care Insurance

Services provided by a LTCI policy may include a broad range of services and supports to help people with a limited capacity for self-care due to a physical, cognitive (such as Alzheimer’s disease), or mental disability or condition. Health care and LTSS are different. Health care services typically treat specific acute and chronic medical conditions in a medical setting by a medical professional. LTSS, on the other hand, include a wide range of health and health-related support services provided on an informal or formal basis to people who have functional disabilities or cognitive impairments over an extended period of time with the goal of maximizing their independence.¹ Unlike medical treatments, LTSS primarily assist individuals in their day-to-day activities. These “activities of daily living” (ADLs) include bathing, dressing, eating, toileting, and transferring (from a bed to a chair or vice-versa). Generally, LTCI policyholders are eligible to begin to receive benefits if they have at least two of the ADL limitations.

LTCI policies may be sold to an individual directly or to a group as part of an employer-sponsored policy. The premiums charged for LTCI vary by age of purchase, with higher premiums charged to those purchasing at older ages. This age differential reflects the higher risk of needing LTSS at advanced ages. One study has estimated that over two-thirds of individuals who turn 65 years old will require LTSS at some point before they die.²

¹ Connie J. Evashwick, “The Continuum of Long-Term Care: An Integrated Systems Approach,” 2004.

² P. Kemper, H.L. Komisar, and L. Alexih, “Long-Term Care Over An Uncertain Future: What Can Future Retirees Expect?” *Inquiry* 42, winter 2005-2006.

Current Financing of Long-Term Services and Supports

Although private LTCI is available to finance LTSS costs, only about 6% of LTSS spending was paid by LTCI in 2010. Nearly half of LTSS spending (nearly 43%) was financed by the Medicaid program, which is funded jointly by the federal government and states.³ Medicaid is intended to provide a safety net and is not available to everyone. To be eligible, individuals must meet certain functional criteria as well as state-specified income and asset thresholds.⁴ Medicare (which currently provides health care to older Americans and certain disabled individuals) financed about 22% of LTSS, but these funds were predominantly for post-acute care for short-stays in a skilled nursing home following hospitalization or for skilled home health care.

Individuals who seek paid LTSS but do not qualify for public funding or do not have private LTCI must pay for these services directly out-of-pocket. In 2010, about 16% of LTSS spending was paid out-of-pocket.⁵ The magnitude of out-of-pocket costs will depend on the setting, intensity (including the skill level of the provider), and the duration of LTSS. For example, the setting of care can include care provided in one's own home, in a community-residential care setting such as an assisted living facility, or in an institutional setting such as a nursing home. For those receiving care at home, in 2012, the average cost of personal unskilled care (such as bathing, dressing, and transferring) was \$19 an hour.⁶ Studies have found that individuals use on average about 18.4 hours a week of informal care, which would result in an annual cost of about \$18,179 a year in 2012. The annual cost of care will also vary by intensity and duration of care, with individuals receiving care in an institutional setting paying more than those staying at home. For example, assisted living facilities that provide hands-on personal care for those who are not able to live by themselves (but do not yet require constant care provided by a nursing home) cost on average \$39,600 annually in 2012. Nursing home care, on the other hand, generally costs more in that it provides LTSS assistance 24 hours a day. In 2012, the annual cost of a nursing home stay was \$73,000 for a semi-private room and \$81,030 for a private room.⁷ These estimates are national figures and can vary widely by geographic region.

Long-Term Care Insurance Industry Trends

The private LTCI market has undergone significant changes in the past three decades. The employer-sponsored market has grown as a share of total LTCI sales and the overall market has become more concentrated in terms of the number of companies selling the product. Further, a number of newer product lines have been introduced that combine LTCI with other retirement and life-insurance products. The following discussion provides greater details on these trends.

There are currently between 7 million to 9 million Americans with an active LTCI policy (often called "in-force").⁸ The growth in the number of LTCI policies in both the individual and group markets increased at double-digit rates from 1995 to 2002 before slowing in more recent years

³ CRS Report R42345, *Long-Term Services and Supports: Overview and Financing*, coordinated by (name redacted).

⁴ The income and asset criteria vary by state.

⁵ See footnote 3.

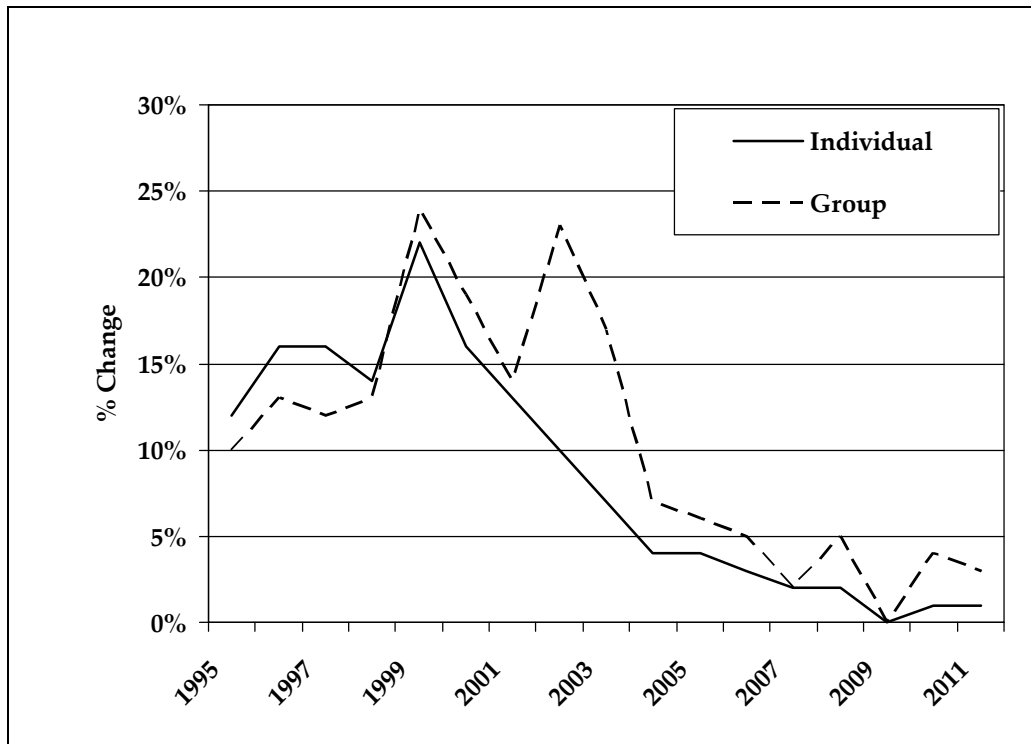
⁶ Genworth Financial, *Executive Summary: Genworth 2012 Cost of Care Survey*, April 20, 2012.

