Ohio Department of Insurance

Long Term Care Insurance Incentive Study

FINAL REPORT

December 28, 2022

PFM Group Consulting LLC
BNY Mellon Center
1735 Market Street
42nd Floor
Philadelphia, PA 19103

Contents

Executive Summary

Introduction

The state and national populations are aging, and this trend is expected to continue – and accelerate – in the future. As U.S. citizens grow older and live longer, the needs associated with that population grow. These include health care broadly, and long-term services and supports (LTSS) in particular. While LTSS is often associated with nursing home care, it also includes in-home care, assisted living facilities, and other types of settings. One predictive model finds that 56 percent of Americans turning 65 will develop a disability serious enough to require LTSS, and 22 percent will have a disability requiring LTSS of more than five years.

The general population tends to believe that Medicare, which is the national health insurance program for those ages 65 and older, will cover the costs associated with LTSS. While Medicare will cover healthcare required nursing home care, it will only do so for a maximum of 100 days and only fully cover the costs for 20 days. In fact, the payer of last resort for those who cannot afford nursing home care is Medicaid, but it has income restrictions and generally requires a significant spend down of assets before individuals are eligible for coverage.

While Medicare is a health insurance plan paid for by taxes paid by both employers and employees, Medicaid is program jointly funded by federal and state appropriations. While it had a modest beginning in the 1960s, it has grown exponentially since then in terms of covered services and the cost. While the federal government pays a minimum of 50 percent of the costs associated with Medicaid (with states with a lower share of national personal income getting a larger federal match), the expenditure burden on the states is significant. For nearly all states, Medicaid is either the largest or second largest category of expenditure (with support for public K-12 education being the other primary category).

For most people – and for states – Medicaid as the payer of last resort for nursing home care is sub-optimal. As a result, looking for answers to reduce the state costs associated with long term care (LTC) makes sense. This would include strategies that reduce the likelihood of needing LTSS, such as healthy living approaches, but, as previously noted, LTSS is still going to be needed by a significant share of the population (and includes those who may require these services well before they reach ages 65 and older). As a result, it is worth considering options that would provide insurance coverage for those needing LTSS, which leads to the discussion of long-term care insurance (LTCI).

Long Term Care Insurance Issues

LTCI was created in the 1970s, and insurance carriers viewed it as an extension of their life insurance business. Today, LTCI cover a wide range of services and facilities, including assisted living, in-home health care services, adult day care as well as traditional nursing home care. As with any insurance policy, the cost will be determined by factors that include the age and health of the person insured, the services that will be covered, the length of time the policy will pay benefits, and an inflation factor. If benefits are paid on the policy, there are differing methods, primarily a per-day amount or an expenses incurred amount. Each of these options will have an impact on the overall cost.

While LTCI was originally offered by numerous companies, that number has declined significantly. While about 100 carriers were offering LTCI as late as 2004, that number is now down to about 12 active carriers. Premium rate increases have been an issue of concern related to LTCI. There have been significant rate increases over the years, which have been attributed to the industry underestimating the growth in the need for LTSS as well as the costs associated with it. It is notable that a federal program for its employees that provides coverage for LTCI is suspending the program because of insurance premium cost increases.

As noted, the insurance premiums for LTCI will vary considerably based on a variety of factors. As a point of comparison, the average premium cost for LTCI for a male age 55 is $1,700 a year and $2,675 for a female

age 55, while a combined policy for a couple would be $3,050. The premium costs will be expected to grow at a rate larger than the inflation rate.

Given the expense associated with LTCI, and the very real possibility that no claims will be made against the policy during its lifetime, LTCI is not necessarily the right choice for many people. For individuals with limited financial means, the ability to access Medicaid to cover LTC costs may well be the right financial decision. On the other end of the spectrum, for those who have the financial resources to pay for LTC, there is no need to purchase insurance. That still leaves a significant 'sweet spot' of people where it would make financial sense to purchase LTCI.

It is likely that the number of Ohioans who should have LTCI is much larger than the number who do. Only about two percent of Ohioans currently have LTCI. The number of lives covered by LTCI policies is just over 200,000. Given the small number who purchase it, it makes sense to determine if there are methods to increase the numbers of Ohioans who carry LTCI.

Current Long Term Care Insurance Incentives in Ohio and Other States

Most states provide some incentive for those who purchase LTCI. In most states (and the federal government) this is a tax deduction. Many states fashion their tax deduction to align with the federal tax requirements. These define the deduction for LTCI as a health care-related deduction. To claim it, a taxpayer must itemize their deductions and non-reimbursable health care expenses must exceed 7.5 percent of taxable income. As a result, this deduction is not useful for most taxpayers.

There are many states (including Ohio) where the deduction may be claimed without meeting the federal requirements. However, it should be noted that in all states, the state personal income tax rates are well below the federal income tax rates, which means that the value of a deduction of taxable income is not a large change in taxes owed to the state. In the case of Ohio, for a taxpayer with an income of $50,000 and a LTCI premium of $2,000, the existing state income tax deduction results in a tax benefit of approximately $65. This is unlikely to be an inducement to the purchase of LTCI.

An alternative that is used in a smaller number of states is to provide an income tax credit as an incentive. In most situations, a tax credit is preferable to a tax deduction, as it reduces the amount of tax owed, rather than reducing the income subject to tax. As noted, tax credits are in place in about seven states, but these credits are also limited, generally in terms of the amount of the benefit that can be claimed, either for an individual or an employer.

There is no real evidence that either the existing deductions or credits changes the behavior of individuals related to the purchase of LTCI. The project team examined the dollar value of LTCI incentives and found no correlation with the percentage of state population that purchased LTCI or its relationship to the per capita population accessing Medicaid for LTC.

There are likely several reasons for this, but the primary ones that might shape Ohio's choice of policy alternatives are:

1. **The general population does not perceive the need for insurance.**
   In this case, no incentive is going to be effective, because there is not a belief that the purchase has value, no matter the discount associated with the incentive. In this instance, it is likely that a much stronger, focused educational campaign is necessary.

2. **The offered incentive is insufficient to motivate a behavior change.**
   This is an important consideration, and one the project team believes is a significant part of the lack of performance of existing tax credits. This includes those who decided to purchase it without the

incentive. This is what is often described as the 'but for test' – would individuals have done what you are incentivizing them to do even without the incentive. In the case of LTCI, it is likely because the incentive (even in the cases of tax credits) is not sufficient to motivate a behavior change.

Incentive Options

The existing incentives to promote the purchase of LTCI do not seem to have changed behavior. It is important to note that this may also be a result of changes in the industry, premium increases, etc. It is entirely possible that incenting the purchase of this product is not in the best interest of the state. That is outside the scope of this analysis.

When looking at alternatives, Ohio may consider going to a tax credit. This certainly increases the tax benefit for those who take it. However, even in states where it is offered, it is generally limited in ways that reduce its effectiveness as an incentive for the purchase of LTCI. From the analysis, it is not likely that this has materially impacted the number of individuals covered by LTCI in the states that have a credit.

When thinking about incentives, tax incentives are often a sort of 'shot gun' approach, as the incentive applies to all who qualify. So, the 'incentive' will be available, for example, to taxpayers who had already chosen to purchase LTCI. They still get to realize the benefit even if it did not motivate them to purchase LTCI.

A more focused approach would be to subsidize the first-time purchase of LTCI. While a full subsidization of the insurance costs would be extremely costly and not likely to fit within state budget parameters, it might be possible to structure a one-time program that would significantly increase LTCI participation. The following are ways that it might be structured:

- **Dollar for dollar credit for insurance companies.**
  An incentive program could be designed where companies writing new LTCI receive a credit for a reduction in the premiums for policies against what they owe in insurance premium tax. This could be structured as a first come, first served program so that the lost revenue for the state could be controlled. That limitation might also spur participation. The additional value of providing it as an incentive for insurance companies is that they, rather than the state, would market it and seek to drive consumers to it. In that case, the state would have to set eligibility parameters.

- **Subsidization via a non-tax credit.**
  In many cases, tax credits are not the best way to incent behavior. First, they provide a benefit to people who would have done so anyway (in this case, the purchase of LTCI). Second, they may not target it to the primary audience. In this way, tax incentives are a 'shotgun blast' rather than a 'rifle shot.'

  In most instances, some form of a program with eligibility criteria and then a grant or loan can have the same impact as a tax incentive and better target the results for the expected impact. That could certainly be the case here. The following are methods that Ohio could consider to increase LTIC participation:

  - **Subsidize a portion of the insurance premium**.
    A program could provide a payment for a dollar value or percentage of the payment for a first-time purchase of LTCI. This could be structured to be a meaningful first-time payment. The expectation would be that the person would then continue to premium payments in following years, which would be a reasonable expectation. In this case, the first subsidization would be the 'carrot' to incent that participation.

- **Incorporate hybrid policies into the state LTC partnership program.**
  Hybrid policies provide consumers with components of both life insurance (with a death benefit) and long-term care service payments. Combining these two could provide value to Ohio consumers.

- **Allow the use of non-taxed retirement assets for the purchase of LTCI.**
  Individual retirement accounts, such as 401ks, are not taxed for the federal and state income tax purposes at the time of contributions. It would be possible for the state of Ohio, for its personal income tax, to not tax distributions that went for payment of LTCI. This would not apply to the federal tax treatment so might not be a useful incentive.

Summary

The need for long-term care is significant, and it is likely to grow over time. There is a disconnect with the general population related to what will cover the costs of long-term care. It is likely that until this knowledge gap is closed, it will be difficult to close the gap between those who have LTCI and those who should.

There is no evidence that current tax incentives – which are often small – are impacting people's decision to purchase LTCI. It is likely that a more impactful incentive, as discussed here, will be necessary for a significant behavior change.

Chapter 1: Introduction and LTC Issues

Introduction

Language in the state of Ohio's fiscal year (FY) 2022-2023 biennium budget bill (House Bill 110) required the Departments of Insurance and Medicaid to conduct an objective study examining the issuance of tax and non-tax incentives for the purchase of long-term care insurance (LTCI). Specifically, the study was required to address the following topics:[1]

- Whether allowing an incentive such as a tax credit or other incentive based on the cost an individual incurs to purchase LTCI would increase the number of Ohioans that purchase such insurance;
- Whether employers or other group insurance plan providers should be able to purchase LTCI policies for their employees or members, and whether allowing an incentive such as a tax credit or other incentive to such employers or providers would increase the number of Ohioans with such insurance;
- Whether hybrid life insurance policies should be included in the state long-term care (LTC) partnership program;[2] and
- Incentive options and a range of incentive amounts, if any, that could effectively increase the number of Ohioans that purchase LTCI.

Via a competitive Request for Proposals (RFP) process, PFM Group Consulting was selected in June 2022 to conduct the study, which commenced in July 2022. A description of the project approach and activities is provided in Appendix A.

The project primarily discusses two topics: incentives and long-term care (LTC). Incentives are anything that motivates a person to do something. In this case, the primary considerations are economic incentives, which are financial motivations for people to take certain actions – in this case, the purchase of LTCI.

The remainder of this chapter identifies key issues related to LTC. While LTC is often considered to be synonymous with nursing home care, that is not the case. The U.S. Department of Health and Human Services' Centers on Medicare and Medicaid Services (CMS) defines LTC as "Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age."[3] In fact, LTC for those with physical or developmental disabilities is the largest expenditure cohort.

CMS also notes that "Medicare and most health insurance plans don't pay for LTC." This is an important point, and one that is often misunderstood by the general public.

[1] Ohio House Bill 110, Section 757.30. Accessed electronically at https://search-prod.lis.state.oh.us/solarapi/v1/general_assembly_134/bills/hb110/EN/07/hb110_07_EN?format=pdf
[2] As defined in Section 3923.41 of the Ohio Revised Code, the LTC partnership program allows individuals to purchase LTCI policies while keeping assets that would otherwise disqualify the individuals from Medicaid.
[3] Glossary of terms, Healthcare.Gov, accessed electronically at https://www.healthcare.gov/glossary/long-term-care/

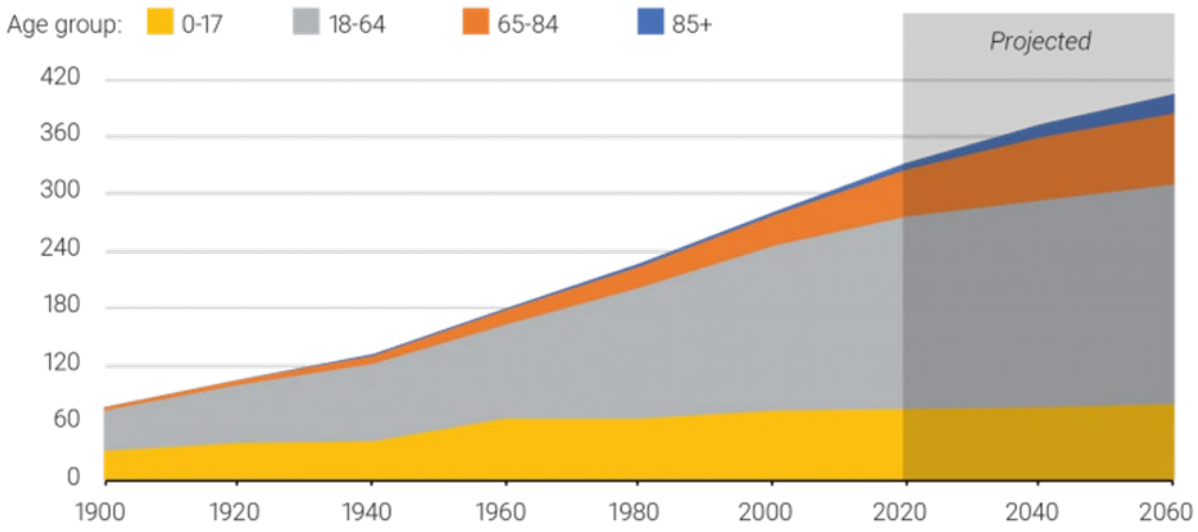
Demographics

The Aging U.S. Population

By nearly any objective measure, the U.S. population is aging. In fact, the growth in the population ages 65 and over is unprecedented in U.S. history. Since the year 1900, the percentage of Americans ages 65 and older has grown, from 4 percent in 1900 to 16 percent in 2019. Besides the numerical growth, the population continues to become increasingly older. In 2019, the 65-74 age group (comprised of 31.5 million people) was more than 14 times larger than in 1900 (2.2 million); the 75-84 group (16 million people) was 20 times larger than in 1900 (0.8 million); and the 85 and older group (6.6 million) was more than 53 times larger (0.1 million).[4]

Based on current trends, it is expected that this growth will continue. As the following figure demonstrates, Census Bureau population estimates to the year 2060 suggest that the number of persons in the 0-17 age group will remain relatively flat in the period from 1960 to 2060. While the estimate is that there will continue to be substantial growth in the age cohort from 18-64, on a percentage basis, the growth is larger for those in the ages 65-84 and 85 and over cohorts.

Figure 1: U.S. Population by Age Group (millions), 1900 to 2060



Source: U.S. Census Bureau, Decennial Census and Vintage 2017 Population Projections

The number of U.S. residents ages 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060, and the 65-and-older age group's share of the total population will rise from 16 percent to 23 percent.[5] The 85 and older population is projected to more than double, from 6.6 million in 2019 to 14.4 million in 2040, which is a 118 percent increase.[6]

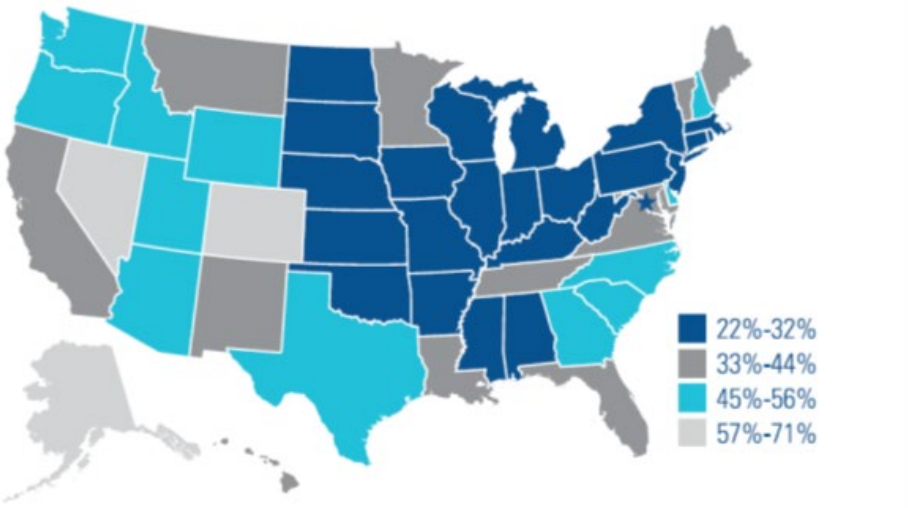
As it relates to aging, Ohio resembles the U.S. In 2019, more than half the persons ages 65 and older lived in nine states, and Ohio ranked sixth among the states. It's notable that the states with the largest populations of persons ages 65 and older are also those with the largest overall population. California leads with 5.8 million

[4] "2020 Profile of Older Americans, The Administration for Community Living, U.S. Department of Health and Human Services, May 2021, p. 4.
[5] "Fact Sheet: Aging in the U.S." Population Reference Bureau, July 15, 2019, accessed electronically at https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/
[6] "America's Changing Population," Population Bulletin, Population Reference Bureau, June 2019

of its residents ages 65 and older, followed by Florida (4.5 million), Texas (3.7 million), New York (3.3 million), Pennsylvania (2.4 million), Ohio (2.0 million), Illinois (2.0 million), Michigan (1.8 million), and North Carolina (1.8 million). The only state in the top 10 in overall population not on this list is Georgia (which had the eighth largest total population); the only state in the top 10 for population ages 65 and over not in the top 10 for overall population was Michigan (which ranked 11th in overall population).

