

## **Long-Term Care Innovation (B) Subgroup: Federal Policy Options to Present to Congress**

The following is a list of federal policy changes that have been raised by various stakeholders, submitted to all Subgroup members. The Subgroup believes these federal policy changes could help to increase private LTC financing options for consumers. The federal laws primarily identified by stakeholders that would require changes include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Deficit Reduction Act of 2005 (DRA).

- **Option 1: Permit retirement plan participants to make a distribution from 401(k), 403(b) or Individual Retirement Account (IRA) to purchase LTCI with no early withdrawal tax penalty.** Related considerations include whether premium payments should be made directly from the retirement plan to the insurer; allowing purchase of combination or hybrid products as well as traditional LTCI; whether premium payments would be counted for purposes of satisfying the minimum distribution requirements; and permitting tax-favored contributions and distributions to pay for long term care services and supports or LTC insurance including allowances of LTCI as a plan investment.
- **Option 2: Allow Creation of LTC Savings Accounts, similar to Health Savings Accounts (HSAs) and/or Enhance Use of HSAs for LTC Expenses and Premiums.** HSAs are tax-advantaged medical savings accounts available to taxpayers who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit. Advantages of HSAs include: 1) the account is tax-advantaged, meaning that money goes into the account before tax, thereby incenting savings; 2) the funds roll over from one year to the next; 3) the money can be invested in order to gain returns from stocks or other financial instruments, which helps the account grow more quickly; and 4) money withdrawn (including any investment growth) for approved expenses (which include LTCI premiums under current law) is tax-free. Consideration should be given to stand-alone accounts which could be used for LTC expenses and LTCI premiums. Such accounts should not be conditioned upon having a HDHP, since health insurance coverage generally does not cover LTC costs. Consideration also should be given to enhancing use of HSAs such as allowing an additional contribution (similar to a “catch-up contribution”) to HSAs for owners of LTCI.

- Option 3: Remove the HIPAA requirement to offer 5% compound inflation with LTCI policies and remove the requirement that DRA Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection.** In an LTCI policy with inflation protection, the LTC benefit increases each year at a specified rate; the aim of inflation protection is to ensure that the value of the benefit keeps up with inflation. Inflation protection substantially increases LTCI premiums. For tax-qualified policies and those governed by the NAIC Model Regulation, a 5% inflation protection option must be offered, although a purchaser may choose not to take it. However, if the purchaser is under 75, they must accept inflation protection in order for the policy to be Partnership qualified. For group coverage, this option must be offered to the group policyholder (usually an employer), but it is not generally required that it be offered to each individual group member, although some states require this as well. Removal of the requirement that insurers offer 5% compound inflation with LTCI policies and the requirement that Partnership policies include inflation protection would increase insurer flexibility when designing products and could lead to lower premium costs. At the same time, consideration should be given to requiring an offering of some type of inflation protection to ensure consumers continue to have the option to protect themselves against increasing LTC costs. [Note: this would require both federal changes, changes to the NAIC models, and adoption of revised NAIC models by states.]
- Option 4: Allow flexible premium structures and/or cash value beyond return of premium (HIPAA and DRA).** Flexible premium policies with clear consumer disclosures and protections built in could increase consumer choice and flexibility by allowing prefunding for LTC needs under a variety of premium payment patterns. Cash value or cash surrender value is the amount of money the insurance company pays a policyholder or beneficiary when they terminate a life insurance policy or annuity contract that has a cash value feature. Federal law (HIPAA) prohibits tax qualified LTCI policies (but not hybrid products) from containing a cash value feature. Prohibiting cash value creates a “use it or lose it” design for LTCI, because a policyholder only receives a benefit from their policy if they need LTC services. [Note: some flexible premiums structures may be permissible under current federal law, but they are limited by the prohibition on cash value.]
- Option 5: Allow products that combine LTC coverage with various insurance products (including products that “morph” into LTCI).** Many stakeholders emphasized the need for regulatory changes at the federal level to allow for LTCI innovation and market expansion. One consistent view of stakeholders is the need to expand products that can address a consumer’s needs over time. Products that offer life, disability, critical illness, supplemental, and other benefits could be allowed in various combinations with or for conversion to LTCI, such as after the policyholder reaches a certain age. Legislative changes specifically allowing this type of product would be required for pertinent federal tax and NAIC governing documents.

- Option 6: Support innovation by improving alignment between federal law and NAIC models (HIPAA and DRA).** HIPAA and the DRA require that LTC policies comply with specific provisions of outdated versions of the NAIC model act and regulation. The NAIC regularly updates its models, and this may result in confusion as the NAIC models evolve while federal law continues to reference old models. Therefore, it may make sense for federal law to reference and require compliance with pertinent provisions of the “current” version of the NAIC model for newly issued contracts (with appropriate transition rules to address model amendments) rather than require compliance with specific provisions of a specific version of the model. This would allow federal law to evolve as the NAIC, a collaborative body with active involvement of consumer and industry representatives, updates the models as needed. This would increase the flexibility of federal law to adapt to the evolving LTC market and regulatory requirements, and reduce confusion and possible inconsistencies between state and federal law.
- Option 7: Create a more appropriate regulatory environment for Group LTCI and worksite coverage (HIPAA and DRA).** Ideas for consideration could include addressing concerns that may prevent an employer from providing LTCI on an opt-out basis by a) providing a safe harbor to limit the employer’s fiduciary liability and b) allowing an employer to offer expanded “catch-up” contributions; and/or permitting LTCI to be available for purchase through cafeteria plans.
- Option 8: Establish more generous federal tax incentives.** Ideas for consideration include allowing a full federal tax deduction for LTCI premiums (rather than for expenses over 7.5-10% of Adjusted Gross Income) each year an LTCI policy is in force and/or allowing purchases of LTCI under cafeteria plans and from FSAs (consideration may be given to whether tax incentives should be income-based or means tested to focus on lower and middle-income Americans who may not otherwise purchase a LTCI policy); and/or allowing shorter maximum benefit plans (<1 year) to be tax qualified to incent market expansion through lower-priced, shorter duration products.
- Option 9: Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans.** Medicare provides extensive acute care coverage but more limited post-acute coverage (home health and skilled nursing facility care). Medicare Advantage and Medigap plans fill the gaps in Medicare. But most LTC services are not covered by Medicare, leaving a considerable gap in coverage for post-acute care. The most comprehensive Medicare Advantage and Medigap plans do not cover LTC services, other than the daily Medicare co-payment for the 21st to 100th day of Medicare covered skilled care; they do not cover intermediate care, assisted living, Alzheimer's, custodial or adult day care. Medigap and Medicare Advantage plans only supplement Medicare covered nursing home care on a temporary basis, and help with hospice coverage. There has been discussion

of adding either something akin to a long term care benefit or, less extensive, new home and community based benefits either to Medicare (which would affect supplemental carriers) or to Medicare Advantage and/or Medigap plans. If new benefits were provided in supplemental coverage it could make those products more expensive, though that increased cost might be offset by savings from delaying or preventing the use of more expensive institutional care. [Note: this would require federal changes to Medicare, changes to the NAIC models governing Medigap benefits, and adoption of revised NAIC models by states.]

- **Option 10: Federal education campaign around retirement security and the importance of planning for potential LTC needs.** The federal government could provide funding and partner with states to provide education to consumers about retirement security. Such a campaign would focus on encouraging people to think about their future retirement and long term care needs and provide education on the array of private products available to help finance these costs.