⁷ Ibid.

⁸ America's Health Insurance Plans, "Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market," March 2012.

(see **Figure 1**). The composition of the market has also changed as employer-sponsored LTCI has grown as a share of the total LTCI market. In 2011, employer-sponsored LTCI represented about one-third of all active policies, compared with less than 3% in the mid-1990s. Employer-sponsored LTCI is distinct from employer-sponsored health insurance in that employers typically do not contribute to LTCI premiums. Rather employer-sponsored LTCI provides the advantage of a larger risk pool and generally lower premiums than if LTCI is purchased in the individual market. Among employers offering LTCI, the federal government is the largest employer offering group LTCI.

Figure 1. Percentage Change in Growth of Active LTCI Policies, 1995-2011



Source: LIMRA International Inc.

Over the past decade, the number of companies selling LTCI has declined significantly. Between 1987 and 2002, more than 100 companies were selling LTCI. A downturn in sales beginning in 2003 prompted many insurers to exit the market or merge with other firms.⁹ As a result, the LTCI market has become much more concentrated, with the top 10 LTCI companies producing 88% of new sales in 2010.¹⁰ This number has fallen further in recent years. Since 2010, a number of well-known companies have exited the LTCI market. MetLife has announced that it has discontinued new sales of LTCI effective December 30, 2010. MetLife assured existing policyholders that their coverage will continue without any interruptions or changes. In February of 2011, Unum Group announced it will no longer sell group policies. In March of 2011, Prudential announced it will no

⁹ U.S. Government Accountability Office, "Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions," March 2006.

¹⁰ C. Pfau, D. Helwig and A. Schmitz, "2011 Individual Long-Term Care Insurance Survey," *Broker World Magazine*, July 2011.

longer sell LTCI policies to individuals and will instead focus on the group market. The consolidation of the LTCI industry reflects several factors, including high administrative expenses for policies relative to premiums, lower than expected terminations (i.e., lapse rates) that increased the number of people likely to submit claims, low interest rates that reduced the expected return on investments, and new government regulations limiting direct marketing by telephone.¹¹

Hybrid Long-Term Care Insurance Products

A number of legislative changes have enabled insurers to begin to develop hybrid products that combine LTCI with either an annuity or a life insurance product. The Pension Protection Act of 2006 (P.L. 109-280) simplified tax rules regarding combination products (effective in 2010) and added a tax provision specifying that proceeds from an annuity can be used tax-free to purchase an LTCI policy. LTCI policies can also be combined with a life insurance policy through an accelerated death benefit rider. Circumstances that trigger these accelerated benefits include diagnosis of a terminal illness or a medical condition that would drastically shorten the policyholder's life span, the need for LTSS, or permanent confinement to a nursing home. Because these newer hybrid policies are just entering the market, it is too early to tell their impact on demand for LTCI in the future.

In addition to the above-mentioned hybrid LTCI policies, there is also a LTCI product that is linked to Medicaid eligibility. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171)¹² established the Medicaid Partnership Long-Term Care Insurance Partnership Program (hereinafter referred to as the Partnership Program). Individuals who purchase certain LTCI policies may qualify for Medicaid without the same means-testing requirements that other applicants must meet. Generally, Partnership Program purchasers would seek Medicaid for extended coverage of LTSS after their LTCI benefits have been exhausted. For these individuals, Medicaid means-testing requirements are relaxed at (1) the time of application to Medicaid, and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.^{13,14}

The original Partnership Program was established in four states: California, Connecticut, Indiana, and New York in the early 1990s.¹⁵ The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) prohibited other states from implementing the program. However, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) lifted this prohibition and allowed any state with a Secretary-approved Medicaid state plan amendment to operate a Partnership program.¹⁶ As of

¹¹ U.S. Government Accountability Office, "Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions," March 2006.

¹² These provisions are also specified in the Social Security Act Title XIX Section 1917(b)(5)(42 U.S.C. 1396p(b)(5)).

¹³ The Social Security Act requires states to recover from a beneficiary's estate certain amounts Medicaid paid for LTSS and other services.

¹⁴ Most Medicaid applicants may protect no more than \$2,000 in assets for an individual and \$3,000 for a married couple. In general, Partnership Program policy owners may protect amounts equivalent to the value of the benefits paid by the LTCI policy purchased (e.g., \$100,000 of nursing home or assisted living benefits paid enables that individual to retain up to \$100,000 in assets and still qualify for Medicaid coverage in that state). This is referred to as the dollar-for-dollar model. Two states have exceptions to this design model. New York uses a total asset protection model in which purchasers with certain state-approved policies may qualify for Medicaid while retaining all of their assets. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection.

¹⁵ Iowa received approval from the Secretary of HHS to operate a program before OBRA 93, but it did not fully do so.

¹⁶ The DRA also added new minimum federal requirements for LTCI plans to qualify as Partnership policies. Among (continued...)

July 2011, 40 states, including the 4 original partnership states, elected to adopt a LTCI Partnership program.¹⁷ Ten states have yet to adopt a LTCI Partnership Program.¹⁸ There are about 641,000 Partnership Program policies in force, accounting for 9% of all LTCI policies in force.¹⁹

Factors Affecting the Demand for Private Long-Term Care Insurance

After 15 years of strong growth, demand for private LTCI has slowed considerably since 2004.²⁰ In 2008, the latest year in which demographic data are available, about 11% of the population aged 55 and older and 12% of the population aged 65 and older owned a LTCI policy.²¹ Low demand for this product has occurred despite enhanced tax incentives (mainly at the state level), increased emphasis on consumer protections, and the enactment of a private LTCI program for federal employees.

The factors affecting the demand for LTCI can be viewed by comparing two key cohorts: those under the age of 65 and those aged 65 and older. For those under the age of 65, annual LTCI premiums are generally lower.²² However, this cohort also faces competing demands of the cost of raising families and saving for retirement. Many do not fully understand their future risks or coverage options for LTSS. According to a survey by America's Health Insurance Plans, 28% of non-buyers believe Medicare will cover their LTSS needs, and another 22% do not know who would pay.²³ Although Medicare does cover up to 100 days of care in a skilled nursing facility,²⁴ and limited home health care,²⁵ it does not cover longer stays in a nursing home or personal home care.