Besides the sheer number of Ohioans ages 65 and over, the percentage increase in this population ranks Ohio among the leading states from 2009 to 2019.[7]

Figure 2: Increase in Population Age 65 and Older, 2009-2019



Source: U.S. Census Bureau Population Estimates

Characteristics of an Aging Population

There are some notable trends related to the aging U.S. population. These include a reduction in the number of workers per retiree, which is important but largely outside the scope of this study. Another characteristic that touches on key aspects of this study are rising healthcare expenditures.

National health expenditures in the aggregate continue to grow. National health spending is projected to grow at an average annual rate of 5.4 percent from 2019 to 2028.[8] Because national health expenditures are projected to grow 1.1 percentage points faster than gross domestic product (GDP) per year on average over this time frame, the health share of the economy is projected to rise from 17.7 percent in 2018 to 19.7 percent in 2028.

The aging population is fueling health care expenditure growth. Per person health care spending growth is highest among the population ages 65 and older. Per person health care spending for the population ages 65 and older was $19,098 in 2014, over five times higher than spending per child ($3,749), and it is almost three times the spending per working age-person ($7,153).[9]

[7] Ibid.
[8] "National Health Expenditure Data, U.S. Centers for Medicare and Medicaid Services, accessed electronically at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet
[9] Ibid.

Health Care: Who Pays for It?

Unlike many other countries, the U.S. does not have universal health care, but even in countries with forms of universal health care, the private share of costs for nursing home care may be substantial.[10] Within the U.S. health care system, there are a variety of payers. For the total share of personal health care expenditures in 2019, private insurance was the source for 33 percent of payments, followed by Medicare (23 percent), Medicaid (17 percent), out of pocket payments (13 percent) and all other sources (14 percent).[11]

However, Medicaid becomes the leading source of expenditures for nursing care facilities and related services. For these services in 2020, Medicaid was the funding source for 27 percent of total payments. The other primary sources were out of pocket payments (23 percent), Medicare (20 percent), other third-party payers (18 percent), and private insurance (9 percent).[12] The small percentage of funding via private insurance is a key issue related to this study.

LTC Basics

As noted in the introduction, long-term services and supports (LTSS) include a range of assistance, most of which is not medical care. This can include tasks such as bathing, dressing, and eating – often referred to as activities of daily living (ADL). One microsimulation model estimates that 56 percent of Americans turning 65 today will develop a disability serious enough to require LTSS, and 22 percent will have a disability requiring LTSS of more than five years.[13]

The model also estimates that, on average, an American turning 65 today will incur $120,900 in future LTSS costs, measured in current dollars. According to the model, Medicaid will pay 43 percent of the total, families will pay 37 percent of the costs themselves, other public assistance will pay 15 percent, and private insurance will account for the remaining 5 percent.[14] The small percentage associated with private insurance is consistent with insurance coverage in Ohio, where just 2 percent of Ohioans have long term care insurance (LTCI).

The need for care will also vary considerably from person to person. According to the U.S. Department of Health and Human Services, women generally need some type of LTSS longer than men (3.7 years compared to 2.2 years). One third of today's 65-year-olds may never need LTSS. The following table provides a general breakdown of the distribution and duration of LTC services:[15]

[10] England, for example, requires significant private payment for much of its nursing home care. See "Paying for Residential Care, Age UK, accessed electronically at https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-a-care-home/ . Likewise, services and the cost vary by province in Canada are not all that dissimilar from the U.S. See "LTC Homes in Canada – How are They Funded and Regulated?, Hill Notes, Library of Parliament, October 22, 2020, accessed electronically at https://hillnotes.ca/2020/10/22/long-term-care-homes-in-canada-how-are-they-funded-and-regulated/

[11] "Health Care Expenditures," National Center for Health Statistics, accessed electronically at https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm

[12] "MACStats: Medicaid and CHIP Data Book," Medicaid and CHIP Payment and Access Commission, 2021, accessed electronically at https://www.macpac.gov/macstats

[13] "Long-term Services and Supports for Older Americans: Risks and Financing, 2022," ASPE Research Brief, US Department of Health and Human Services, August 2022, accessed electronically at https://aspe.hhs.gov/sites/default/files/private/pdf/265126/LTSSOlAmRB.pdf

[14] Ibid.

[15] "How Much Care will You Need," U.S. Department of Health and Human Services, Administration for Community Living, February 18, 2020, accessed electronically at https://acl.gov/ltc/basic-needs/how-much-care-will-you-need

Table 1: Distribution and Duration of LTC Services

Type of care	Average number of years people use this type of care	Percent of people who use this type of care (%)
Any Services	3 years	69
	At Home	
Unpaid care only	1 year	59
Paid care	Less than 1 year	42
Any care at home	2 years	65
	In Facilities	
Nursing facilities	1 year	35
Assisted living	Less than 1 year	13
Any care in facilities	1 year	37

Source: U.S. Department of Health and Human Services, Administration for Community Living

Public Perception Related to LTC

There is a perceived need for more planning for LTC. According to a 2022 AARP survey of more than 1,000 U.S. adults aged 50 and older, nearly 7 in 10 believe that they will need assistance with their daily activities as they get older. While most understand the need for future assistance, fewer than 3 in 10 have given serious thought to how they will continue to live independently if they need assistance. While more than 4 in 10 respondents indicated they had carried out a variety of activities to help prepare for their end-of-life plans (such as talking with family members about life support, writing a will, and setting aside money for funeral expenses), just 12 percent indicated they had purchased private LTCI.[16]

Other public opinion surveys have found a similar disconnect related to government assistance for LTC. A 2017 Associated Press-NORC Center for Public Affairs Research survey found that 57 percent of respondents plan to rely on Medicare "quite a bit" or "completely" for their own ongoing living assistance if they need it. By contrast, only 25 percent indicated they plan to rely on Medicaid, even though it is more likely to pay for LTC.[17] That poll also found a similar lack of planning as the later AARP survey. Two-thirds of the respondents ages 40 and up said they've done little or no planning for their own LTC needs.

SeniorLiving.org conducted annual surveys of Americans ages 50 and over in both 2020 and 2021 on LTCI. Those surveys found that respondents were about evenly split between those who have already purchased or plan to purchase the insurance versus those who don't plan to purchase it:[18]

[16] AARP Research, "LTC Readiness Report," (June 2022). Accessed electronically at https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2022/long-term-care-readiness-report.doi.10.26419-2Fres.00555.001.pdf

[17] "Poll: Most Older Americans Want Medicare to Cover LTC," CNBC News, May 26, 2017, accessed electronically at https://www.cbsnews.com/news/poll-most-older-americans-want-medicare-to-cover-long-term-care/

[18] "Annual Report on LTCI: 2021, SeniorLiving.org, May 28, 2021, accessed electronically at https://www.seniorliving.org/finance/long-term-care-annual-report/

Table 2: Purchasing Plans by Year

Plan	2020	2021
Already purchased	27%	22%
Plan to purchase	16%	18%
Don't plan to purchase	39%	39%
Undecided	19%	21%

Source: SeniorLiving.org

The survey also found that many Americans are not well informed about the costs of LTCI, which may drive some of the decision making around purchasing decisions. Only about one-third of survey respondents accurately identified the estimated range of LTCI premium costs for an average 55-year-old single man or woman.[19]

Finally, the 2017 Associated Press-NORC Center for Public Affairs Research poll found that 56 percent of Americans ages 40 and older think Medicare should have a major role in paying for LTC, with another 30 percent responding it should make a moderate effort to do so. The poll also found that 70 percent of those polled favor a government administered LTCI program. Most also favor the ability to use non-taxed retirement savings accounts to pay for LTCI premiums.[20]

Paying for LTC: Government Programs

Many assume that Medicare will bear the primary financial responsibility for LTC for the U.S. population ages 65 and older. A recent survey by AARP found that 46 percent of those ages 50 and over that were surveyed believe Medicare covers care in a nursing home or care in the home from a home health aide.[21] However, this is generally not the case, as demonstrated in the health care expenditure data from the prior section. In fact, more frequently, this funding responsibility falls to the Medical Assistance (Medicaid) program. It is helpful to provide some history of how Medicare and Medicaid were established and how they have evolved over time.

Medicare and Medicaid Early History

Both Medicare and Medicaid were established in the Social Security Amendments of 1965.[22] It created Medicare (title XVIII of the Social Security Act), a health insurance program for persons aged 65 and older, and Medicaid (title XIX), a program providing health insurance for lower income persons and dependent children, as well as individuals with disabilities or blindness. Both programs were funded via payroll taxes on employee earnings and matching employer contributions.

Medicare originally contained two health insurance programs for persons ages 65 and older: a hospital insurance plan covering the costs of hospital and related care, and a medical insurance plan covering payments for physicians' services and other medical and health services to cover certain costs not covered by the hospital insurance plan.[23] The original Act provided limited coverage for institutional care in certain types

[19] Ibid.
[20] "Poll: Most Older Americans Want Medicare to Cover LTC," CNBC News, May 26, 2017, accessed electronically at https://www.cbsnews.com/news/poll-most-older-americans-want-medicare-to-cover-long-term-care/
[21] "LTC Readiness," American Association of Retired Persons, June 2022, p. 6, accessed electronically at https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2022/long-term-care-readiness-report.doi.10.26419-2Fres.00555.001.pdf
[22] Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," Social Security Bulletin, September 1965, p. 3, accessed electronically at https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf
[23] Ibid., p. 9.

of facilities outside of a hospital, generally 100 days or fewer. Similar limits continue in the Medicare program to this day.[24]

While Medicare coverage for nursing facility care is limited, it is still an important funding component. Medicare is not a LTC option. It will provide 20 days of care at 100 percent of the cost; for the remaining 80 days that are eligible for Medicare funding, recipients must pay a portion of the daily cost, which for 2022 is $194.50. This varies depending on the individual's type of Medicare coverage.[25]

Unlike Medicare, which is federally administered, Medicaid may be, but does not have to be provided in each state. In practice, all 50 states now provide and administer a Medicaid program (Arizona was the last state to opt into Medicaid, in 1982). Part of the inducement to provide a Medicaid program is federal government matching funding at varying percentages of participation, which is based on a formula that takes into account the average per capita income for each state relative to the national average. All states receive at least a 50 percent federal match.

States have significant latitude in administering the Medicaid program and establishing benefits. The original Medicaid program scope required states to provide inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for individuals aged 21 and over, and physician's services in locations that include a skilled nursing facility.[26]

Medicaid Evolution

Since that original 1965 start, the Medicaid program has evolved significantly. In general, these changes have broadened benefits (and the state and federal costs associated with the program). The following are a few of the major changes that relate to LTC:[27]

- **Eligibility Tied to Supplemental Security Income (1972).** This created a uniform eligibility standard for services for elderly, blind, and disabled individuals.
- **Provision of Community-based Care Waivers (1981).** State Medicaid programs were allowed to provide non-medical services in community and home settings as an alternative to institutional settings.
- **Greater Protections for Nursing Home Residents (1987).** New and expanded requirements on quality of care as well as mandatory use of a standardized Resident Assessment Instrument to improve assessment and care.
- **Expansion of Eligibility for Long-term Care (2010).** The Patient Protection and Affordable Care Act (ACA) reduced eligibility requirements for the Medicaid program, which provided greater opportunity

[24] See, for example, "Medicare Coverage of Skilled Nursing Facility Care," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, accessed electronically at https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf
[25] See, for example, "Paying for Nursing Home Care: Medicare, Medicaid & Other Assistance," Paying for Senior Care.com, June 16, 2021, accessed electronically at https://www.payingforseniorcare.com/nursing-homes
[26] Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," Social Security Bulletin, September 1965, p. 19, accessed electronically at https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf
[27] "Medicaid: A Brief History of Publicly Financed Health Care in the United States," Center for Health Care Strategies, October 2019, accessed electronically at https://www.chcs.org/media/Medicaid-Timeline-Fact-Sheet_01.14.20v2.pdf

for LTC for those under age 65.[28] The ACA also increased nursing home transparency and reporting requirements.[29]

Besides these changes identified for the LTC population, there have been additional major Medicaid expansions related to eligibility, particularly Medicaid expansion through the Children's Health Insurance Program (CHIP) and the Patient Protection and Affordable Care Act (ACA).

A significant change in service provision has been the increased emphasis on home and community-based services (HCBS), which are generally provided through Medicaid waivers granted by CMS. HCBS allows individuals to be served in local, non-institutionalized settings, meaning they have more control over their care and can remain active in their neighborhoods and communities. It also often means they may receive services in their home or similar settings. In general, these waivers are granted with the expectation that they will result in overall cost savings for the program.

As it relates to long-term services and supports (LTSS), HCBS 1915 waiver programs are particularly important. These waiver programs cover a variety of LTSS needs and settings.

Ohio provides several HCBS 1915 waiver programs. For several Ohio waiver programs, eligible participants must require a nursing facility level of care.[30] These include the Ohio Home Care waiver, PASSPORT waiver, and Assisted Living waiver.

The Ohio Home Care Waiver allows individuals with physical disabilities and unstable medical conditions to receive care in their homes and communities instead of nursing facilities, hospitals, or rehabilitation facilities; this program is for participants from birth to age 59. The PASSPORT waiver helps older Ohioans get the long-term services and supports they need to stay in their homes or other community settings, rather than enter nursing homes. PASSPORT services may include personal care, homemaker, and chore services; adult day care and independent living assistance; medical equipment and supplies; medical transportation; and waiver nursing. PASSPORT is available for Medicaid recipients ages 60 and over.

The Assisted Living waiver program pays the costs of care in an assisted living facility for certain people with Medicaid, allowing the consumer to use his or her personal resources to cover room and board expenses. There are two types of services provided, Assisted Living and Community Transition. Assisted Living services include 24-hour on-site response, personal care, supportive services (housekeeping, laundry, and maintenance), nursing, and transportation, three meals per day, and social/recreational programming. Community Transition Services are available to individuals who are leaving a nursing facility to enroll in the Assisted Living waiver. These services help them get essential household furnishings and other items to set up their new homes.

HCBS have become the predominant method for providing LTSS in the U.S. The following figure demonstrates the steady growth in HCBS in comparison to institutional care.[31]

---

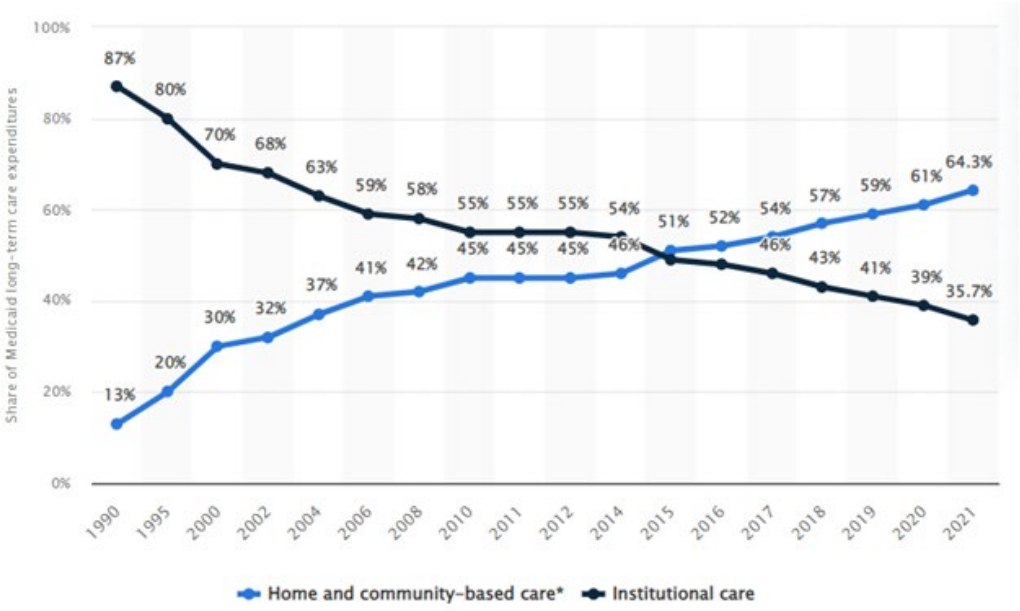
[28] Victoria Walker, Morgan Ruley, Laikyn Nelson, Whitney Layton, Alberto Coustasse, "The Effect of the Affordable Care Act on Medicaid Payments in LTC Facilities," Marshall University Management Faculty Research, November 2020, p. 14, accessed electronically at https://mds.marshall.edu/cgi/viewcontent.cgi?article=1242&context=mgmt_faculty

[29] "Implementation of Affordable Care Act Provisions To Improve Nursing Home Transparency, Care Quality, and Abuse Prevention," Kaiser Commission on Medicaid and the Uninsured, January 2013, accessed electronically at https://www.kff.org/wp-content/uploads/2013/02/8406.pdf

[30] The technical requirements for this level of care can be found on the Ohio Department of Medicaid website, accessed electronically at https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/waivers/hcbs-waivers

[31] Statista, accessed electronically at https://www.statista.com/statistics/245439/distribution-of-medicaid-long-term-care-services-expenditures-by-type/

Figure 3: Distribution of Medicaid LTC Services by Type of Service



Source: Statista

Another major change in how services are provided has been the increase in the use of managed care as an alternative to fee-for-service (FFS). As the name implies, in an FFS model, care providers are paid for each service performed. In a managed care model, states enter into contracts with managed care organizations (MCOs) that accept a set per member per month (capitation) payment for provided services. When Arizona became the last state to opt into Medicaid, it did so by creating a managed care system – the first statewide managed care system in the U.S.

In a managed care system, the provider has an incentive to control costs, as they are receiving a per member per month cost to provide services. By contrast, in a fee-for-service model, the provider is only reimbursed when they provide services, and there is generally no cap on the number of services or amount of service that may be provided. As a result, there is an implicit level of cost control (or at least known cost) in the managed care model that does not exist in a fee for service system.

The general concern with the managed care model is that the cost controls may negatively impact on the quality of care. This is an ongoing topic of discussion and debate – and likely will continue for the life of the Medicaid program. The Medicaid and CHIP Payment and Access Commission (MACPAC) has noted that "While much research has been conducted on whether managed care delivery systems result in better outcomes than traditional FFS, there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries."[32] This discussion is outside of the scope of the study, but it is notable that the rise of managed care systems is generally considered to reduce costs in state Medicaid programs.

Nationally, managed care has been increasing over time. Total Medicaid managed care spending (including the federal and state share) was $421 billion in federal fiscal year (FFY) 2021, up from $360 billion in FFY2020. Medicaid managed care spending has increased at a compound annual growth rate (CAGR) of

[32] "Managed care's effect on outcomes," Medicaid and CHIP Payment and Access Commission, accessed electronically at https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

16.1 percent since FFY 2007, which is significantly greater than the 6.6 percent growth in total Medicaid spending.[33]

The Ohio Medicaid managed care program was initiated in 1978. In 2006, Ohio's managed care program was expanded to all 88 counties. As of December 2022, Ohio has five MCOs operating in its three designed Medicaid regions. According to the Ohio Department of Medicaid, over 90 percent of Medicaid-eligible residents are part of its managed care program.[34]

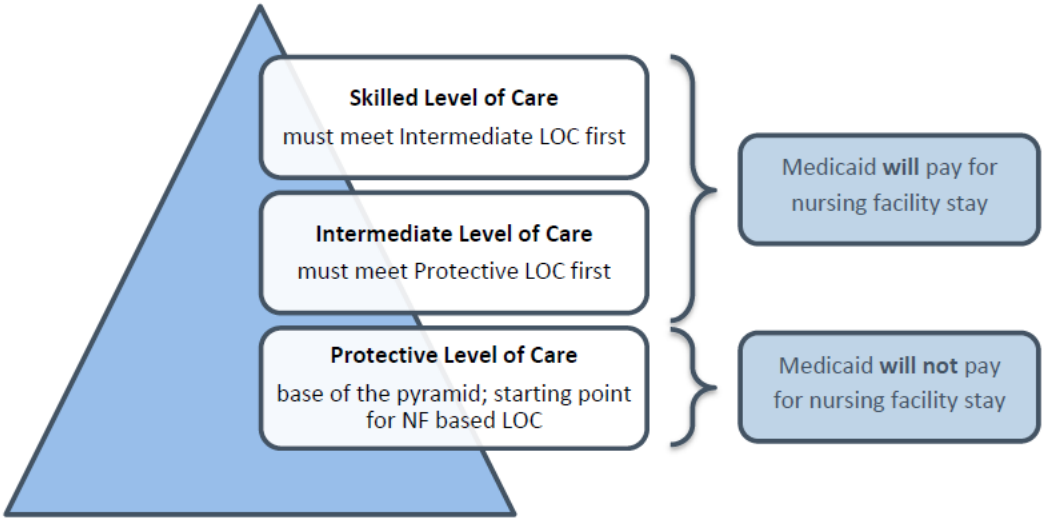
Medicaid LTSS Eligibility Requirements

Medicaid is a complex program, and its eligibility requirements are similarly complicated. While there are basic services that each state must provide to receive federal matching funds, there is also latitude to shape the program, in terms of both eligibility and benefits.

There are two primary eligibility requirements related to LTC services within the Medicaid program, related to necessary levels of care and income requirements. Both must be met, and both are established by the state.

The federal government will only pay for LTC under the Medicaid program that is medically necessary. There are different classifications related to level of care. The following figure, from the Ohio Department of Medicaid, provides broad categorization of eligibility for different types of care:[35]

Figure 4: Medicaid Eligibility for Various Levels of Care



Source: Ohio Department of Medicaid

The Medicaid eligible care in institutional settings (often referred to as institutional Medicaid, nursing home or nursing facility Medicaid) is an entitlement for all who meet income eligibility criteria. As has been noted, there are other services that Medicaid will pay for based on HCBS waivers. However, these Medicaid waiver

[33] "Medicaid Managed Care Spending Tops $420 Billion in 2021," Health Management Associates, September 1, 2022, accessed electronically at https://www.healthmanagement.com/blog/medicaid-managed-care-spending-tops-420-billion-in-2021/
[34] "Managed Care," Ohio Department of Medicaid, accessed electronically at https://medicaid.ohio.gov/families-and-individuals/mcare/managed+care
[35] "Frequently Asked Questions: Nursing Facility Definitions," Ohio Department of Medicaid, October 2018, accessed electronically at https://medicaid.ohio.gov/static/Providers/ProviderTypes/Managed+Care/PolicyGuidance/NF-Definitions-Common-Terminology.pdf

programs are not an entitlement, and the number of program participants is capped. When that participation cap is reached, those eligible for services beyond the cap are placed on a waiting list.[36]

As has been explained, Medicaid is the 'payer of last resort' for those who cannot otherwise afford to pay for LTSS. Besides the requirements related to required level of care, there are also income requirements. For 2022, the individual monthly income limit (which includes wages, social security benefits, pensions, individual retirement accounts, etc.) is $2,523.[37] Besides the monthly income requirement, the Medicaid program takes into consideration the person's assets and will require those to be spent down to $2,000 (or $3,000 where both spouses are applying for LTC), with some exceptions.[38] When the spouse continues to live in the community, there are allowances for maintaining assets and income.[39] In summary, while a non-institutionalized spouse is generally able to retain their assets (and, depending on the circumstances, some of the income of the institutionalized spouse), LTSS is expensive, and it will generally be a drain on the household assets and income.[40]

Medicaid Utilization

As noted in the history of the Medicaid program, it was intended to extend the federal 'safety net' for qualified lower income individuals, including dependent children. Similar 'safety net' programs include Medicare, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance (SNAP, formerly known as the Food Stamp Program). Children comprise the largest share of Medicaid enrollees. The following figure identifies the share of Medicaid enrollees by eligibility group.

[36] "Answers to All of Your Questions About Medicaid LTC," American Council on Aging, February 28, 2022, accessed electronically at https://www.medicaidplanningassistance.org/medicaid-long-term-care-faq/

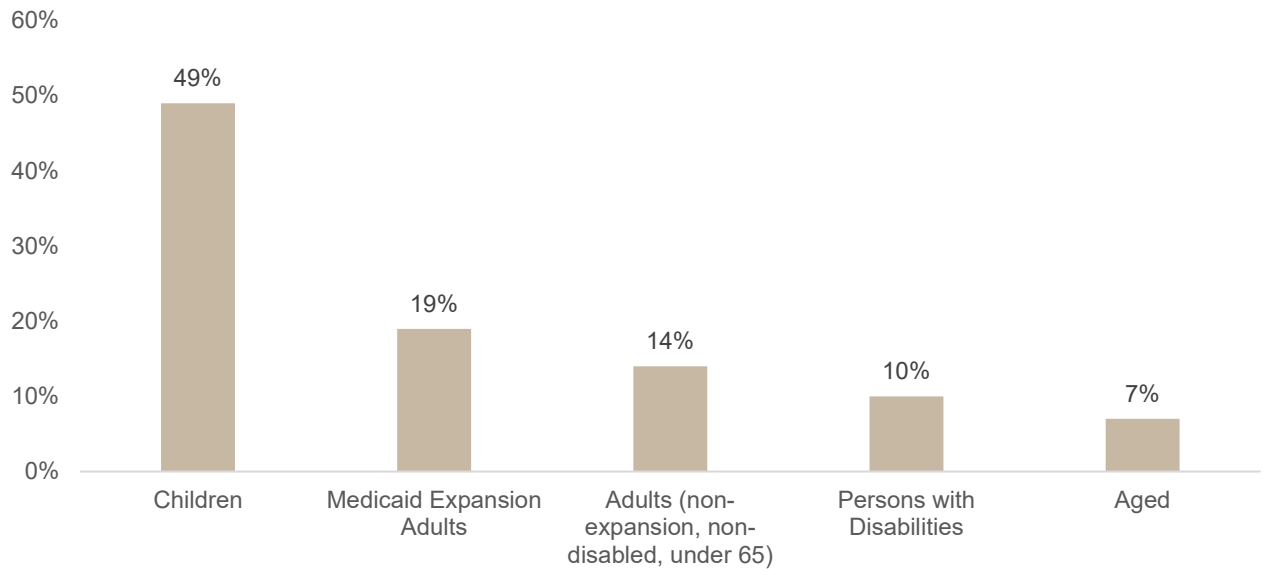
[37] In Ohio, a person may still be able to qualify for Medicaid with income above the monthly limit if income over the limit is not sufficient to pay for your monthly medical expenses.

[38] One car is exempt, as is a home with an equity value of $636,000 if planning to return, a spouse, a child under 21, or a disabled person resides in it.

[39] Ohio also has a spousal refusal law, which, under certain circumstances, allows a spouse to refuse to contribute to the LTC costs of the other spouse.

[40] A useful explanation of the income and asset eligibility rules and regulations can be found on the website for the American Council on Aging, accessed electronically at https://www.medicaidplanningassistance.org/medicaid-eligibility-ohio/

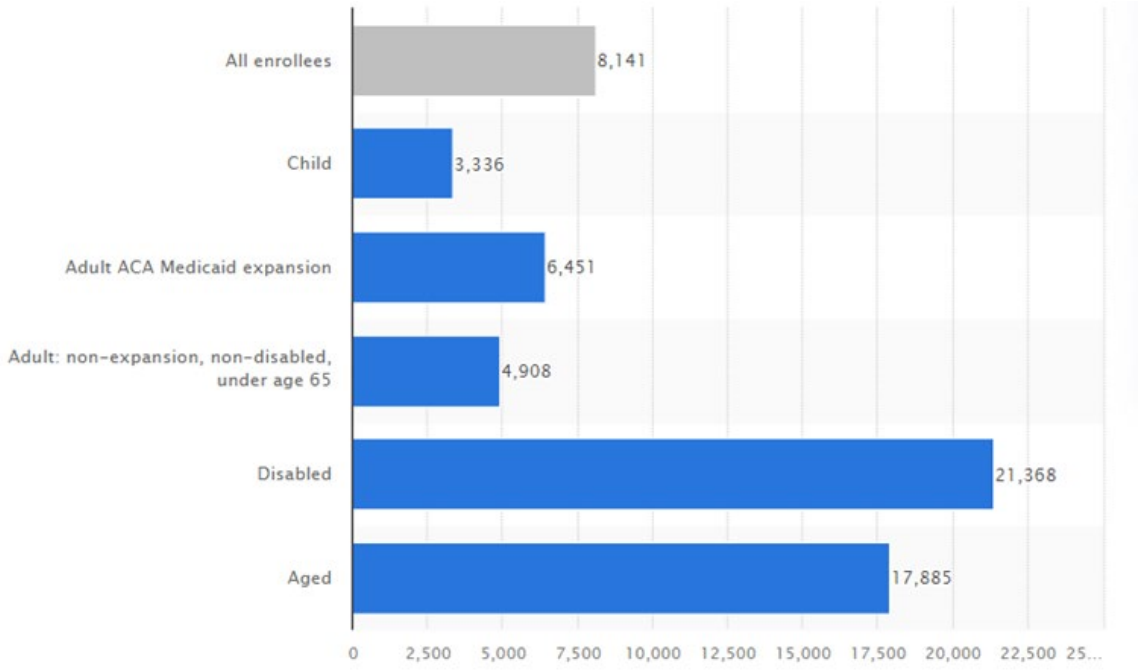
Figure 5: Share of Medicaid and CHIP Enrollment by Eligibility Group[41]



Source: U.S. Department of Health and Human Services, Centers on Medicare and Medicaid Services

While children make up the largest number of enrollees, persons with disabilities and those ages 65 and over make up the largest share of expenditures. While their numbers are not as large, they often require more critical care and care for longer periods of time (including institutional care), which is costly.

Figure 6: Medicaid Benefit Spending per Enrollee, by Eligibility Group, 2019[42]



Source: Statista

[41] "Who Enrolls in Medicaid & CHIP?" U.S. Department of Health and Human Services, accessed electronically at https://www.medicaid.gov/state-overviews/scorecard/who-enrolls-medicaid-chip/index.html
[42] Statista, accessed electronically at https://www.statista.com/statistics/1289081/medicaid-spending-per-enrollee-by-eligibility-group/

State Medicaid Expenditures

While the initial state outlays for the Medicaid program were modest, it has grown substantially, both in dollar amounts and shares of state budgets. In FY1987, Medicaid spending was just over 10 percent of state budgets. By 1990, at 12.1 percent, Medicaid had replaced higher education as the second largest spending category.[43]

Nationally, Medicaid is now the largest or second largest state general fund item in every state. While elementary and secondary education is the largest on average (35.8 percent), Medicaid is second at 17.8 percent – and there are states where it ranks first. Higher education ranks a distant third, at 9.4 percent.[44]

Ohio is similar to the rest of the nation in its Medicaid spending share. In FY2020, elementary and secondary education ranked first, at 21.6 percent, while Medicaid was 18.0 percent, and higher education was 6.1 percent.[45] In Ohio, in FY2021, total payments for LTC (excluding developmental disability waiver services and care in Intermediate Care Facilities for Individuals with Intellectual Disabilities – or ICFs/IID) were $4,350.2 million.[46]

There are many factors that will drive Medicaid and LTC state expenditure requirements. As noted, the federal Medicaid match (known as FMAP) is computed from a formula that takes into account the average state per capita income for each state relative to the national average. From FY2015 to FY2019, Ohio's federal Medicaid participation percentage varied from year to year between 62.32 percent and 63.09 percent. However, during the COVID-19 pandemic, the federal government upped the FMAP for all states, and for FY2020 to FY2022, Ohio's FMAP varied between 69.22 and 70.30 percent. When the additional federal assistance expired, Ohio's rate dropped to 63.58 percent in FY2023.

There may be other factors that have and will impact on Medicaid LTC expenditures. The COVID-19 pandemic caused serious upheaval in the nursing home industry, and how that will impact on supply and demand is an open question.

Finally, states have considerable latitude, because federal Medicaid rules do not determine how to reimburse nursing facilities or at what rate (or rates). Medicaid payment policies provide some guidance – they should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization. There is also a requirement that states develop rates through a public process and publish them.

As previously noted, states generally rely on either FFS or managed care. Under FFS payment arrangements, state Medicaid programs typically pay nursing facilities a daily rate, called a per diem. Each state arrives at its per diem rate by taking into consideration a variety of factors, and no two states arrive at the rate from exactly the same method. As a result, the rates can vary considerably, even among what might be considered regionally or demographically similar states.

Among the factors that may be considered in the state rate setting process are the frequency that rates are rebased, whether and how inflation factors are built into rates, possible ceilings for costs associated with administration, capital, direct and indirect care; variations based on geographic location, supplemental

[43] "1992 State Expenditure Report," National Association of State Budget Officers, April 1993, accessed electronically at https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives
[44] "State Expenditure Report," National Association of State Budget Officers, 2021, p. 17, accessed electronically at https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2021_State_Expenditure_Report_S.pdf
[45] "Medicaid as a Share of States' Total Budgets and State-Funded Budgets," Medicaid and CHIP Payment and Access Commission, accessed electronically at https://www.macpac.gov/publication/medicaid-as-a-share-of-states-total-budgets-and-state-funded-budgets/
[46] Based on data provided by the Ohio Department of Medicaid.

payments and incentives.[47] As it relates to basis of payment, Ohio sets price-based per diem rates. In the price-based system, the per diem is established prospectively for each facility. According to the Medicaid and CHIP Payment and Access Commission, in 2019, 15 states used this approach. In 2022, Ohio's price-based per diem payments varied from a low of $171.40 to a high of $298.67. It is notable that neighboring Pennsylvania's nursing facility per diem payments varied from a low of $137.08 to a high of $322.46.