(...continued)

these requirements are consumer protections related to inflation protection, unintentional lapse, disclosure, and nonforfeiture of benefits.

¹⁷ Thomson Reuters, *The Long-Term Care Partnership Program: 5 Years After Enactment Under the Deficit Reduction Act*, October 17, 2011.

¹⁸ The states that have not yet adopted a DRA Partnership Program are AK, DE, HI, IL, MA, MI, MS, NM, UT, and VT as indicated on <http://w2.dehpg.net/LTCTPartnership/StateReciprocity.aspx> as of January 15, 2013.

¹⁹ Thomson Reuters, *The Long-Term Care Partnership Program: 5 Years After Enactment Under the Deficit Reduction Act*, October 17, 2011.

²⁰ J. Douglas and K. Fisherkeller, "U.S. Individual Long-Term Care Insurance: 2011 Supplement," LIMRA, 2011.

²¹ R. Johnson and J. Park, "Who Purchases Long-Term Care Insurance," Urban Institute, Issue Brief, No. 29, March 2011.

²² Once the policy is purchased, premiums cannot increase with age, but they can increase for other reasons.

²³ America's Health Insurance Plans, "Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market," March 2012.

²⁴ Medicare covers up to 100 days of post-hospital care for skilled nursing or rehabilitative services on a daily basis (after a three-day hospital stay). There is no beneficiary cost-sharing for the first 20 days. Days 21-100 are subject to daily coinsurance charges (\$144.50 in 2012).

²⁵ Medicare covers visits by personnel from a participating home health agency for beneficiaries who, among other requirements, (1) are confined to home, (2) need skilled nursing care on an intermittent basis, or (3) need physical or occupational therapy or speech language therapy. The services must be provided under a plan of care established by a physician for a 60-day episode of care.

By the time individuals reach the age of 65 or so, if they have not sufficiently planned for their LTSS needs, the cost and complexity of the LTCI policies become a major barrier to purchase. In addition, increased concerns have arisen about the adequacy of consumer protections for LTCI as a result of inconsistencies in LTCI laws and regulations across the states. More recently, adverse publicity about potential problems with premium stability, claims denials by LTCI companies, and heightened concerns about the future solvency of LTCI companies in the current economic environment have further dampened demand. The following section discusses these issues in greater detail.

Cost and Complexity of Long-Term Care Insurance

The cost of LTCI has been cited as a major deterrent to purchasing the product. Among potential buyers of LTCI who choose not to purchase a policy, 87% cite cost as a “very important” or “important” reason for their decision.²⁶ Over the past decade, LTCI premiums have increased significantly above the overall rate of inflation.

As shown in **Table 1**, between 1995 and 2010, average age-adjusted premiums have increased 71% (above the overall rate of inflation) for individuals aged 55 to 64 and by 64% for those aged 65 to 69, growing at an annual average rate of 3.7% and 2.8% (respectively) over and above the general rate of inflation. Higher average premiums reflect increased demand for more comprehensive benefit packages (including inflation protection) and higher daily benefit amounts. In addition, low rates of return on investments and under estimates of lapse (termination) rates have prompted insurers to raise premiums for both current and new policyholders.

Table 1. Average Annual Age-Specific LTCI Premiums, By Purchase Year
(in 2010 Inflation-Adjusted Dollars)

Age	1995	2000	2005	2010	% Change 1995 to 2010	
					Annual Average Rate	Cumulative Rate
55 to 64	\$1,315	\$1,536	\$2,096	\$2,255	3.7%	71%
65 to 69	\$1,684	\$1,883	\$2,236	\$2,759	3.3%	64%
70 to 74	\$2,186	\$2,316	\$2,614	\$3,294	2.8%	51%

Source: CRS estimates using CPI-U to adjust nominal premiums reported in America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market,” March 2012.

Although more comprehensive policies have raised annual premiums, they have also increased the complexity of the purchase decision. According to the America’s Health Insurance Plans (AHIP) survey, 49% of those who did not buy an LTCI policy when given the opportunity stated that the policy options were “too confusing.” Potential buyers must evaluate the many different possible combinations of product features available.

²⁶ America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market,” March 2012.

Potential policyholders must decide

- the type of coverage,
- the dollar amount of coverage and annual inflation adjustments,
- the length or duration of coverage, and
- the waiting period (which is often referred to as the elimination period).

Type of Coverage

Individuals must choose the type of services to be covered by a LTCI policy. Services covered under a LTCI policy may include care in a variety of settings, such as a nursing home or assisted living facility, or the individual’s own home through home health services. Policies may cover respite care for caregivers, homemaker and chore services and medical equipment. Policies purchased in 2010 tend to be more comprehensive in terms of services covered and are most likely to cover both nursing home and home care services. According to AHIP, 95% of policies purchased in 2010 covered both nursing home and home care as compared with 61% of policies purchased in 1995 (see **Table 2**).²⁷

Dollar Amount of Coverage and Annual Inflation Adjustments

Another factor affecting the cost and complexity of a policy is how much coverage should be purchased in terms of a daily benefit amount and whether to purchase inflation protection. The dollar amount of the daily benefit is often initially chosen based on the current cost of services. But the decision about how much this daily benefit should be adjusted over time to reflect inflation is a more complicated one.

Inflation adjustments (often called inflation protection) are important because a LTCI policy is often purchased 20 to 30 years before services are needed. Thus, a policy purchased today that pays a \$150 a day benefit may not be sufficient given growth in the cost of future LTSS. To ensure that policies cover an adequate amount of services, most companies now offer inflation protection and most public awareness campaigns have urged individuals to purchase inflation protection. As a result of these efforts, policies purchased in 2010 are more likely to include inflation protection (see **Table 2**) as compared with those purchased in 1995.