Medicaid Nursing Facility Costs by State

As previously noted, states have differing approaches to establishing NF reimbursement rates. As a result, there is wide variation in rates. For comparison purposes, it is useful to compare the NF shared room annual cost, as in most cases, unless there is a medical reason for a private room, Medicaid will only cover the cost of a shared room. The following table provides 2021 statewide average annual costs for a private and a shared room. Also included are the regional price parities by state, as calculated by the U.S. Department of Commerce, Bureau of Economic Analysis (BEA). Regional price parities measure the differences in price levels across states for a given year and covers all consumption goods and services, including housing rents. This 2020 data is expressed as a percentage of the overall national price level in other words, when the regional price parities are above 100, the costs are above the national average, and when it is below 100, they are below the national average. As the following table shows, Ohio and all of its neighboring states have regional price parities below the national average.[48]

Table 3: Comparison of State Average Yearly Nursing Home Costs, 2021

Location	Private Room	Shared Room	Regional Price Parities
U.S. as a whole	**$108,405**	**$94,900**	**100.0**
Ohio	$98,550	$87,600	91.7
Indiana	$104,405	$87,235	92.5
Kentucky	$95,630	$86,140	89.8
Michigan	$118,260	$109,135	94.0
Pennsylvania	$133,882	$124,841	97.6
West Virginia	$146,548	$139,430	88.0

Source: American Council on Aging, Bureau of Economic Analysis

As illustrated in the preceding table, West Virginia has both the highest nursing home costs and lowest cost of living among the comparison states. This helps to demonstrate that statewide costs are not entirely correlated with the cost of living within a state.

[47] "Nursing Facility Fee-for-Service Payment Policy, Medicaid and CHIP Payment and Access Commission, December 2019, accessed electronically at https://www.macpac.gov/wp-content/uploads/2019/12/Nursing-Facility-Fee-for-Service-Payment-Policy.pdf. The state-by-state comparison may be accessed electronically at https://www.macpac.gov/publication/nursing-facility-payment-policies/

[48] "Nursing Home Costs by State and Region," American Council on Aging, March 4, 2022, accessed electronically at https://www.medicaidplanningassistance.org/nursing-home-costs/. "Regional Price Parities," U.S. Department of Commerce, Bureau of Economic Analysis, accessed electronically at https://www.bea.gov/news/2021/real-personal-consumption-expenditures-and-personal-income-state-2020

Chapter 2: LTCI Industry and Products

LTCI Basics

Background

LTCI is a financial contract to provide certain benefits in exchange for a premium payment. It is an agreement to spread the risk of the benefits over a larger group of individuals. This is similar to other types of insurance where a large group in a class can "pool" their experience and costs to determine the overall premium.

LTCI was created in the 1970s to cover nursing home care. At the time, there was little focus on home health care or other types of living arrangements. Assisted living facilities were not widely established, and regulations were not in place. Today, LTC policies/contracts offered for sale cover a wide range of services and facilities including assisted living facilities, in-home health care services, adult day care, and nursing home care. It should be noted that long-term care insurance coverage is not limited to services paid at a certain age. They will provide services reimbursement to disabled individuals who are much younger than the typical age of retirees or senior citizens.

LTCI Policy Characteristics

The cost of a policy is determined by the types of benefits and services covered by the contract. Policy provisions can include the type of facility covered, daily payment amounts, length of time the policy will pay benefits, and length of elimination periods (or when policy benefits will begin to be paid following admission to the facility).

The policy specifies when benefits will be paid. This is often known as a "trigger." For benefits to be paid, plans usually require either the policyholder needs substantial aid for at least two of the six ADLs (which are bathing; dressing; toileting; transferring, which is getting in or out of a chair; eating; and continence) or they have cognitive impairment and need regular supervision.

Most LTCI policies do not pay the entire cost within a facility. Instead, most cover a specific dollar amount of expenses per day. Most policyholders will not access the policy benefits for many years after the purchase, while the cost of daily care in a facility will likely increase during this time. Hence, the original daily amount purchased may not cover the increased cost of services provided at some future point in time.

To deal with this concern, many offered policies include options to purchase inflation protection. Some offered policies provide up to a 5 percent inflation option that allowed the policy benefits to increase as the daily rate of covered services increased. At the same time, the inflation protection rider significantly increased the cost of the premium, especially if the policy coverage was lifetime in nature.

Before benefits are paid, there are several requirements that must be met by the policyholder:

- Meet the level of need specified in the policy;
- Be in a qualified facility as defined in the policy;
- Receive care from a qualified person as required by the policy; and
- Meet the elimination period set forth in the policy.

A policyholder cannot collect benefits until the criteria within the policy have been met. Generally, a qualified medical professional must certify to the insurance carrier that a policyholder needs the LTCI benefits by meeting the policy triggers. For home-health care benefits, it has been the practice that only trained professionals can provide services to the insured. However, some states are changing those requirements to allow family members to provide some services.

If there is an elimination period in the policy contract, the policyholder must complete the waiting period before the benefits can be paid. The elimination period can be up to 100 days. During this period, the policyholder is required to pay the LTC expenses of the facility or home health care. A longer waiting period will be reflected in a lower premium rate for the policyholder.

The insurance carrier can require a medical review to determine whether the policyholder has met the level of needs stated in the policy prior to paying benefits. This form of preauthorization may lead to a denial of benefit payments. Case management may also be used to determine appropriate coverage and eligibility.

LTCI Benefits

There are two methods of paying benefits: a per-day amount or an expense-incurred amount. A policy may pay up to a set amount per day for a set length of time, both of which are chosen by the policyholder at the time of purchase. Alternatively, a policy may pay the expenses incurred by the policyholder at the facility or through home health care up to a total maximum amount, which is again chosen by the policyholder at the time of purchase.

Traditionally, policies did not always pay benefits for care received in all facilities. Policy language was often tailored to the licensing facility definitions in state law. For example, if a policy only covered nursing home facilities, it did not cover benefits and services received in an assisted living facility or from in-home health care services. Carriers are modifying their contract provisions to include all licensed facilities in their contract language and including in-home health care services as well.

Most policies provide a “waiver of premium” component. This addition to the policy provides that further payment of premium is not required once the policyholder receives care under the terms of the policy for a certain period of time.

Many states require that all prospective LTCI policyholders be offered a non-forfeiture benefit. The benefit allows the policyholder to receive back some of the policyholder’s investment in the policy should the policyholder stop paying premium and allow the policy to lapse for any reason. This benefit provides for some permanent coverage in the form of a paid-up policy with a shorter benefit period. The non-forfeiture benefit adds cost to the policy premium but provides some protection and coverage should the policyholder decide at a later date to discontinue paying the premium.

LTCI Premiums

The premium rate of a LTCI policy is based upon the benefits of the plan as previously described. In addition, insurance companies price policies based upon the age and the health of the policyholder at the time of issue. Most policies provide that the premium will not increase due to changes in the age or health conditions of the policyholder.

Insurance carriers can increase rates, however, for an entire class of individuals (all policyholders of a certain policy), based upon the overall experience of that group. Therefore, when more policyholders access benefits sooner than expected and for longer periods of time, the carrier may raise rates. This is especially true for carriers that no longer actively write new policies. With no new individuals entering the policy pool or book of business, the experience of the group will need to be spread over a smaller population of policyholders.

Policy forms (and contracts) as well as the premium rate increases are approved at the state level by the state insurance departments. Each state has its own laws and regulations regarding LTCI forms, policy provisions, and rating requirements, including annual filing of rate increases. A carrier selling LTCI in more than one state is required to file the forms and any ongoing rate increase or changes in the various where they do business. As a result, rate requests and approvals will vary between the states. It is not uncommon

for some state departments to grant policy changes or rate increases differently, with some states denying any increase or changes to the policy form.

LTCI Industry

The LTCI industry has developed over the last 50 years. Large life insurance carriers saw LTCI as an extension of their life insurance business, which could easily be sold to a similar set of perspective policyholders.

With the evolution of senior living arrangements, including assisted living centers, memory care facilities, and other levels of care for seniors and the aging population, the life insurance industry extended policyholder coverage to include those facilities as well as some in-home health care coverage.

A robust market began to grow in the 1970s, 1980s, and 1990s. Many of the largest writers of life insurance in the U.S. were actively writing LTCI. According to information from the National Association of Insurance Carriers, about 100 carriers were writing LTCI as late as 2004. But by 2020, that number was down to around a dozen active writers. Carriers who have left the active market are either selling their blocks of business to other carriers or running off their active book of business and not actively selling new policies. With low lapse rates, longer time spans of using services, as well as low interest rates, carriers with no new business are seeking large premium rate increases to maintain levels of coverage.

The size of LTCI premium increases is a concern, particularly for government efforts to incent its purchase, which may be seen as an endorsement. If insurance premium increases make it unaffordable, the public may have an unfavorable view of the government efforts. It is notable that the Federal Long Term Care Insurance Program (FLTCIP) for federal employees is being suspended for two years beginning December 19, 2022, in anticipation of a sizable hike in premiums. The Office of Personnel Management (OPM), in announcing the decision wrote that "OPM is suspending applications for coverage in the FLTCIP to allow OPM and the FLTCIP carrier to assess the benefit offerings and establish sustainable premium rates that reasonably and equitably reflect the cost of the benefits provided."[49]

LTCI Products

There are three primary forms of LTCI products. They are:

- **Traditional LTCI:** These policies exclusively cover LTC expenses in a nursing facility or, more recently, at home.
- **Hybrid LTCI:** These combine LTCI with life insurance or an annuity. These policies provide some assurance that if an individual does not require LTC, there will still be a policy death benefit payout.
- **Life insurance with a LTC Rider:** These allow the policyholder to add additional coverage for LTC via a rider. The rider allows the use of some of the life insurance policy's death benefit to pay for LTC needs while the policyholder is still alive.

[49] "OPM Will Suspend Long Term Care Insurance Applications as a Sizeable Premium Increase Looms," Government Executive, December 5, 2022, accessed electronically at https://www.govexec.com/pay-benefits/2022/12/opm-will-suspend-long-term-care-insurance-applications-sizeable-premium-increase-looms/380467/

As previously noted, LTCI was originally sold to cover only nursing home services. As new types of senior living facilities and arrangements developed, LTCI coverage expanded. With the cost of LTC services increasing and the cost of long-term insurance going beyond the reach of many consumers, insurance companies evolved their product offerings.

While consumers may still purchase traditional forms of LTCI, new products known as hybrid LTCI products are finding their way into the market. Hybrid LTCI products are offered in a variety of forms and price points. Hybrid products give consumers choices in how to receive benefit payments while allowing them some protection should services never be necessary by allowing for a death benefit payment. These life/annuity LTC hybrid policies may be either reimbursement or indemnity products. A "chronic illness" benefit is also possible which provides for an accelerated death benefit.

These non-traditional LTC policies can be more costly, but the ability to have coverage plus the opportunity for a death benefit can be attractive to some consumers who want their premiums to provide some type of benefit. These policies include a single premium permanent life insurance policy, which is a life insurance policy with a LTC acceleration rider and a LTC extension rider. This allows the policy holder to access the death benefit to pay for qualified LTC services.

An annuity-long-term hybrid policy provides a single premium deferred annuity to allow for penalty-free withdrawals from the account for LTC services. There are also impaired-risk payout annuities that can be attractive to an individual who retires early because of a disability. This is a single-premium immediate annuity.

Seniors may also utilize a life settlement from the sale of an in-force life insurance policy for a market-based settlement value in excess of the cash surrender value. This would generate resources to pay for LTCI needs. These proceeds can fund an account with a bank or trust company to make monthly payments directly to a designated long-term care provider.[50]

There are carriers selling policies that provide a set amount of coverage (i.e., dollar limitation). For example, a person may purchase a LTCI policy that has a dollar limit of coverage (perhaps $250,000). The premium is based upon that dollar limit. As a result of the maximum benefit, carriers and consumers have greater knowledge going into the contract of the premium costs and benefits, as there is a set limit on how much coverage is provided.

Some states have provided for a more limited form of coverage for care services. Often known as "recovery care" or "short-term LTC" policies, these provide similar coverage as traditional LTCI, but it is for a limited time frame of coverage, which is often less than one year, with an allowed one-year renewal. These policies may have a shorter elimination or waiting period for coverage to begin. They may also have a variety of inflation factor options.

The "recovery care" policy may be attractive to consumers who have some assets to pay for services but wish to have some limited form of coverage, even if it is just for a year. In addition, consumers may already have a LTC policy that has a lengthy elimination or waiting period. The "recovery care" policy would provide benefits during that waiting period and thus bypass a larger out of pocket expense for the consumer.

In addition, with the increase in short term stays in nursing homes for recovery of illnesses and accidents, recovery care or short-term long term care policies can aid families and the insured in receiving appropriate services while reducing the assets needed to pay for limited care stays. With a shorter elimination period, the insured will not need to liquidate assets. Family members who often bear the cost of short convalescent care through payment or on-site care assistance will be shielded from these costs or time commitments.

[50] NAIC-CIPR Program, "The State of Long-Term Care Insurance," (2018).

The National Association of Insurance Commissioners (NAIC) adopted a limited long-term care insurance model law in 2018 to provide greater uniformity for states who wanted to provide this additional type of assistance to consumers. Detailed regulations were also adopted in 2018 to assist states in the oversight of the policy forms and provisions. Several states allow the product, including Iowa, Maine, and New Hampshire.[51]

Federal and state officials have also provided opportunities to assist consumers in purchasing LTCI. As previously noted, the LTCI Partnership Program began in the 1990s, which allows the insured to qualify for Medicaid LTC funds with less strenuous asset spend-down requirements once the long-term care insurance benefits have been exhausted. The policies require that the private insurance pay first, which generally reduces the reliance on Medicaid.

Purchasing a partnership-qualified LTCI product allows for a dollar-for-dollar asset disregard or "spend down" protection. Individuals who purchase one of these products "earn" one dollar of Medicaid asset disregard for every dollar of insurance coverage paid on their behalf. This allows the consumer to protect assets above what the normal Medicaid requirements are in order to qualify for Medicaid benefits.

Early policies required a five percent inflation benefit feature, which added cost to the overall premium. This made the policy unattractive to many consumers who saw the cost as unaffordable. Many states have lowered this benefit to three percent or less. Originally only four states offered the program. In 2006, federal law authorized additional states to develop the partnership plans. States were required to provide outreach to consumers to explain the policies and encourage their sales. This was not always successful due to limited budgets. However, the 2006 Deficit Reduction Act authorized additional states to develop Partnership Qualified plans which encouraged states to develop plans that also included less strenuous asset spend-down requirements in order to qualify for Medicaid LTC funds. More states joined the program, including Ohio. In 2007, Ohio Revised Code (ORC) 5164.86 authorized the Ohio Department of Job and Family Services (now the Ohio Department of Medicaid) to develop the Ohio partnership program in conjunction with the Ohio Department of Insurance, the Ohio Department of Aging and the insurance industry. The program is known as LTC4Me.

While not uniform across all states, most standalone long-term care insurance products offer the qualified option. Hybrid policies are being incorporated into the mix of partnership plans as well to allow more flexibility and options for consumers.[52]

Use of LTCI

As has been discussed, there are many factors that should be taken into consideration when determining the value of LTCI. These include the likelihood of the need for LTSS, the costs associated with it, the fact that these costs are generally not borne by Medicare, and the need to 'spend down' assets and income to qualify for Medicaid payment for these costs.

Even with incentives to purchase LTCI, individuals may make an informed choice that LTCI is not in their financial best interest. The following are factors that may make the purchase of LTCI infeasible or suboptimal for the individual or household:

[51] NAIC Model Law 642-1 Limited Long-Term Care Insurance Model Act 2018 and NAIC Model Regulations 643-1 Limited Long-Term Care Insurance Model Regulations.
[52] American Academy of Actuaries, "Long-Term Care Financing Reform Issues Brief," (July 2021).

- **The individual or household has limited assets and/or limited income.** In this case, it is likely that there are more critical short-term spending needs, and Medicaid should be viewed as the logical 'safety net' should there be a need for LTC.

- **The individual or household's only source of income is a Social Security benefit or Supplemental Security Income (SSI).** In this instance, the individual is also likely to be covered as needed by Medicaid for LTC.

- **LTCI is not affordable for the individual or household.** There may be competing or more immediate financial needs. For example, a household with children preparing for higher education expenses may determine that LTCI cannot be built into the family budget. The affordability issue is one of the points of an incentive; based on the incentives in place in most states, these are unlikely to tip the balance in favor of purchasing LTCI when there are competing major financial needs. As a result, there is concern that LTCI is now out of the financial reach of most middle-income Americans and for that reason, it is not likely to play a meaningful role in financing LTSS costs in the coming decades.[53]

Conversely, there are situations where the purchase of LTCI may be advisable for an individual or household. These include:

- **There are significant individual or household assets or income.** It is notable that even when this is the case, there are mechanisms to protect a significant share of assets and/or income.

- **There is sufficient income or assets to self-fund LTC if necessary.** While LTC is expensive, the average stay in a nursing home is about one year, and this will generally be required for about one-third of individuals. For those with significant resources, a cost benefit analysis might determine saving and investing the same amount as the LTCI premiums and self-funding in the event it is necessary is a better approach.

- **Financial certainty is important.** LTCI can reduce risks of the unknown, and this may occur at any age. While much of the discussion has been associated with the financial costs associated with nursing home care, LTCI covers situations where LTC may be necessary for younger people as well. This may be the result of, for example, a debilitating brain or spinal injury. Most LTCI policies have coverage limits, so financial certainty may not be entirely certain.

As has also been noted, even when key factors would support the purchase of LTCI, there can be a significant disconnect within the general public between the need for and the likelihood to purchase this type of insurance.

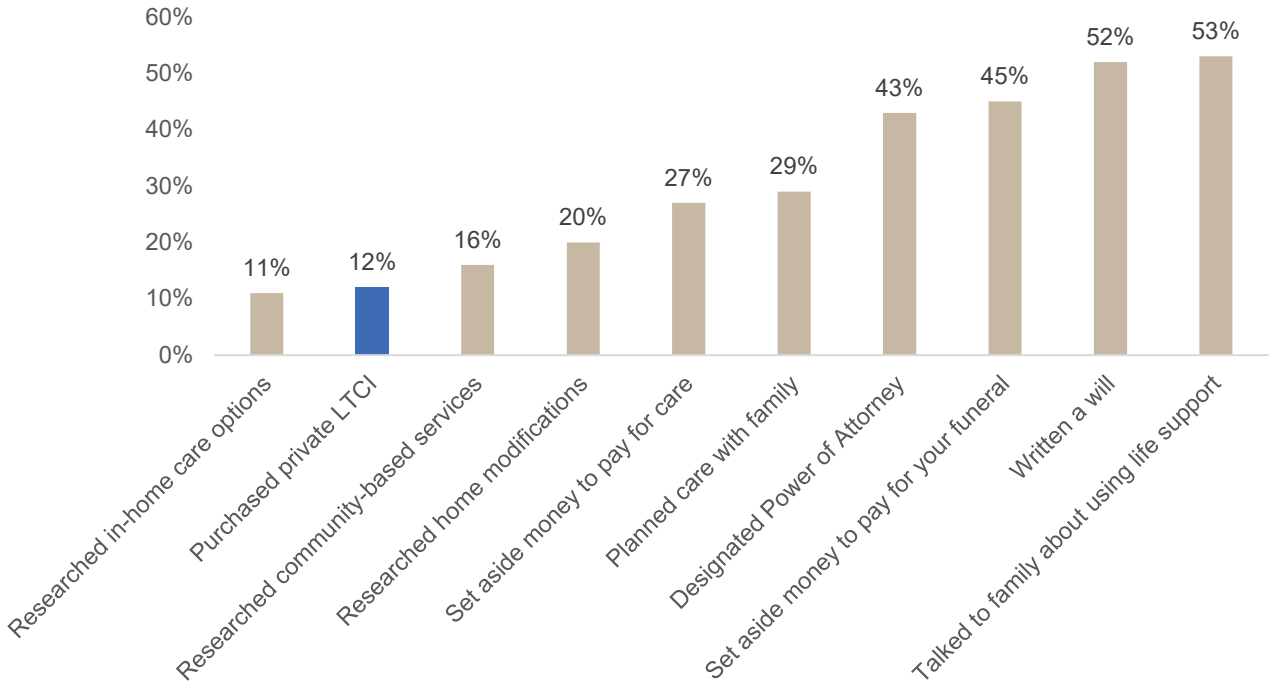
Public Education/Awareness Efforts

According to a 2022 AARP survey of more than 1,000 U.S. adults aged 50 and older, nearly 7 in 10 believe that they will need assistance with their daily activities as they get older. Even with this understanding, fewer than 3 in 10 have given serious thought to how they will continue to live independently if they need assistance. Further, while more than 4 in 10 respondents indicated they had carried out a variety of activities to help prepare for their end-of-life plans (such as talking with family members about life support, writing a will,

[53] Center for Consumer Engagement in Health Innovation, "Learning from New State Initiatives in Financing Long-Term Services and Supports," (July 2020). Accessed electronically at https://www.ltsscenter.org/wp-content/uploads/2020/07/State-LTSS-Financing-Full-Report-July-2020.pdf

and setting aside money for funeral expenses), just 12 percent of respondents indicated they had purchased private LTCI.[54]

Figure 7: Share of Survey Respondents Preparing for the Future



Source: AARP LTC Readiness Survey, 2022

A 2015 study by independent nonprofit research institute RTI International sought to answer three questions:[55]

1. What are the general public's knowledge, experience, and concerns about long-term services and supports?
2. What are the general public's preferences for a range of public policy options for LTC financing reform?
3. What are individuals' preferences for specific key features of LTCI policies and what are people willing to pay for those features?

To answer these questions, RTI designed, tested and analyzed the results of a Survey of LTC Awareness and Planning, which included general survey items (including LTC knowledge and experience, attitudes and concerns; preferences on public policy options for LTC financing; and core sociodemographic characteristics) as well as a Discrete Choice Experiment (DCE) involving choice of LTCI policies with different features and prices. According to the results of the study, which used a nationally representative sample of noninstitutionalized adults between the ages of 40 and 70 residing in the U.S.:[56]

[54] AARP Research, "LTC Readiness Report," (June 2022). Accessed electronically at https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2022/long-term-care-readiness-report.doi.10.26419-2Fres.00555.001.pdf
[55] RTI International, "LTC Awareness and Planning: What Do Americans Want?" (July 30, 2015). Accessed electronically at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//84886/Awareness.pdf
[56] HHS Office of the Assistant Secretary for Planning and Evaluation, "Issue Brief: Findings from the Survey of LTC Awareness and Planning," (July 2015). Accessed electronically at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//72336/SLTCAPrb.pdf

- Despite high expectations of surviving to old age, not as many respondents expected to need nursing home services in the future. Although a significant proportion of respondents believed there was a substantial risk of their using nursing home care, nearly 43 percent assessed their chances of moving into a nursing home in the future as less than or equal to 20 percent.

- Only about one-fifth of respondents correctly estimated the average cost of a month of nursing home care in their state of residence, and 15 percent correctly estimate the average cost of one hour of home health aide care in their state.

- Respondents also did not understand how LTC is currently financed, with approximately 25 percent of all respondents correctly identifying Medicaid as the government program that pays the most for LTC services in the U.S.

- Respondents were generally supportive of the concept of LTCI, but many had competing demands for their money. Nearly two-thirds of respondents either agreed or strongly agreed that "knowing I have some LTCI will give me peace of mind," but almost half reported they had other priorities for their money than buying LTCI.

- Respondents generally favored voluntary responsibility for LTC financing and voiced substantial mistrust of how the government would manage a public LTCI program.

The study's authors concluded that, given somewhat conflicting public views, the challenge for policymakers is to find a strategy that will both successfully address the problems of the LTC system and have broad political support.

Some studies have identified the need for public education investments to highlight these issues. As one example, a 2021 analysis by the Bipartisan Policy Center recommended that the Financial Literacy and Education Commission (established under the Fair and Accurate Credit Transactions Act of 2003 to develop a national strategy on financial education) suggested that various federal agencies coordinate to strengthen educational resources on LTC needs and planning and incorporate LTC planning into retirement education topics. This should address common public misconceptions about LTC – for example, providing clear warnings that Medicare does not cover such services and emphasizing that the Medicaid program has strict income and asset limits that an individual must meet to quality for LTSS coverage through Medicaid.[57]

Based at least partly on these types of studies, government awareness campaigns have been initiated. Among these efforts by the federal government (often in collaboration with state governments) to increase awareness of LTC needs – as well as the availability of LTCI to help pay for it. These include:

- **"Own Your Future" Awareness Campaign:** Between 2005 and 2010, the U.S. Department of Health and Human Services and state governments partnered in a campaign to raise awareness about LTC and encourage Americans to take an active role in planning for LTC needs. A comprehensive research agenda was undertaken between 2000 and 2005 to explore why people do not plan, how to best motivate planning, and what factual information and motivational messages people need to feel that planning ahead for LTC needs is both beneficial to them and feasible. The campaign used both qualitative and quantitative research methods to determine the best means and messages to encourage planning. Specifically, numerous focus groups, a comprehensive consumer survey, best practice interviews with leading experts in messaging on LTC, and a literature review

[57] Bipartisan Policy Center, "Bipartisan Solutions to Improve the Availability of LTC," (September 2021). Accessed electronically at https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/09/BPC_Health_Long_Term_Care_RV4-min.pdf

were conducted in order to inform the best communication strategies and messages to help raise awareness of the need to plan and give consumers the planning tools they need.[58]

- **National LTC Awareness Month:** National LTC Awareness Month is observed in November each year. The month-long observance highlights the LTC needs of men and women over the age of 65, and how they should be assisted in their daily lives.

- **LTC Ombudsman Programs:** Created in 1972 as a demonstration program under the Older Americans Act (OAA), today each state has an Office of the State LTC Ombudsman, headed by a full-time state LTC Ombudsman. Among the programs' requirements are the provision of information to residents about LTSS.

- **State Information Programs.** Many states provide significant information related to LTC and LTCI on their websites. The state of Ohio is a good example, as the Department of Insurance has an informative Guide to Long-Term Care Insurance on its website.[59] The guide includes discussions of many of the issues discussed in this report, including the need for LTC and well as LTCI; Medicaid and LTC; the Ohio LTC Partnership Program; LTCI benefits, exclusions, and premiums; tax issues; and a self-assessment.

[58] The SCAN Foundation, "CLASS Technical Assistance Brief Series – The *Own Your Future* LTC Awareness Campaign: Implications for CLASS," (Spring 2011, No. 13). Accessed electronically at http://www.thescanfoundation.org/sites/default/files/TSF_CLASS_TA_No_13_Own_Your_Future_FINAL.pdf

[59] "Guide to Long-Term Care Insurance," Ohio Department of Insurance, accessed electronically at https://insurance.ohio.gov/consumers/long-term-care/guide-long-term-care-insurance

Chapter 3: Tax Incentives and Benchmarking

Federal and State Tax Incentives

It is generally understood that people respond to incentives. Both the federal and state tax codes provide a variety of favorable tax treatments for certain types of activities. These are generally provided to induce certain types of economic activity. Examples include federal and state deductions for mortgage interest paid, and tax credits for childcare costs. In many instances, these deductions and credits come with income and/or expense limits for tax purposes.

LTCI will, in some cases, qualify for federal and state tax deductions as health insurance. The previous discussion has already noted that to be eligible for reimbursement expenses through either the Medicaid or Medicare program, the nursing facility care has to be medically necessary. This is also often the case for private LTCI as well.

Federal Deduction of LTCI Premiums

Premiums paid for many LTC policies that provide coverage for nursing facilities and related services are accepted by the U.S. Internal Revenue Service (IRS) as deductions for health insurance. [60] However, there are limits to the federal income tax deduction. First, if a taxpayer does not itemize deductions, they are not generally deductible. Second, there are limits on the amount of the premium that may be deducted, which depends on the age of the taxpayer at the end of the tax year. The following are the deduction limits for tax year 2022. Any premiums paid that exceed these amounts are not deductible:

Table 4: Federal Taxes LTCI Deduction Limits, Tax Year 2022

Age at the End of the Tax Year	Maximum Premium Deduction
40 or less	$450
More than 40 but not more than 50	$850
More than 50 but not more than 60	$1,690
More than 60 but not more than 70	$4,520
More than 70	$5,640

Source: U.S. Treasury Department, IRS

There is a third important limitation: the LTCI premiums are tax deductible to the extent that they, along with other unreimbursed medical expenses, exceed 7.5 percent of the insured's adjusted gross income. For many households, that is a significant hurdle, particularly at younger ages.

Even if these hurdles are met, the deduction simply reduces taxable income. For many individuals or households, depending on their tax bracket and other deductions, exemptions, and credits, it may not have a significant impact on the overall taxes paid.

Finally, it should be noted (as was discussed in the section on types of LTCI) that hybrid or linked-benefit LTCI policies do not generally qualify for the federal income tax deduction for individuals. However, business taxpayers may be able to gain a tax benefit; C-corporation's LTCI premiums should be fully deductible to the employer as accident and health insurance. For owners of pass-through entities (such as S-corporations and LLCs), there is no requirement that unreimbursed medical expenses exceed 7.5 percent of adjusted gross income. As a result, the tax treatment of LTCI premiums is more favorable for business taxpayers.

[60] These incentives are for LTCI policies that qualify under 26 United States Code (USC) § 7702B(b)(1). These policies only provide coverage for qualified LTC services and does not pay or reimburse for expenses that are reimbursable under Title XVIII of the Social Security Act. These contracts must also be guaranteed renewable.

State Tax Treatment of LTCI Premiums

States treat LTCI premium payments for tax purposes in one of three ways. Along a continuum, there are states without a state income tax, and there are no other incentives offered in those states. Those states are Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Washington, and Wyoming.

There are also states with an income tax that provide no state tax benefits. Those are Arizona, Connecticut, Delaware, Georgia, Illinois, Massachusetts, Michigan, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Vermont.

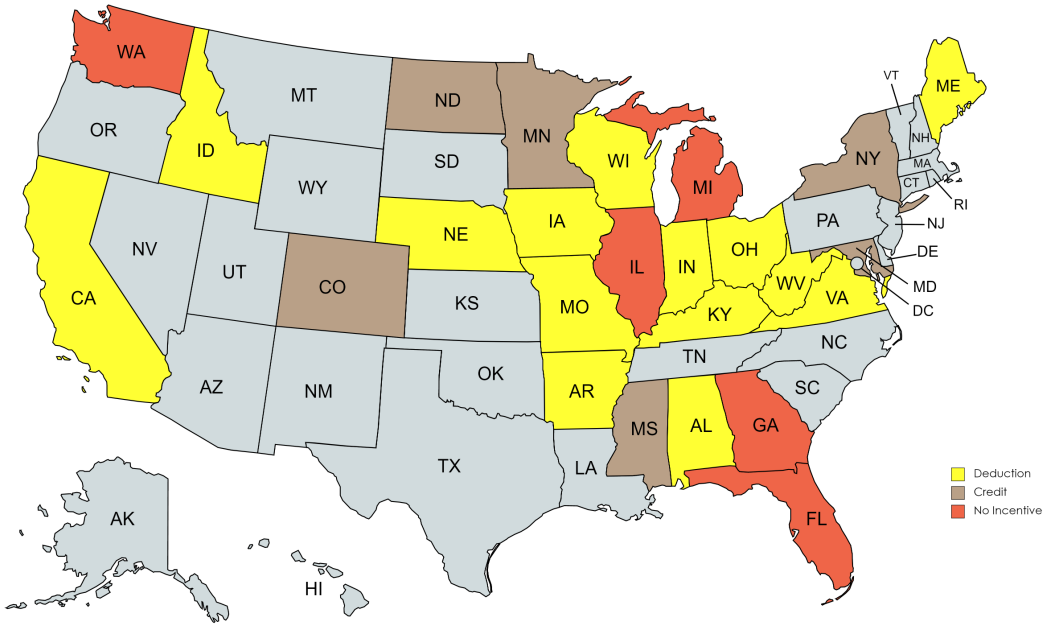
States that provide an incentive generally fall into two groups: states that provide a deduction or states that provide a credit. Among the states that provide a deduction, some treat the insurance premiums for state income tax purposes as they are treated in the federal tax code. Other states provide a broader deduction, particularly related to the federal limits on the amount of premiums that may be deducted. Other states allow a deduction that differs in other ways from the federal tax treatment. One state, Montana provides both a deduction of the entire amount of premiums as well as a credit.

The remaining states provide a tax credit. While a tax deduction reduces taxable income, a credit reduces the tax that is owed. If the credit is refundable, the state reimburses the taxpayer for the entire amount of the credit, even if there is no tax liability. None of the states provide a refundable credit, so the incentive only applies if the taxpayer has state income tax liability. Among the states that provide a tax credit, the amount of the credit and the years when it may be claimed vary.