Table 2. Characteristics of LTCI Policies Purchased Since 1995

Policy Characteristics	1995	2000	2005	2010
Policy Type (% With)				
—Nursing Home Care Only	33%	14%	3%	1%
—Nursing Home & Home Care	61%	77%	90%	95%
—Home Care Only	6%	9%	7%	4%
Daily Benefit Amounts (Nominal \$)				

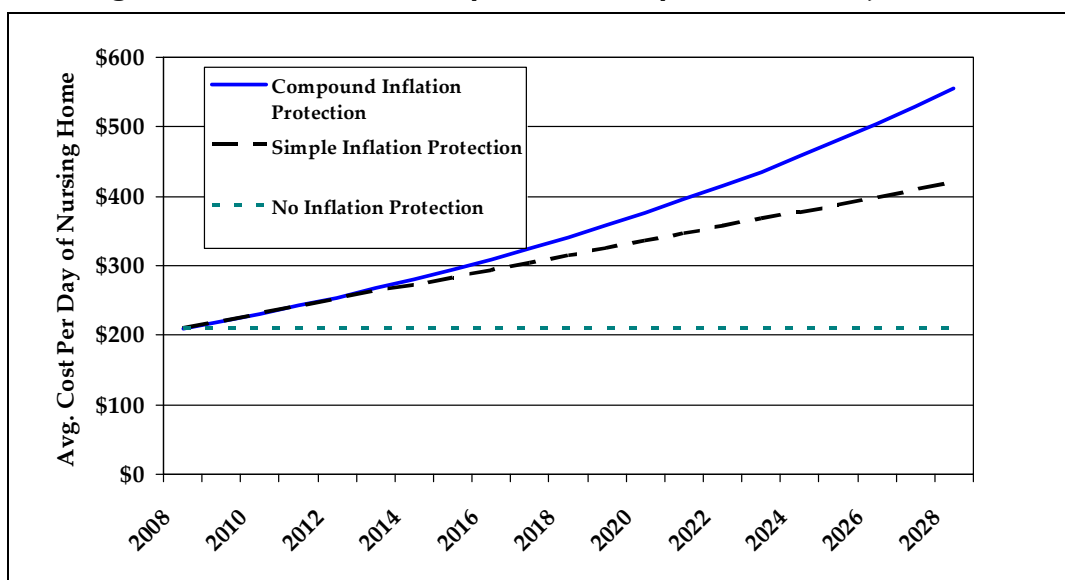
²⁷ America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market,” March 2012.

Policy Characteristics	1995	2000	2005	2010
—Nursing Home Care	\$85	\$109	\$142	\$153
—Home Care	\$78	\$106	\$135	\$152
% With Inflation Protection	33%	41%	76%	74%
—Simple	14%	17%	23%	12%
—Compound	15%	22%	49%	49%
—Indexed to CPI	4%	2%	4%	13%
Elimination Period for Nursing Home Benefit	46 days	47 days	81 days	90 days

Source: America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market,” March 2012.

In terms of the type of inflation protection, companies offer both simple and compound inflation adjustments. Although both methods increase the daily benefit by a fixed percentage, they vary on which year the percentage is applied. Simple inflation adjustments increase annually based on a fixed percentage of the daily benefit amount calculated from the *first year the policy is purchased*, so annual adjustments are a fixed dollar amount. Whereas compound inflation adjustments increase the daily benefit amount annually based on a fixed percentage calculated from each *previous year’s* daily benefit amount (see **Figure 2**), so the annual adjustments of the daily benefit amount increase over time.

Once the policyholder chooses the type of inflation protection, he or she then must decide how much inflation-protection to purchase annually. In making this decision, one approach would be to rely on historical data. For example, since 2000, the price of nursing home care increased at an annual average rate of 4.3%. However, it is unknown whether these trends will continue in the future. Potential policyholders must decide whether they should choose inflation protection based on historical trends or choose a higher or lower rate based on expectations about the future. This decision affects both the complexity and the cost of the policy.

Figure 2. Illustration of Compound vs. Simple Inflation Adjustments

Source: CRS Estimates. Daily benefit amounts in 2008 derived from Genworth Financial 2008 Cost of Care Survey, April 2008.

Notes: Inflation adjustments assume 5% annual rate of growth.

Duration of the Benefit

The length of coverage (in years) of a LTCI policy is called the *duration of the benefit*. Deciding how much coverage to purchase further complicates the decision process. LTCI policies can cover two to five years of services and some policies can provide lifetime benefits. Although potential policyholders want to purchase a policy that may sufficiently cover future risks, most do not know what that risk may be because it varies widely across the older population. For example, researchers have estimated that, of those who turned 65 years old in 2005, approximately one-third will not require any LTSS over their remaining lifetime. At the same time, one in five will require LTSS for more than five years.²⁸ The longer the duration of coverage, the higher the premiums.

Elimination Period

LTCI policies often have a waiting or elimination period that is the length of time between the onset of qualifying impairments and commencement of payment for LTSS. The elimination period is selected by the policyholder when he or she purchases the policy. This elimination period is conceptually similar to a deductible in a health care plan—the longer the elimination period the lower the cost of the policy, all other things equal. Policies purchased in 2010 tend to have a longer waiting (“elimination”) period, as compared with 15 years earlier (see **Table 2**). Unlike other policy design features, a longer elimination period (holding other design features constant) can reduce premiums.

²⁸ Kemper et al., “Long Term Care Over An Uncertain Future: What Can Current Retirees Expect,” *Inquiry*, winter 2005-2006.

Adequacy of Consumer Protections For Long-Term Care Insurance Policyholders

In addition to the cost and complexity of products, there has been a growing concern that many LTCI policies do not have sufficient consumer protections. These consumer protections are important given that a LTCI policy is often purchased 20 years or longer before the actual benefit is used. This long-time horizon introduces a great deal of uncertainty regarding the nature of future benefits, long-run affordability of premiums for purchasers, and the financial stability of insurers. Many of the laws and regulations that have been established by federal and state governments attempt to address these issues. However, each state has its own set of laws and regulations and there is wide variation across states.

State Oversight

State governments have primary jurisdiction for regulating the LTCI market. To do this, states have established laws and regulations for LTCI carriers and the products they sell and play an active role in verifying carriers' and products' compliance with these requirements. To help guide states in their LTCI oversight efforts, the National Association of Insurance Commissioners (NAIC) has developed a number of "Model Laws" and "Model Regulations" (hereinafter referred to as Model provisions), which provide recommended guidelines for state lawmakers and regulators to adopt. These Model provisions are updated periodically by the state insurance commissioners. Because each state ultimately establishes its own LTCI laws and regulations, state oversight requirements are not consistent across states, leaving gaps in consumer protections. According to the NAIC, all states, with the exception of Alaska, have adopted some components of the NAIC Model provisions, but there is wide variability in which provisions were adopted.²⁹

Federal Oversight

Since 1996, the federal government has attempted to standardize these regulations at a national level for certain LTCI products. Federal law has included provisions for federal tax benefits and minimum consumer protection standards for purchasers of "tax-qualified" LTCI policies as authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191).³⁰ HIPAA tax-qualified products must conform to most of the provisions in the 1993 NAIC Model Law and Regulations. These products are also required to offer (but not mandate) inflation protection.