State Benchmarking Comparisons

In order to understand the extent of the effects of tax deductions and credits for LTCI purchases, the project team selected a sample of states that offer these incentives and compared them across numerous outcomes to a control group of states that offer no incentives at all. Twenty-five states were ultimately selected: 14 that offer deductions, 6 that offer credits, and 5 that offer no benefits at the state level. These benchmark states are identified in the following map:

Figure 8: Map of Benchmark States



Tax Deductions

Ohio allows tax deductions on eligible long-term care premiums up to a certain amount:[61]

Table 5: Ohio Maximum Premium Deductions by Age

Age at the End of the Tax Year	Maximum Premium Deduction
40 or less	$200
More than 40 but not more than 50	$375
More than 50 but not more than 60	$750
More than 60 but not more than 70	$2,000
More than 70	$2,500

Source: Ohio Department of Taxation

The benchmark states that offer deductions have policies similar to what is offered in Ohio. Many of these deductions are the same as what is offered on the federal level, in addition to the federal benefit. For example, Arkansas provides a deduction similar to what is offered on the federal level: the deduction can be taken in certain circumstances as long as unreimbursed medical expenses do not exceed 7.5 percent of taxpayer's AGI.[62] California offers the same deduction as what is offered on the federal level.[63]

Alabama, Idaho, Indiana, Wisconsin, and Kentucky allow individuals to deduct all premiums on their state tax returns. Maine and West Virginia allow deductions for all premiums as long as they are not eligible on the federal level.

A few of the benchmark states offer a variation of benefits. Virginia offers a state deduction only if the deduction is not claimed on a person's federal tax return. Nebraska limits deductions to $1,000 for a single individual or for $2,000 for joint filers.[64] Beginning in 2006, Missouri allows a deduction for all non-reimbursed premiums as long as they are not included in the individual's itemized deductions.[65]

Table 6: State Tax Deductions for LTCI

State	Year Enacted	Maximum Individual Benefit
Ohio	**1999**	**All premiums are deductible up to a certain limit**
Wisconsin	1998	All premiums are deductible
Alabama	1995	All premiums are deductible
Indiana	1999	All premiums are deductible
Idaho	2004	All premiums are deductible
West Virginia	2000	Can deduct premiums that are not deducted on the federal level
Arkansas	1997	Similar deduction to what is offered on the federal level
California	1993	Same deduction as what is offered on the federal level
Iowa	1997	Same deduction as what is offered on the federal level for medical expenses and applies to long-term health insurance coverage for nursing homes only.
Kentucky	Unknown	All premiums are deductible
Maine	2003	Can deduct premiums that are not deducted on the federal level
Missouri	1999	Can deduct a portion of premiums

[61] Email from Ernie Massie, Ohio Department of Taxation, September 28, 2022.
[62] Arkansas Reg. §1.26-51-423(a)(2)
[63] CA Rev & Tax Code § 17201 (2021)
[64] Ne. Rev. Stat. §77-2716.11.a
[65] Mo. Rev. St. §135.096

State	Year Enacted	Maximum Individual Benefit
Nebraska	2018	$1,000 for an individual or $2,000 for a married couple
Virginia	2014	Cannot deduct if individual has claimed a federal deduction

Source: State statutes

Tax Credits

Six benchmark states offer tax credits for paying premiums on long term care insurance policies, whose qualifications typically mimic what is eligible for deductions on the federal level. New York offers a credit of up to $1,500 per individual for those with an adjusted gross income below $250,000. The amount of the credit is limited to 20 percent of what the individual paid on LTCI premiums.[66] The other benchmark states offering tax credits provide a credit of up to a few hundred dollars per individual. New Mexico used to offer a credit up to $2,800 for those over the age of 65 for medical expenses, including LTCI premiums. Individuals were only eligible if their annual expenses are greater than $28,000 and are not otherwise compensated for. This tax credit was line item vetoed by the governor in 2018 after going into effect in 2000.[67]

Two states currently offer tax credits for employers to offer LTCI as part of their benefits packages: Maryland and Maine.

- **Maryland:** Under this credit, any employer[68] that provides LTCI as part of an employee benefit package may claim a credit for costs incurred during the taxable year. It cannot exceed the lesser of $5,000 or $100 per employee covered by LTCI. However, unused credit can be carried forward for five tax years.[69]

- **Maine:** If an employer offers LTCI as part of a benefit package, it can claim a tax credit that is the lowest of the following: $5,000, 20 percent of the costs incurred by the employer to provide LTCI as part of its benefits package(s), or $100 for every employee covered under the eligible policies.[70] This tax credit is offered in addition to the deduction offered to individual taxpayers. Individuals can deduct the total premiums paid after subtracting the amount deducted on the federal return.[71]

While no longer offered, Oregon previously provided a LTCI tax credit for employers and individuals but repealed it in 2015. The individual or a corporation could claim a credit of up to $500 per individual or employee.[72]

The following table provides a snapshot of the six benchmark states that offer a tax credit to individuals and the two benchmark states that offer a credit to employers who offer long term care insurance as part of their benefits packages.

Table 7: LTCI Tax Credits by State

State	Year Enacted	Maximum Individual Benefit	Maximum Employer Benefit
New York	Unknown	$1,500	-
Minnesota	1997	$100	-
Colorado	1999	$150	-
Maryland	2000	$500	$5,000

[66] N.Y. Tax Law §606(aa)
[67] https://law.justia.com/codes/new-mexico/2018/chapter-7/article-2/section-7-2-35/
[68] This includes 501(c)(3) or 501(c)(4) organizations that are exempt from taxation.
[69] C2ER State Business Incentives Database
[70] Maine Revised Statute Title 36 §2525-A
[71] Maine Revised Statute Title 36 §5122
[72] Oregon Revised Statute §315.610 Sec. 38

State	Year Enacted	Maximum Individual Benefit	Maximum Employer Benefit
Maine	1999	-	$5,000
Mississippi	1972	$500	-
North Dakota	2009	$250	-

Source: State statutes

Other State LTCI Policies, Programs and Regulations

Effective July 1, 2023, the state of Washington will implement the "LTC Trust Act," which was enacted in 2019.[73] This will a consist of a payroll tax of 58 cents per $100 of earnings[74] for everyone over the age of 18[75] who does not own a qualifying LTCI policy. Those who do not own a policy will receive a state-supplied benefit of $36,500 of lifetime benefits to pay for extended care.[76]

There are concerns associated with this program. First, it does not coordinate with other LTCI providers, so it may cover duplicative services. Additionally, not everyone who needs care may be qualified. The program does not cover those who are currently retired, individuals who do not receive W-2s, and the spouses or dependents of qualified residents. It also does not account for those who pay into the system but leave the state before they need benefits or while receiving care.[77]

Eleven states are considering implementing a similar payroll tax to incentivize the purchase of LTCI. These states include Alaska, California, Colorado, Hawaii, Oregon, Illinois, Michigan, Minnesota, New York, North Carolina, and Utah.[78] In October 2019, California approved Assembly Bill 567, which established a LTCI Task Force within the Department of Insurance. The bill requires the Department to produce an actuarial report on recommendations on the design and implementation of a state-wide LTCI program.[79]

Incentive Impacts

Of the benchmark states, Ohio has the fifth largest total population and the fifth largest population over the age of 65. It has a comparatively typical proportion of its population over the age of 65; its share of senior citizens is 6.1 percent above the benchmark group's median, ranking it 6th of the 25.

[73] AARP Public Policy Institute. "Advancing Action: A State Scorecard on Long-Term Services and Support for Older Adults, People with Physical Disabilities, and Family Caregivers." Long-Term Services and Supports State Scorecard 2020 Addition. Page 21. Accessible at: https://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Short%20Report%20PDF%20923.pdf

[74] LTC News, "Multiple States Considering Implementing Long-Term Care Tax", October 29, 2021, accessible at: https://www.ltcnews.com/articles/multiple-states-considering-implementing-long-term-care-tax

[75] AARP Public Policy Institute. "Advancing Action: A State Scorecard on Long-Term Services and Support for Older Adults, People with Physical Disabilities, and Family Caregivers." Long-Term Services and Supports State Scorecard 2020 Addition. Page 21. Accessible at: https://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Short%20Report%20PDF%20923.pdf

[76] LTC News, "Multiple States Considering Implementing Long-Term Care Tax", October 29, 2021, accessible at: https://www.ltcnews.com/articles/multiple-states-considering-implementing-long-term-care-tax

[77] American Academy of Actuaries. "Issue Brief: LTC Financing Reform Proposals That Involve Public Programs." July 2021. Page 6-7.

[78] Matt Meyer, Nasdaq, "Will the 'Long-Term Care Tax' Be Coming to Your State Soon?", March 11, 2022, accessible at: https://www.nasdaq.com/articles/will-the-long-term-care-tax-be-coming-to-your-state-soon

[79] AB-567 Long-term care insurance. (2019-2020). Accessible at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB567

Table 8: Population and Age Demographics, Benchmark States (2021)

State	Incentive Category	Population	Population Over 65	Percent Over 65	Median Age
Ohio	**Deduction**	**11,780,017**	**2,102,569**	**17.8%**	**39.6**
California	Deduction	39,237,836	5,964,526	15.2%	37.6
Florida	None	21,781,128	4,598,996	21.1%	42.8
New York	Credit	19,835,913	3,477,337	17.5%	39.8
Illinois	None	12,671,469	2,103,309	16.6%	39.0
Georgia	None	10,799,566	1,585,687	14.7%	37.5
Michigan	None	10,050,811	1,823,284	18.1%	40.2
Virginia	Deduction	8,642,274	1,406,480	16.3%	38.8
Washington	None	7,738,692	1,251,640	16.2%	38.2
Indiana	Deduction	6,805,985	1,115,579	16.4%	38.2
Missouri	Deduction	6,168,187	1,084,768	17.6%	39.2
Maryland*	Credit	6,037,624	930,875	15.4%	38.8
Wisconsin	Deduction	5,895,908	1,054,247	17.9%	40.1
Minnesota	Credit	5,707,390	959,272	16.8%	38.8
Colorado*	Credit	5,695,564	807,855	14.2%	36.9
Alabama	Deduction	5,039,877	885,809	17.6%	39.8
Kentucky	Deduction	4,509,394	768,416	17.0%	39.1
Iowa	Deduction	3,193,079	567,581	17.8%	38.5
Arkansas	Deduction	3,025,891	525,153	17.4%	38.5
Mississippi	Credit	2,949,965	496,945	16.8%	38.6
Nebraska	Deduction	1,963,692	322,833	16.4%	37.2
Idaho	Deduction	1,900,923	314,010	16.5%	37.3
West Virginia	Deduction	1,807,426	360,246	19.9%	42.7
Maine	Deduction	1,372,247	297,101	21.7%	44.7
North Dakota	Credit	774,948	123,840	16.0%	35.8
Ohio Rank	-	**5 of 25**	**5 of 25**	**6 of 25**	**8 of 25**
Median (Excluding Ohio)	-	**5,801,649**	**945,074**	**16.8%**	**38.8**
Ohio Variance From Median	-	**103.0%**	**122.5%**	**6.1%**	**2.1%**

Source: U.S. Census Bureau, ACS 1-Year Estimates (2021)
** Maryland statistics per ACS 5-Year Estimates (2020), as 2020 is most recent year for which tax expenditure data is available.*
*** Colorado statistics per ACS 1-Year Estimates (2018), as 2018 is most recent year for which tax expenditure data is available.*

Compared to benchmark states, Ohio has a lower-than-average median income, ranking 19th of 25. 9.5 percent of its senior citizens are below the poverty line; however, Ohio's poverty rate for those over 65 is 0.5 percent above the median of the benchmark states.

Table 9: Income Demographics, Benchmark States (2021)

State	Median Income	Percent Below Poverty Line	Percent Over 65 Below Poverty Line
Ohio	**$62,262**	**13.4%**	**9.5%**
Maryland*	$87,063	9.0%	7.9%
California	$84,907	12.3%	11.1%
Washington	$84,247	9.9%	8.2%
Virginia	$80,963	10.2%	8.0%
Minnesota	$77,720	9.3%	8.5%
New York	$74,314	13.9%	12.2%
Illinois	$72,205	12.1%	10.0%
Colorado**	$71,953	9.6%	7.4%

State	Median Income	Percent Below Poverty Line	Percent Over 65 Below Poverty Line
Wisconsin	$67,125	10.8%	8.7%
Nebraska	$66,817	10.8%	8.7%
Georgia	$66,559	14.0%	10.0%
North Dakota	$66,519	11.1%	9.4%
Idaho	$66,474	11.0%	9.5%
Iowa	$65,600	11.1%	8.4%
Maine	$64,767	11.5%	9.2%
Michigan	$63,498	13.1%	9.3%
Florida	$63,062	13.1%	11.0%
Indiana	$62,743	12.2%	8.6%
Missouri	$61,847	12.7%	9.5%
Kentucky	$55,573	16.5%	11.7%
Alabama	$53,913	16.1%	11.4%
Arkansas	$52,528	16.3%	11.7%
Mississippi	$48,716	19.4%	13.8%
West Virginia	$48,037	17.1%	9.8%
Ohio Rank	**19 of 25**	**8 of 25**	**11 of 25**
Median (Excluding Ohio)	**$66,474**	**12.2%**	**9.5%**
Ohio Variance From Median	**-6.3%**	**9.8%**	**0.0%**

Source: U.S. Census Bureau, ACS 1-Year Estimates (2021)
** Maryland statistics per ACS 5-Year Estimates (2020), as 2020 is most recent year for which tax expenditure data is available.*
*** Colorado statistics per ACS 1-Year Estimates (2018), as 2018 is most recent year for which tax expenditure data is available.*

Incentive Costs

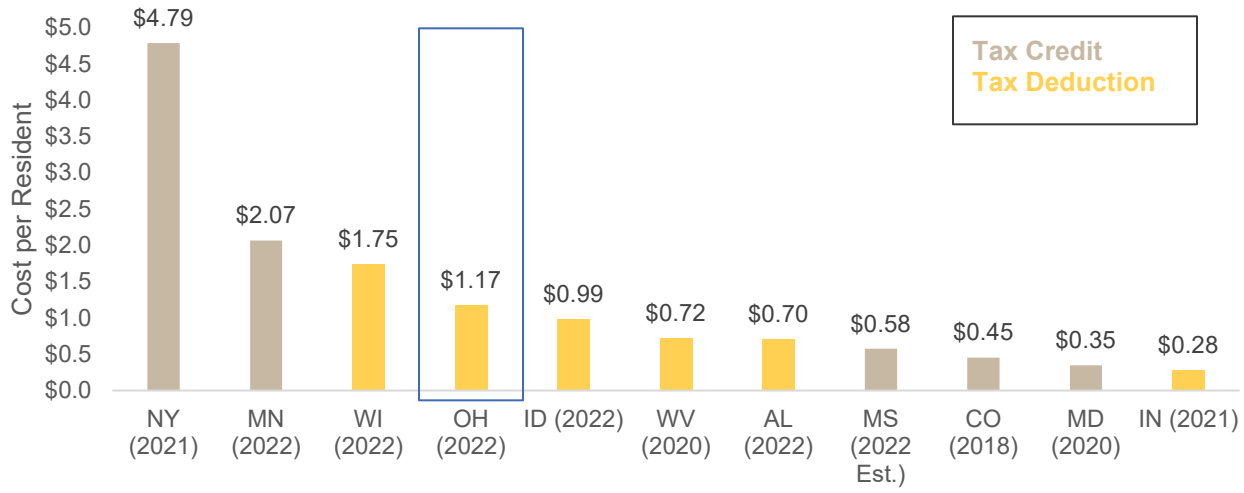
Of the 20 benchmark states offering incentives for LTCI, 11 estimate the costs of the programs – in the form of foregone tax revenue – in their respective tax expenditure reports. It should be noted that tax expenditure reports are issued by states at differing points in time, so it is not possible to use a uniform tax or fiscal year for the analysis. As shown in the following table, Ohio ranked 2nd in total cost of the available tax benefit and 4th in the cost per capita, following New York, Wisconsin, and Minnesota.