The Medicaid Partnership Program established under DRA (see discussion earlier about hybrid LTCI products) includes minimum consumer protection requirements for the LTCI plans sold under the Partnership Program as specified in the 2000 NAIC Model Provisions (see **Table 3**). In contrast to the HIPAA voluntary 5% compound inflation-protection requirement, the DRA provisions include a mandatory inflation-protection provision for certain age groups for the Partnership Program. DRA, however, does not specify the amount of inflation-protection that is required and instead leaves this decision up to the individual states.

²⁹ NAIC's Compendium of State Laws on Insurance Topics, Long-Term Care Insurance Act Provisions, November 2011.

³⁰ These provisions for tax-qualification are also specified in the Internal Revenue Code (IRC) Section 7702(B)).

**Table 3. Summary of Consumer Protections for LTCI Specified
By Different Versions of the NAIC Model Provisions**

	1993 NAIC Model Provisions	2000 NAIC Model Provisions	2006 NAIC Model Provisions	2009 NAIC Model Provisions
Revised Pricing and Eligibility for LTCI	Yes	Yes	Yes	Yes
Strengthened Suitability and Rate Stability Provisions	No	Yes	Yes	Yes
Imposed Stricter Criteria for Training and Certification of Insurance Agents	No	No	Yes	Yes
Independent Review of Benefit Trigger Denials	No	No	No	Yes
Current Federal Law Requirements	Health Insurance Portability and Accountability Act (P.L. 104-191)	Deficit Reduction Act of 2005 (P.L. 109-171) ^a	None	None

Source: Congressional Research Service.

Notes: The term NAIC Model Provisions includes both the Model Regulations and the Model Law promulgated by the NAIC.

- a. The LTCI Partnership consumer protections described in the Deficit Reduction Act of 2005 did not include the rate stability language in the NAIC 2000 Model provisions.

However, federal laws standardizing LTCI regulations have become outdated and do not include all of the relevant provisions of a specific NAIC Model. For example, neither the HIPAA tax-qualified policies or the Medicaid Partnership Program were ever updated to include the rate stability provisions in the NAIC 2000 Model. These federal laws also do not address recent concerns about the misrepresentation of LTCI by unqualified sales agents nor inappropriate denial of claims. The following section provides more detail about each of these issues.

Premium Instability

Generally, premiums for LTCI are lower when policies are purchased at younger ages. Yet, younger purchasers will also be paying premiums over a longer period of time and long-run stability of premiums is important to ensure their affordability in the future. Although insurers are prohibited from increasing an individual's premium based on a change in the policyholder's circumstances (i.e., increased age or onset of disability), insurers, however, are still able to request permission from a state insurance commissioner to increase premiums for a class of insured.³¹

Comprehensive data on the extent of premium increases across all LTCI companies are not available. However, press reports suggest that major LTCI carriers have applied for or received approval for premium increases between 10% and 40% in one or more states.³² In addition, the

³¹ A class of insured is generally defined as all individuals of the same age with the same policy in the same state and with the same coverage.

³² A. Tergesen and L. Scism, "Long-Term Premiums Soar," Wall Street Journal, October 16, 2010.

Office of Personnel Management (OPM) announced that premium rates for current federal workers enrolled in the federal LTCI program who had purchased automatic compound inflation protection would increase 25% for most policyholders. These rate increases were a result of a new negotiated LTCI contract for federal workers that included a new benefit option with increased home health care reimbursements, new benefit periods, and higher daily benefit amounts. However, current enrollees who did experience premium increases were provided the opportunity to keep their current premiums substantially the same by making changes to their benefit package.³³

Premium increases can be necessitated by inadequate medical underwriting, premiums that were initially set too low, or insufficient growth in reserves to cover future claims.³⁴ Thus, premium or rate stability depends largely on the ability of insurers to adequately predict future claims. In addition, lower than predicted voluntary termination (lapse) rates and lower than predicted rates of return on investments have been cited as a key reason for the most recent round of increases.

Initially, in 2000, the NAIC revised its model provisions to require companies to provide actuarial information to certify the adequacy of all proposed rates and to show that the vast majority of premium increases are devoted to paying claims. In addition, when premiums are increased, 85% of the increased portion of the premium must be available to cover claims. Further, the 2000 NAIC Model Act requires reimbursement of unnecessary rate increases to policyholders. Policyholders are also provided the option to escape the effect of rising rate spirals by being guaranteed the right to switch to another lower premium policy. Finally, the 2000 NAIC Model provisions authorized the commissioner to ban from the market place for five years companies that persist in filing inadequate initial premiums. But most states have not adopted the full NAIC Model language for premium stability.³⁵

To address these concerns, the NAIC is currently re-evaluating its rate stability model language. Under the current model regulation an actuarial certification is required when companies submit a premium increase. Specifically, the NAIC model provision states that:

“The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.”

The NAIC has recognized that there are potential problems with the “moderately adverse” language because there is no explicit definition of what this means. As a result, the interpretation relies on the judgment of the pricing actuary which makes it difficult to regulate, even for states with an actuary on staff. Regulators are poorly equipped to judge the reasonableness of the company’s assumptions.³⁶ To address these concerns, the NAIC is currently exploring various options to strengthen its rate stability standards including the development of a more concrete definition of “moderately adverse events.”

³³ Office of Personnel Management, “OPM Awards New Long Term Care Insurance Contract,” press release, May 1, 2009.

³⁴ R. Desonia, “The Promise and Reality of Long-Term Care Insurance,” National Health Policy Forum. 2004.

³⁵ NAIC’s Compendium of State Laws on Insurance Topics, Long-Term Care Insurance Act Provisions, February 2009.

³⁶ T. Serbinowski, Utah Insurance Department, Presentation at the 12th Annual Intercompany Long-Term Care Insurance Conference, “Academy Practice Note Revisions and NAIC Model Regulation: Issues Relating to Rate Stability,” March 20, 2012.

Inappropriate Sales Practices

Following the 1993 NAIC Model Act, there had been a concern that some private sector insurers and agents were inappropriately selling products to persons with low income and assets who may otherwise be eligible for public assistance under Medicaid. In other words, these LTCI policies would not be *suitable* for certain individuals given their circumstances. There was also a concern that individuals may not fully understand the future value of the benefits they purchase. To address these issues, the 2000 NAIC Model required insurers to develop and use suitability standards, and to train agents with respect to the standards. Both insurers and agents must ascertain an applicant's ability to pay and his or her goals and needs through the use of a personal worksheet. There are a number of disclosure requirements related to suitability, including the requirement that the agent and insurer must distribute to the potential policyholder a brochure on the "Things to Know Before You Buy." Since then, the 2006 NAIC Model added provisions concerning training of insurance agents to address concerns about suitability. The 2006 Model also includes a new section on producer (insurance agent) training, which requires producers to complete a one-time eight-hour training course before selling LTCI. According to the NAIC, as of November 2008, 27 states have some form of agent's licensing requirements in their state legislation, but not all of them comply fully with the 2006 NAIC Model Act language.³⁷

Inappropriate Denial of Claims

There has been anecdotal evidence that some LTCI policyholders are having difficulty in accessing their benefits once a claim is filed.³⁸ Recent actions by the NAIC against a large LTCI company have heightened these concerns. National level data from the NAIC have also shown that the number of complaints regarding LTCI has increased between 2004 and 2006.³⁹ One of the key areas for complaints is the denial of claims. Although the number of claims denials has increased, the increase is not as large when adjusted by the number of claims submitted. The total percentage of claims denied for all policies increased since 2004 from 3.2% to 3.9% in 2006. The percentage of claims denied for comprehensive policies increased from 4.1% to 4.9% over the same period.⁴⁰ This data reflects activity from 2004 to 2006 and does not provide any information on more recent years.

Denial of claims can occur for a number of reasons. For example, a number of issues within the reimbursement process could lead to a delay in payment. The first relates to the eligibility for payments from the insurer. The policyholder (or his/her guardian) must notify the insurer and document that the policy has been "triggered." For example, for non-cognitive impairments this means the policyholder meets the requirement of needing assistance with two or more activities of daily living (ADLs).⁴¹ Documentation can include a written statement from the policyholder's physician verifying this information or the insurer may require an assigned care manager to assess eligibility. Thus, a claim can be denied if the insurer does not receive supporting documentation regarding eligibility for payment in a timely manner.

³⁷ NAIC's Compendium of State Laws on Insurance Topics, Long-Term Care Insurance Act Provisions, February 2009.

³⁸ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term?*, hearing, July 24, 2008.

³⁹ National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

⁴⁰ National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

⁴¹ ADLs include eating, bathing, dressing, toileting, transferring, or walking across the room.

Another reason for denying a claim is that the policyholder has not yet reached the end of the policy's elimination period. Between 2004 and 2006, denied claims for home care only policies because the elimination period had not been met increased 16.3%, for comprehensive policies they increased 37.5%. Finally, denied claims for nursing home benefits where the elimination period had not been met increased 17.7% over the same period.⁴²

Although anecdotal evidence raised concerns among policymakers that some insurers are further delaying claims on purpose,⁴³ national level data from the NAIC do not validate these concerns. According to the NAIC, denial of payments beyond 60 days was not a major issue between 2004 and 2006.⁴⁴ Other survey data support the fact that relatively few claims are denied. According to a Lifeplans Survey of 1,500 policyholders over a 2½-year period, 96% of claims were approved and 4% were denied. Those who conducted the survey suggest this indicates an industry-wide initial claims denial rate of 4%. The same survey reported that the vast majority (93%) of denied claims had a decision rendered within a two-month period and the remaining 7% within another two months.⁴⁵

Although problems in the delay of claims processing are not evident in the NAIC data collected between 2004 and 2006, there is evidence that the problem may be isolated for policies issued by one large insurer. The recent settlement against Conseco, Inc. highlights the use of improper processing practices by the company. In May 2008, state insurance regulators and the NAIC brought a regulatory settlement against Conseco, Inc. for mishandling of LTCI claims. Specifically, claims were not handled in a timely manner and claims files were not documented or maintained. The Conseco investigation found that the primary problem in most cases was a delay in payment of the claim, rather than a denial.

Given these concerns the NAIC adopted in 2009 language to the NAIC Model Act that provides for external independent review of benefit trigger denials. The NAIC also created a subgroup to review existing methods by which companies report claims denials. The subgroup recommended and the NAIC adopted changes to the reporting form so that it is clear which method is being used (per claimant, or per transaction).⁴⁶

Solvency of Long-Term Care Insurance Companies

Following the recent economic downturn, concerns about the long-run solvency of LTCI companies may adversely affect the demand for the product. Amidst this uncertainty, potential LTCI policyholders may decide to wait until the economic situation improves before contemplating a purchase of LTCI. In addition, there are concerns about the guarantee of benefits for current policyholders.

The insurance industry does provide a number of safeguards to protect LTCI policyholders from an insolvent insurer. The current system of protection for LTCI policyholders is called insurance

⁴² National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

⁴³ Charles Duhigg, "Aged, Frail and Denied Care by Their Insurers," *New York Times*, March 26, 2007.

⁴⁴ National Association of Insurance Commissioners, "Long-Term Care Data Call and Analysis Report," May 9, 2008.

⁴⁵ Testimony of M. Cohen, president, LifePlans, Inc., before the U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term?*, hearings, July 24, 2008.

⁴⁶ Based on conversations with NAIC staff on April 21, 2009.

guaranty funds. This interdependent system is a cooperative effort among regulators and insurers in the states where the insolvent insurer operated. It is administered state-by-state and funded by assessments on insurers.⁴⁷ When an insurer's financial condition deteriorates to the point where it may have trouble meeting its obligations, it is placed into receivership. In effect, the company and its policies are taken over by the insurance commissioner of the state where the insurer is domiciled. In the absence of bankruptcy, the commissioner may need to establish a plan to ensure policyholders receive coverage or benefits. For example, the insurance commissioner may allow other insurers to purchase parts of the troubled insurer's business. If, however, the company is liquidated, a state guaranty association may need to assume or reinsure policies of the failed insurer.