Table 10: LTCI Incentive Costs, Select Benchmark States

State	Incentive Type	Most Recent Year	Most Recent Tax Incentive Annual Cost	Average Cost per Resident
Ohio	**Deduction**	**2022 (estimate)**	**$13,800,000**	**$1.17**
New York	Credit	2021	$95,000,000	$4.79
Minnesota	Credit	2022	$11,800,000	$2.07
Colorado	Credit	2018	$2,585,000	$0.45
Maryland	Credit	2020	$2,100,000	$0.35
Mississippi	Credit	2022 (estimate)	$1,700,000	$0.58
Wisconsin	Deduction	2021	$10,300,000	$1.75
Alabama	Deduction	2022	$3,550,000	$0.70
Indiana	Deduction	2021	$1,890,000	$0.28
Idaho	Deduction	2022	$1,873,000	$0.99
West Virginia	Deduction	2020	$1,300,000	$0.72

Source: State Tax Expenditure Reports

Figure 9: Tax Incentive Cost Per Resident, Benchmark States*



Source: State Tax Expenditure Reports, ACS 1 Year Estimates
** The year of each state's tax expenditure report is provided in parentheses.*

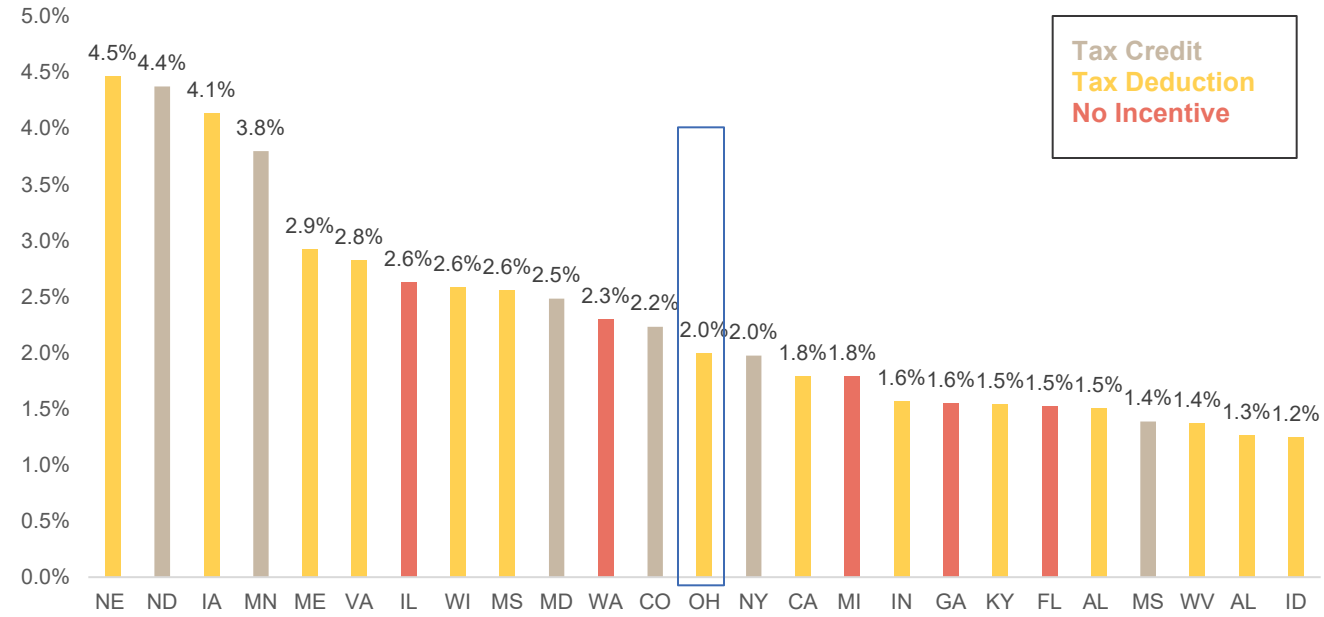
Outcomes and Impacts from Peer Programs

There does not appear to be a correlation between spending on tax benefits for LTCI and the number of lives covered by LTCI policies. Ohio ranked 13th out of the 25 benchmark states for number of lives covered by LTCI per capita, despite spending the fourth most per capita on LTCI tax incentives. Just 2.0 percent of Ohio's population is covered by a LTCI policy, or 235,000 individuals in 2020.[80] By contrast, 4.5 percent of Nebraska's population is covered by LTCI. Notably New York, which offers the highest tax credit for purchasing a LTCI policy, had a similar number of lives covered by LTCI (1.98 percent) to Ohio.

As with total spending, there was no apparent pattern associated with those states that offered tax incentives and LTCI ownership across the population, as shown in the following figure.

[80] National Association of Insurance Commissioners. "Long-Term Care Insurance Experience Reports for 2020." 2021. Accessed at: https://content.naic.org/sites/default/files/LTC-LR.pdf

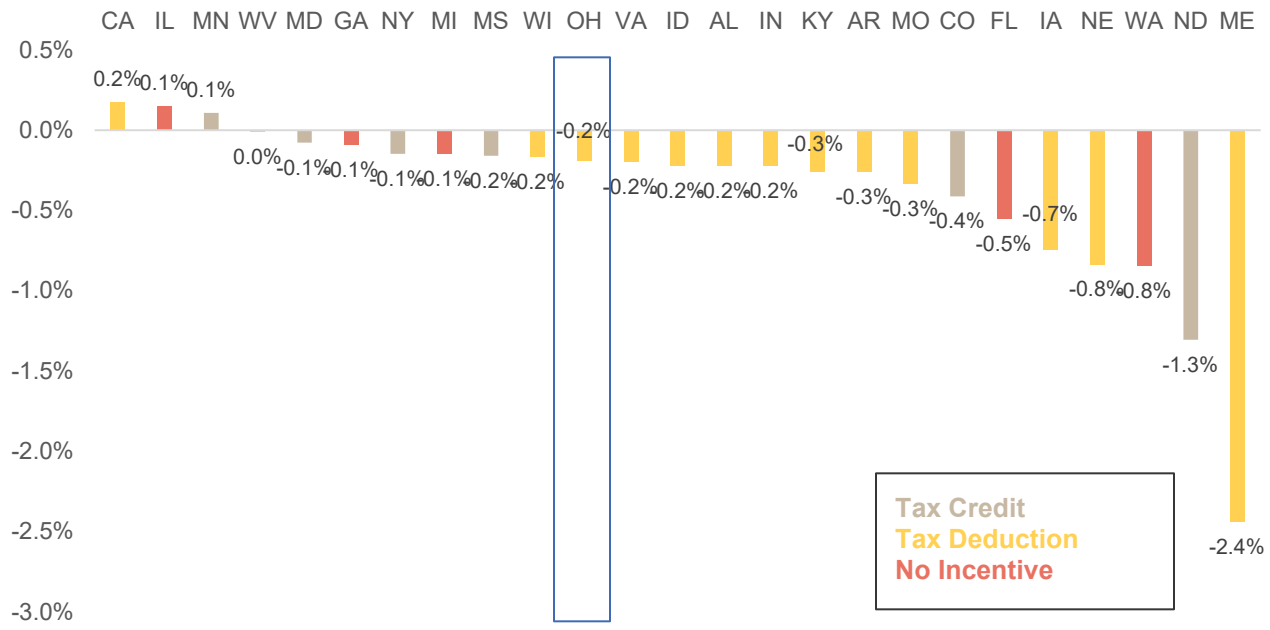
Figure 10: LTCI Ownership Per Resident, 2020



Source: National Association of Insurance Commissioners

To provide a historical perspective, when comparing current figures with LTCI coverage rates 10 years ago, the proportion of lives covered by LTCI policies remained relatively consistent. As shown in the following figure, most benchmark states reduced their coverage rates over the past ten years by less than one percentage point, including Ohio. Only three states (California, Illinois, and Minnesota) increased the proportion of residents covered by LTCI, but only by 0.2 percent or less. In 2010, North Dakota, Maine, and Nebraska had the highest proportion of residents covered by LTCI.

Figure 11: LTCI Ownership per Resident, % Change 2010-2020



Source: National Association of Insurance Commissioners

The lack of correlation between LTCI policy coverage and tax incentive availability is consistent with findings from other studies. A 2012 study in Virginia, for example, found that tax incentives had no effect on LTCI purchases. At the time, Virginia had a tax deduction and a credit intended to encourage individuals to purchase private LTCI. Both preferences were enacted to reduce LTC costs to individuals and/or the state. Of the two, the deduction provides a greater reduction in taxpayers' liability, reducing the aggregate tax bill by $8 million in TY 2008. In comparison, the credit reduced taxpayers' liability by $1 million in TY 2008. Although utilization of private LTCI increased in the years leading up to the study, these preferences dd not appear to be responsible for such increases.[81]

The Colorado Office of the State Auditor published a study in April 2022 that found the tax credit offered in Colorado was too low to have an impact on residents' decisions to purchase LTCI. Per state statute, Colorado limits the credit to $150 annually for each policy. The maximum credit amount has remained the same since the incentive was enacted in 1999. However, the cost of premiums has more than doubled between 2000 and 2015, reaching up to $2,624 for individuals aged 55 to 64 and $5,241 for individuals over the age of 75. The credit provides a lower incentive for residents to purchase a policy as premium costs rise.[82]

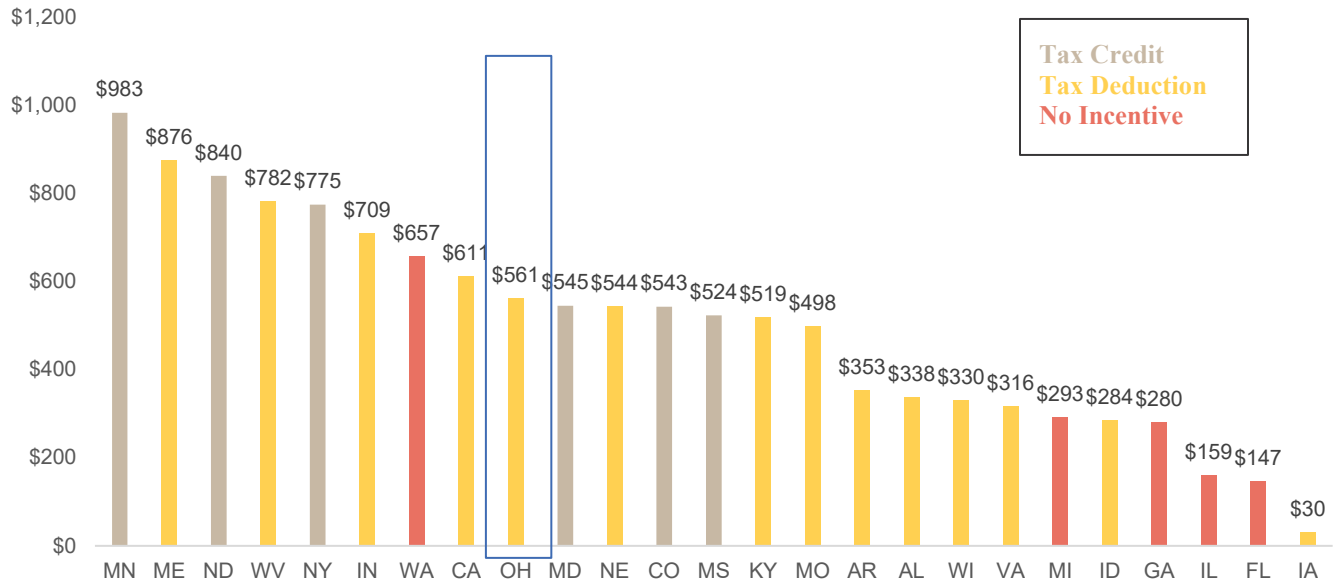
Tax Incentives and Medicaid Spending

There does not appear to be a correlation between spending on tax incentives for LTCI and state Medicaid spending on LTC. However, comparing Medicaid spending and tax incentive availability does not prove whether or not the tax incentive was effective at changing behavior or preserving state financial resources. As previously noted, states have different federal Medicaid matching rates and differing reimbursement rates and methodology, making it difficult to make meaningful state-to-state comparisons.

[81] Virginia Joint Legislative Audit and Review Commission, "Review of the Effectiveness of Virginia Tax Preferences," (January 2012). Accessed electronically at http://jlarc.virginia.gov/pdfs/reports/Rpt425.pdf
[82] Colorado Office of the State Auditor. "LTCI Credit: Evaluation Summary." April 2022.

Of the benchmark states, Ohio ranked 9th for total Medicaid spending on LTC per capita. The following chart demonstrates that there is no evident correlation between or pattern associated with those states that offer tax deductions, tax credits, or no incentives for LTCI and overall long term care Medicaid spending. Notably, despite offering the largest tax credit and having the highest tax incentive cost per resident, New York had the fourth highest expenditures per capita on LTC.

Figure 12: LTC Medicaid Spending Per Resident



Source: Kaiser Family Foundation, FY 2021 Distribution of Medicaid Spending by Service

Chapter 4: Incentive Design Considerations

Elements of Effective Incentive Design

The incentive benchmarking suggests that there is little direct evidence that state tax credits and deductions have been effective in either substantially increasing the number of people with LTCI or reducing Medicaid LTC costs. The design of these incentives may be partly responsible for their weak performance.

Past evaluations of similar incentives have found that state tax incentives have been too small to make a meaningful difference in the decision to purchase LTCI. Other factors that inhibit their impact are the characteristics and costs of eligible LTCI policies that may make them unattractive or unaffordable. Their cost also has meant that higher-income and lower-risk individuals are more likely to participate in the LTCI market, making it less likely that states would see substantial Medicaid savings resulting from these insurance purchases.

This chapter presents a set of questions that should inform incentive design considerations to position any potential new incentive to be both effective and fiscally responsible.

What Outcome is the Incentive Striving to Achieve?

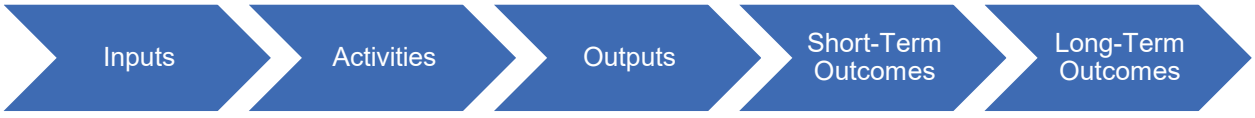
Good incentive design includes clear and measurable goals connected to the outcome it is trying to achieve. Many tax incentives do not specify the expected outcome from offering the incentive. Others have vague objectives (like “increase economic development” or “reduce costs”) that make it difficult to determine the public policy purpose behind the incentive and ultimately to assess its effectiveness. Setting clear and measurable goals at the outset helps focus the incentive on the outcomes that matter most.

In this case, Ohio could decide if its primary objective is to reduce the cost of LTCI for residents, increase the number of Ohioans with LTCI, reduce Medicaid costs associated with LTC, improve the quality of LTC to Ohioans who need it, or other policy outcomes. The RFP indicates that the primary objective is to increase the number of Ohioans with LTCI, but interviews indicated a much wider range of expected benefits than growth in insurance policyholders.

How is an Incentive Likely to Influence the Expected Outcome?

Incentive design should consider how a proposed incentive is connected to the policy goal that has been established. A simple logic model exercise can help articulate how inputs, such as a tax credit, can be expected to translate into an outcome, such as an increase in the number of LTCI policyholders or lower Medicaid costs. Logic models that make explicit the steps that occur between the policy and the hoped-for outcome can also help identify appropriate metrics and highlight pitfalls that might limit effectiveness.

Figure 13: Illustrative Incentive Logic Model



For example, if a tax credit (input) is to be provided to increase the number of Ohioans with LTCI (short-term outcome), the interim steps could consider:

- Activities such as making taxpayers aware of the existence of the tax credit, enabling use of the tax credit on tax forms, defining the policies that will be eligible for the tax credit, encouraging creation of policies that are more attractive to taxpayers, and collecting data on tax credit use;

- Outputs such as the number of taxpayers likely to take advantage of tax credit, the number of taxpayers who actually access the tax credit, and the cost of the credit to the state. The state may also wish to consider long-term outcomes associated with the tax credit's use, such as lower Medicaid costs or better LTC for residents.

Results-based accountability is another approach to understanding the connection between effort and outcome. [83] A critical question in this framework is determining whether the target audience would be better off as a result of the policy intervention. In this case, simply tallying the change in LTCI policyholders is not sufficient, but, for example, determining whether either healthcare or spending patterns have improved is the focus of the incentive. Ongoing performance measurements that address what was done (such as creation of a tax incentive) and how well it was done (outreach and implementation) are also part of this framework. Finally, results-based accountability recognizes that policy interventions do not occur in a vacuum and encourages consideration of baseline conditions, factors that influence individual behavior, and the role of partners. In this case, it would be sensible to consider the rising cost of LTC policies, the prevalence of incorrect assumptions about the cost of and need for LTC, and the variety of policy, financial, and healthcare partners that are active on issues associated with LTC planning and provision.

Another consideration is whether the incentive is motivating a change in behavior. In this case, how influential is the incentive in encouraging individuals to buy LTCI? Many factors, such as cost and quality of the product, will determine the decision to purchase LTCI, but a new, well-designed incentive would be expected to marginally increase the number of LTCI policyholders. At the same time, depending on how it is structured, a new incentive could effectively reward existing policyholders or people who would have purchased a policy without an incentive. Benefits that are estimated for a new incentive can be adjusted to reflect this dynamic.

Who is the Target Audience for the Incentive?

It is the project team's understanding that the primary audience for this incentive would be individual Ohioans who might purchase LTCI products. Most of this assessment focuses, therefore, on individual policy purchases and how individuals might be influenced by a tax or non-tax incentive. A secondary audience would be Ohio employers who purchase LTCI on behalf of their employees.

Incentives should target the users that are most able to help the state achieve its policy goal. In this case, Ohio might consider the size of the potential pool of incentive recipients. For example, a tax credit might be limited to the individuals who do not take the standard deduction and are above certain income levels. The federal tax exemption is currently limited to filers whose medical expenses reach a certain threshold and itemize their deductions. These are two different pools, and both are smaller than the universe of people whom the state might wish to see access LTCI.