State law requires insurers to become members of the guaranty associations in each state in which they are licensed to do business. For health and LTCI, the average coverage is about \$100,000. One concern about guaranty funds is that the amount of coverage per policy may not be sufficient to insure future potential losses due to insolvency. This does raise the possibility that the guaranty funds would have to raise premium rates and potentially reduce benefits for current policyholders in the future if even a few insurers become insolvent.

Efforts to Expand Participation in the Long-Term Care Insurance Market

If participation rates increase in the private LTCI market, most actuaries agree that the overall costs of policies may be further reduced because the available risk-pool would be larger. Specifically, one of the key premises of insurance is to spread risk across as large a population as possible. Adverse selection occurs when individuals who expect to have a higher risk of needing LTSS in the future (e.g., family history of Alzheimer's) are more likely to purchase a policy than those who do not. In a voluntary program, low participation may limit an insurer's ability to spread risk adequately resulting in adverse selection. When adverse selection is present in a voluntary system, insurers must charge higher premiums to cover the higher risk of the insured group. Thus, the greater the participation among the general population, the lower the effects of adverse selection.

Many of the concerns about adverse selection were raised when the CLASS Program under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) was enacted, which was intended to be a voluntary, federally administered LTCI program.⁴⁸ According to the American Academy of Actuaries, design features of the program, such as guaranteed issue (e.g., no pre-existing condition exclusions), and the voluntary nature of the program may lead to those most likely needing the benefit to opt-in and healthy individuals, who may not need the benefit, to opt-out.⁴⁹ It was anticipated that adverse selection would likely lead to higher than average premiums and further reduce demand for the CLASS program among young and healthy individuals. In fact, after examining the actuarial, marketing, and legal issues for a financially

⁴⁷ For more information on these funds, see CRS Report RL32175, *Insurance Guaranty Funds*, by (name redacted).

⁴⁸ For a complete description of the CLASS program provisions, see CRS Report R40842, *Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

⁴⁹ Ibid.

solvent program over the next 75 years, HHS sent a letter to Congress, stating that the Administration does not see a viable path forward for implementation of the CLASS program at this time.⁵⁰ On January 2, 2013, The American Taxpayers Relief Act of 2012 (P.L. 112-240), among other things, repealed the CLASS program.

Legislative proposals intended to increase the demand for private LTCI policies, and overall participation rates, may include proposals to

- increase tax incentives to lower the after-tax cost of policies,
- improve consumer protections and increase consumer confidence in the product, and
- expand consumer education.

The following describes these proposals in greater detail.

Expand Tax Incentives to Improve Affordability

Under current law, premiums paid by employees may be subject to a premium conversion arrangement under a cafeteria plan (flexible spending type account) and deductible from their taxable income. There are also other tax credits available to certain individuals who purchase health care insurance in the individual market.⁵¹ However, LTCI premiums currently do not have as generous tax incentives as health insurance. But a recent survey by AHIP suggests that increased tax incentives may increase the demand for LTCI. Specifically, according to the AHIP survey, 87% of respondents who chose not to purchase LTCI said they would be “much more interested” or “more interested” if they could deduct premiums from their taxable income.⁵²

This section will first discuss the current tax treatment of LTCI and then detail potential legislative proposals and their implications for after-tax LTCI premiums.

Current Tax Treatment

Under current law, there are some tax advantages provided to some aspects of private LTCI. Benefits from a “qualified” LTCI policy are excluded from the gross income of the taxpayer (i.e., they are exempt from taxation).⁵³ In addition, premiums for LTCI are allowed as itemized deductions to the extent they and other unreimbursed medical expenses exceed 10% of adjusted gross income (AGI) for those under age 65 and 7.5% of AGI for those 65 and older.⁵⁴ LTCI premium deductions, however, are subject to age-adjusted limits. In 2013, these limits range annually from \$360 for persons aged 40 or younger up to \$4,550 for persons over the age of 70.

⁵⁰ Letter from Kathleen G. Sebelius, Secretary of Health and Human Services, to Representative John Boehner, Speaker of the House, October 14, 2011, <http://www.hhs.gov/secretary/letter10142011.html>.

⁵¹ See CRS Report RL32620, *Health Coverage Tax Credit*, by (name redacted).

⁵² America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance in 2010-2011? A Twenty Year Study of Buyers and Non-Buyers in the Individual Market,” March 2012.

⁵³ Health Insurance Portability and Accountability Act, P.L. 104-191 and Section 7702B(b) of the Internal Revenue Code.

⁵⁴ This percentage will increase from 7.5% to 10% in 2016 for those age 65 and older due to changes in IRC 213(d) enacted by ACA.

In addition, under current law, employer contributions toward the cost of tax-qualified LTCI policies are excluded from the gross income of the employee. Self-employed individuals are allowed to include LTCI premiums in calculating their deductions for health insurance expenses. Only amounts less than or equal to the age-adjusted limits can be deducted or excluded from taxable income.

In addition, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) authorized Health Savings Accounts (HSAs), which allow individuals to pay for LTCI premiums on a tax-advantaged basis. Individuals are eligible to establish and contribute to an HSA if they have a qualifying high deductible health plan (HDHP). Individuals enrolled in Medicare are excluded. Withdrawals from HSAs are exempt from federal income taxes if used for purchase of LTCI.⁵⁵

As noted earlier, a number of legislative changes to the tax code have enabled insurers to develop hybrid products that combine LTCI with either an annuity or a life insurance product. The Pension Protection Act (PPA) of 2006 simplified tax rules regarding combination products (effective in 2010) and added a tax provision specifying that proceeds from an annuity can be used tax-free to purchase a tax-qualified LTCI policy (under Section 7702B(b) of the Internal Revenue Code (IRC)). PPA also allows individuals to use the cash surrender value of a life insurance policy as payment for a tax-qualified LTCI policy and exclude these payments from taxable income. Finally, PPA revised Section 1035 of the IRC to allow for tax-free exchanges of certain insurance contracts. Under this provision, no gain or loss is recognized on the exchange of a life insurance contract, an endowment contract, an annuity contract for a qualified LTCI contract or the exchange of one qualified LTCI contract for another.

Legislative Proposals To Expand Tax Incentives

Expanding tax incentives for long-term care insurance may improve the affordability of policies by reducing the after-tax cost of policies and increasing the demand for LTCI. To do this, LTCI premiums could be included in one or more of the following options:

- an employer-sponsored cafeteria or flexible spending account plan, which would exclude them from gross income;
- as an “above-the-line” tax deduction to arrive at AGI; or
- as a credit against tax liability (“tax credit”).

Table 4 summarizes the advantages and disadvantages of each option.

⁵⁵ CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2012*, by (name redacted).

Table 4. Advantages and Disadvantages to Taxpayers of Alternative Tax Incentives for LTCI Premiums

Tax Treatment of LTC Insurance Premiums	Advantages	Disadvantages
Cafeteria Plan or Flexible Spending Account	Not limited to taxpayers who itemize. Reduces AGI for purposes of other tax provisions. Lowers wage base for Social Security and Medicare taxes on wages.	Only available if the employer offers a cafeteria or flexible spending plan.
Above-the-Line Deduction	Not limited to taxpayers who itemize. Reduces AGI for purposes of other tax provisions.	Required to pay Social Security and Medicare payroll taxes on income used to fund premiums.
Tax Credit	Reduces regular tax liability by amount of credit.	Non-refundable tax credit. If tax liability is less than the credit amount then taxpayer would not benefit from full credit.

Source: Congressional Research Service.

Include in Cafeteria and Flexible Spending Accounts

Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional taxable take-home pay) and certain non-taxable benefits. Under this option, LTCI would be an eligible benefit within the plan and the employee would not be taxed on the value of the benefit. This arrangement reduces both income and employment taxes (i.e., Social Security and Medicare payroll taxes). Under some of the current legislative proposals, LTCI could also be an eligible expense in a flexible spending account (FSA). FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. Reimbursements through an FSA are also exempt from income and employment taxes.⁵⁶ Including LTCI in a cafeteria plan or FSA would also reduce adjusted gross income for purposes of other tax provisions. Cafeteria plans and FSAs only benefit individuals whose employer has established such plans.⁵⁷ For an individual filer with \$55,000 in gross income and in the 25% tax bracket, this option would reduce the effective cost of the premiums by 32.65% (this includes a reduction in employment taxes of 7.65% as well).⁵⁸

Above-the-Line Deduction

Under this option, LTCI premiums would be deducted from a taxpayer's gross income. An above-the-line deduction also reduces adjusted gross income for other tax provisions. The key difference from a cafeteria plan is that the provision is available to everyone and not limited to those employers who offer a plan. In addition, under this option, LTCI premiums (even if deducted

⁵⁶ See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law*, by (name redacted).

⁵⁷ Retired workers are not likely to have coverage, as they would not have access to a cafeteria plan and only a former employer and not the individual covered contributes to a retiree's FSA.

⁵⁸ Example assumes a 50-year old individual who is a single tax filer with no dependents, earns \$55,000 a year and is in the 25% tax bracket.

from gross income) would still be subject to employment taxes if the individual were employed. For an individual filer with \$55,000 in income and in the 25% tax bracket, this option would reduce after-tax LTCI premiums by 25%.

Tax Credit

A tax credit is applied directly against a taxpayer's tax liability. The key distinction in a tax credit is whether it is refundable or nonrefundable. A fully refundable tax credit is paid to the taxpayer even if the amount of the credit exceeds the taxpayer's tax liability. Under a nonrefundable credit, if the tax liability is less than the credit amount of all refundable credits available, then the taxpayer would not benefit from the full credit. Under this option, after tax premiums for the individual filer with \$55,000 in gross income would decline dollar for dollar by the amount of the tax credit if the individual's tax liability was equal to or exceeded the amount of all available tax credits.

Other Provisions

Although the discussion above provides a brief overview of the impact of the different options, actual tax savings will vary depending on the specific details of each of the proposals. To minimize the cost to the federal government, many of the current legislative proposals would not allow the full deduction or credit of premiums initially. Instead these proposals would

- phase-in the deduction or credit over time;
- base the percentage of LTCI premiums that is deductible or creditable on the number of years a policy is held; or
- limit the income from which a deduction can be taken, allowing only a deduction from gross income for distributions from a 401(k) or IRA.

Improve Consumer Protections

As the market for LTCI expands, there is a growing concern that current regulations may not be sufficient to protect consumers from potential abuses in claims administration and processing and future rate stability. To address these issues, legislative proposals that are introduced to expand tax incentives for LTCI may also require these tax-qualified policies to meet specific NAIC Model Regulations and Laws. (See **Table 3** for a summary of different versions of the NAIC Model provisions with respect to consumer protections.)

Expand Consumer Education

The Long-Term Care Awareness Campaign is a joint federal-state initiative to increase awareness among the American public about the importance of planning for future LTC needs. The Own Your Future Campaign is a collaboration of the Centers for Medicare & Medicaid Services (see <http://www.cms.hhs.gov>), the Office of the Assistant Secretary for Planning & Evaluation (see <http://www.aspe.hhs.gov>), and the Administration on Aging (see <http://www.aoa.gov>), and it has support from the National Governors Association (see <http://www.nga.org>). The program was started in January 2005. The project's core activities are state-based direct mail campaigns supported by each participating state's governor, and targeted to households with members

between the ages of 45 to 70. Campaign materials include a Long-Term Care Planning Kit and state specific information and resources in both print and on the internet. As of January 2010, 25 states have participated in the Long-term Care Campaign to increase awareness of the need to plan for future LTSS.

The response from consumers to the first two phases of the Own Your Future Campaign exceeded expectations, both in terms of consumer interest and in initiating LTSS planning actions. Research following a five-state phase of the campaign indicated that individuals who received the planning kit were twice as likely to take some type of LTSS planning action as compared to those who did not receive the kit. Based on these successes, Congress provided additional support for these education initiatives by establishing the National Clearinghouse for Long-Term Care Information under the Deficit Reduction Act of 2005. Under Section 6021(d) of the act, Congress appropriated \$15 million in funding for the National Clearinghouse over five years (2006 to 2010). While ACA had extended funding for the Clearinghouse to 2015 in enacting the CLASS program, the recently enacted American Taxpayers Relief Act of 2012, in repealing the CLASS program, also rescinds the unobligated balance of ACA's funds for the National Clearinghouse.

Legislative proposals in the 113th Congress may expand or extend further into the future funding for the National Clearinghouse.

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