The RFP also requests the study to address whether employers or other group insurance plan providers should be able to purchase LTCI policies for their employees or members, and whether allowing an incentive such as a tax credit or other incentive to such employers or providers would increase the number of Ohioans with such insurance. From the review of current tax incentives, it is evident that there are already significant federal tax incentive advantages related to the purchase of LTCI by employers for their employees versus those purchased by individuals. In this case, Ohio might also consider the size of the potential pool of individuals likely to obtain insurance coverage in this manner. Would they need to be full-time employees? Would they need to be associated with a group provider? What would the costs and benefits to the individual be? What would be the expected uptake in policies provided in this manner?

[83] Incentives Compliance Roundtable, Clear Impact presentation by Carlos Delgado, November 2021.

How Should the Incentive Be Structured?

There are many different types of incentives. Business incentives can be categorized as:[84]

1. Financial incentives – subsidies, grants, loans, or investments
2. Fiscal incentives – tax breaks, including exemptions, credits, deductions, reduced rates, carryforwards, or other types of preferential treatment
3. Regulatory incentives
4. Information and technical services – such as data and analysis, technical assistance, advice or consulting

Within these categories, incentives may be further classified by the mechanism through which the incentive is provided, the need that is being met, the target recipient group, and others.[85]

Individual incentives can also take any of these forms. The incentive structure and mechanism should consider the outcome and target audience that have been defined. For example, tax-based incentives are most useful to certain types of taxpayers. A policy intended to help startups grow may avoid tax-based incentives since new companies are likely to have limited tax liability. Grants and technical assistance that can be directed to a growth strategy may be more effective.

In this case, a financial incentive (such as a subsidy provided to all or targeted individuals who purchase LTCI) could be structured to reach more people in the target group than a tax-based incentive, as some in the target population may not have significant tax liability. On the other hand, it may be more costly to the state and more difficult to establish. There may be an opportunity to adjust state regulation of the insurance industry to encourage provision of more attractive and affordable LTCI policies that appeal to the target audience. Research conducted for this project suggests that promotion, advice, and technical assistance to encourage and help individuals to purchase LTCI could be a promising option. These ideas are provided here only as examples to demonstrate the potential for creative thinking about the structure of a potential incentive program.

What Guardrails Are in Place to Limit Risk to the State?

Incentive design needs to consider costs as well as benefits. Conducting a cost-benefit analysis for various incentive options can illuminate the anticipated policy benefits (such as the expected change in the number of Ohioans with LTCI), the expected fiscal impact for the state (including the cost of the incentive, costs/savings in other areas of the state budget such as Medicaid spending, and expected timing of both costs and savings), and the potential economic impact of the change in policy (including direct, indirect and induced effects).[86]

Incentive design can also incorporate protections for the state budget, such as a pay-for-performance design, caps on program outlays, caps on individual benefits, time limits on the number of years a recipient can use the incentive, and incentive sunset provisions.[87]

[84] Rethinking Investment Incentives. Trends and Policy Options. Columbia University Press, 2016.
[85] "State Incentives Database," Council for Community and Economic Research, accessed electronically at https://www.stateincentives.org/
[86] "Cost-Benefit Analysis of Investment Incentives," in Rethinking Investment Incentives. 2016.
[87] The Pew Charitable Trusts, "Avoiding Blank Checks. Creating Fiscally Sound State Tax Incentives," (2012) and "How States Are Improving Tax Incentives for Jobs and Growth," (2017).

How Will the Incentive Be Managed?

Active incentive program management is an underappreciated element of effective incentive program design. Incentives should not run on autopilot. The project team's incentive evaluations and research have consistently found that incentives with a designated lead organization and elements such as applications, review procedures, and required reporting have better data and better performance outcomes. Skilled and dedicated managers should be put in place who can review procedures and outcomes regularly.

Incentive program management should also provide clear guidance to program users, allow for reasonable due diligence on applicant eligibility, establish compliance procedures to ensure rules were followed and expectations met, and provide public reporting for accountability. Active management also makes it more likely for the state to any identify potential problems and make program adjustments as needed. Sufficient staffing and funding for these activities are critical.

In this case, Ohio may need to decide, first, which agency will be in charge of enabling access to any incentive. What steps will the agency need to take to put the incentive in place? What resources will be required? What information will be collected and made available to policymakers to determine the incentive's effectiveness? How will information on incentive outcomes then be used to inform future policy decisions?

Chapter 5: Analysis of Incentive Options

Analysis of Incentive Options

As described in the preceding chapter, many factors influence the effectiveness of any incentive program – and these factors necessarily play a critical role in the state's decisions regarding whether an incentive program would help meet its policy goals of increasing the number of Ohioans with LTCI. However, other issues must be taken into consideration. For example, if the state implements an incentive targeting only new policy holders, it will effectively benefit those who have not yet purchased LTCI and could be perceived as "punishing" those who have previously adopted the desired behavior by obtaining LTCI. At the same time, the goal of most incentives is to drive behavior that is not already happening.[88]

Another key consideration is whether – assuming the state opts to structure its incentive as a tax incentive (as opposed to a non-tax incentive) – that incentive should be a tax deduction or a tax credit. As discussed previously, evidence exists to suggest that tax credits are marginally more effective tools than tax deductions.

The following summarizes potential incentive options for consideration and discusses the key issues related to each option identified.

Option 1: Subsidize All or a Portion of LTCI Premiums for Eligible Ohioans via Tax Credits

As discussed previously, research suggests that, in general, many Americans are unlikely to purchase LTCI for a variety of reasons – and that there is little concrete evidence that incentives to encourage the purchase of LTCI have been effective at increasing the purchase of these policies.

At the same time, it is feasible to assume that there is a correlation between the generosity of an incentive (in terms of the amount of the LTCI premium subsidized) and the number of residents purchasing policies. In other words, the larger the subsidy offered, the more likely that a greater number of residents will purchase coverage. At its logical extreme, if a state opted to fully subsidize the cost of LTCI premiums, the number of residents with such coverage would most certainly increase substantially. However, the cost to the state would be significant to the point of not being a feasible option.

The following provides estimates of the cost to the state of Ohio based on varying degrees of subsidization. The assumptions used in this analysis are summarized below.

- **Eligible Population.** The "sweet spot" for applying for LTCI is between the ages of 55 and 65. After age 70, it becomes difficult to find and be accepted for traditional LTCI coverage. In 2020, 54 percent of applicants for LTCI were between the ages of 55 and 64.[89]

  According to U.S. Census Bureau estimates, Ohio's population in 2021 was approximately 11.8 million. Of that total, approximately 3.7 million were residents aged 55 and older, which is detailed in the following table.

[88] As it relates to incentives for businesses to increase economic activity, sometimes incentives are provided to match competition with other state or local governments; that is not the case here. Sometimes incentives are offered to individuals to improve their productivity or skill sets, such as worker training or retraining incentives. That is also not the case here.
[89] American Association for Long Term Care Insurance, "LTCI Facts – Data – Statistics – 2022 Reports." Accessed electronically at https://www.aaltci.org/long-term-care-insurance/learning-center/ltcfacts-2022.php#2022costs

Table 11: Estimates of Ohio Population Aged 55 and Above (2021)

Age Category	Male	Female	Total
55 to 59	386,096	396,362	782,458
60 to 64	393,247	413,974	807,221
65 and Above	940,309	1,158,690	2,098,999
Total	**1,719,652**	**1,969,026**	**3,688,678**

Source: U.S. Census Bureau Annual Estimates of the Resident Population

- **Share of Eligible Population Purchasing LTCI.** Even if nearly or fully subsidized, a portion of Ohio's 55 and above population would not participate in a program to incent LTCI (unless the credit is made refundable). Some will not have enough tax liability, some will be unaware of the program, some will not file a tax return, and others would opt out due to a mistrust of government or being generally anti-insurance. The following estimates are intended to serve as a proxy to account for these nuances.

Table 12: Estimated Participation Rates by Level of Subsidization

Level of Subsidization of Annual Premium Costs	Estimated Incentive Program Participation Rate
100%	90%
75%	75%
50%	50%
25%	25%

** For demonstrative purposes only*

- **Annual Premium Costs.** According to the American Association for Long Term Care Insurance's (AALTCI) 2022 price index survey of leading LTC insurers selected by consumers, the average LTCI premiums – if purchased at age 55 – are $950 for males and $1,500 for females.[90] Average annual premiums increase as purchase age increases, as shown in the following table.

Table 13: Average Annual LTCI Premium Costs (2022)

Age at Purchase	Male	Female
55	$950	$1,500
60	$1,175	$1,900
65	$1,700	$2,700

Source: American Association for Long Term Care Insurance

Based on the preceding assumptions, the following table provides estimates of the cost to the state of Ohio to offer these benefits to all eligible residents, based on various degrees of the state's subsidization of premium costs.

[90] Rates are for an initial pool of benefits equal to $165,000. Prices are for the State of Illinois as of January 2022.

Table 14: Estimated State Tax Revenue Foregone ($ Millions)

	55 to 59	60 to 64	65 and Above	Total
100% Subsidization				
Male	$330.1	$415.9	$1,438.7	$2,184.7
Female	$535.1	$707.9	$2,815.7	$4,058.6
Total	**$865.2**	**$1,123.8**	**$4,254.3**	**$6,243.3**
75% Subsidization				
Male	$206.3	$259.9	$899.2	$1,365.4
Female	$334.4	$442.4	$1,759.7	$2,536.6
Total	**$540.8**	**$702.3**	**$2,658.9**	**$3,902.0**
50% Subsidization				
Male	$91.7	$115.5	$399.7	$606.9
Female	$148.7	$196.7	$782.1	$1,127.4
Total	**$240.4**	**$312.2**	**$1,181.8**	**$1,734.3**
25% Subsidization				
Male	$22.9	$28.9	$99.9	$151.7
Female	$37.2	$49.2	$195.5	$281.8
Total	**$60.1**	**$240.3**	**$295.4**	**$433.5**

Source: PFM Analysis

It is notable that these figures are estimates and made based on the general assumptions outlined previously and are intended to be for demonstrative purposes only. Further, these figures do not reflect the Ohio's aging population or the fact that costs would be expected to increase each year.

Even without taking into consideration rising future costs, the subsidization at the lowest category, 25 percent subsidization, would be approximately $433.5 million for the state of Ohio. This is in contrast to the current $13.7 million tax expenditure for the income tax deduction for long term care insurance premiums in FY2022.[91] By contrast, the entire state Medicaid expenditure for LTC in Ohio is $4.35 billion. While it may seem worthwhile to provide a large subsidy in order to reduce the Medicaid expenditure, that reduction would likely not occur for several years in the future, and there is a strong likelihood that many in the subsidized population would not require Medicaid-supported LTSS anyway. This suggests that the cost to nearly or fully subsidize the purchase of LTCI for Ohio's older residents is not feasible.

Option 2: Provide Tax Credits to Employers and/or Other Group Insurance Plan Providers Offering LTCI

As discussed previously, two states – Maine and Maryland – currently provide tax credits to employers offering LTCI as part of their benefits packages, restated in the following:

- **Maine**: Tax credit equal to the lowest of (1) $5,000; (2) 20 percent of the costs incurred by the employer to provide LTCI as part of its benefits package(s); or $100 for every employee covered under eligible policies.
- **Maryland**: Tax credit equal to the lesser of (1) $5,000; or (2) $100 for every employee covered under eligible policies. Unused credit can be carried forward for five tax years.

[91] "TAX EXPENDITURE REPORT, The State of Ohio Executive Budget for Fiscal Years 2022-2023, Ohio Department of Taxation, October 29, 2020, p. 10, accessed electronically at https://tax.ohio.gov/static/communications/publications/fy22-23taxexpenditurereport.pdf

This tax incentive could be implemented to encourage employers to cover all or part of the cost of LTCI premiums. The benefit to an individual employee depends on how great a portion of the premiums the employer covers; an individual may be better off purchasing their own plan depending on the amount of the subsidy. As discussed previously, offering such incentives is unlikely to meaningfully increase the number of employees opting to purchase LTCI and is therefore not considered to be reasonable option for consideration.

Option 3: Provide Tax Credits to Insurance Companies

The state could consider an incentive program in which qualified insurance companies writing new LTCI policies receive a dollar-for-dollar credit against their insurance premium tax liabilities, up to a pre-determined share of the yearly premiums (e.g., 10 percent or 20 percent) with a pre-established cap (e.g., between $10 million and $25 million). This would be offered on a first-come, first-served basis, and income limits could be based on age.

This approach would have the benefit of not increasing the expenditure side of the budget. Instead, it would reduce revenue to the state from its insurance premium tax. In this model, the state would only pilot this incentive program for one year, but the expectation would be that the larger subsidy would attract more consumers – and those consumers would maintain their respective policies.

This option could be targeted to a certain age cohort (for example, those over 55). Doing so would increase the likelihood that the state would more quickly realize savings (in the form of foregone tax expenditures) in its Medicaid budget. Modeling possible savings in the state's Medicaid program was not included within the project scope, so the extent and/or timing of those savings cannot be calculated.

A benefit of this approach is that insurance companies would have a vested interest in marketing LTCI and encouraging residents to purchase policies, as they would expand their number of policies without shouldering the cost of the incentives.

The following table demonstrates the potential impact of structuring a LTCI incentive in this manner; it uses a blended rate of $1,654 for the annual LTCI premium cost as of 2022 (the average of the annual rates for males and females between the ages of 55 and 65 at the time of purchase, as described previously).

Table 15: Estimated Impact of LTCI Incentive Program for Insurance Companies

	10% Subsidy	20% Subsidy
$ Value per Subsidy	$165.42	$330.83
Program Size	**Number of LTCI Policies Subsidized**	
$10,000,000	60,453	30,227
$15,000,000	90,680	45,340
$20,000,000	120,907	60,453
$25,000,000	151,134	75,567

As the table shows, a $10 million program that provides a 10 percent subsidy on the average policy could be provided to an additional 60,453 first-time LTCI purchasers in Ohio or 30,227 if a 20 percent subsidy were provided. If the program were $25 million, it could provide a 10 percent subsidy to over 150,000 Ohio purchasers or a 20 percent subsidy to over 75,000 Ohio purchasers.

Option 4: Incentivize Purchase of LTCI via Non-Tax Incentives

While traditional tax incentives (i.e., credits and exemptions) impact the revenue side of a budget, other incentives – such as targeted grants or other similar types of programs apart from traditional tax incentives – impact the expenditure (or spending) side of the budget.

When evaluating which incentive structures are most likely to generate the desired results for the state of Ohio, a non-tax incentive approach is likely to be preferable. The state of Ohio could optimize this strategy by eliminating the current deduction for LTC insurance, which would likely generate a larger result on investment for the state.

If implemented on a standalone basis (i.e., not in concert with other LTC insurance incentive programs), the state could implement a pilot program to be deployed over a finite, five-year period (e.g., FY2024-2029) with a pre-established cap for example, between $10 million and $25 million in the aggregate). As with the prior option, this program could be open to only those who do not currently have LTCI, and it could be offered on a first come, first served basis up to the program cap. It could provide recipients with an annual subsidy equal to a pre-selected share of LTCI premiums for any qualified LTCI policy for Ohio residents (e.g., 10 percent or 20 percent). Income limits could be set depending on the age of the applicant.

Those accepted into the incentive program would receive the same subsidy, in terms of dollar amount, for five years – as long as the policy remains active and does not lapse. In the event that recipients drop out of the program or otherwise fail to meet its eligibility requirements, those on a waiting list would become eligible and would receive the subsidy for the remainder of the five-year period at the same subsidy dollar value. This would allow the state to determine the efficacy of the incentive program, in terms of the number of new individuals purchasing LTCI.

There are practical issues that should be taken into consideration regarding this potential approach. For example, the state would need to ensure that program beneficiaries did not sign up for LTCI, receive the benefit, and then cancel their policy. To protect against this, the state could require that residents own and pay for policies for a full year before issuing funds. While there are administrative costs associated with these guardrails, they would help ensure the program helps the state to achieve its policy goals.

The following table demonstrates the potential impact of structuring a LTCI incentive in this manner; it uses a blended rate of $1,654 for the annual LTCI premium cost as of 2022 (the average of the annual rates for males and females between the ages of 55 and 65 at the time of purchase, as described previously).

Table 16: Estimated Impact of Non-Tax Incentive Program for LTCI

	10% Subsidy	20% Subsidy
$ Value per Subsidy	$165.42	$330.83
Program Size	**Number of LTCI Policies Subsidized**	
$10,000,000	60,453	30,227
$15,000,000	90,680	45,340
$20,000,000	120,907	60,453
$25,000,000	151,134	75,567

Chapter 6: Findings and Alternatives

The need for greater recognition of the possible need for LTSS is evident. The report identifies demographic and economic trends that suggest a significant share of the population will require LTSS in their lifetime, and the costs associated with LTSS are significant – and are likely to increase in the coming years, for a variety of reasons. As a result, it is an opportune time to examine whether – and how – the state might seek to increase financial stability related to LTSS for at least some of its citizens. From the analysis in the report, it is evident that a tailored and layered approach to increasing the numbers of Ohioans who purchase LTCI will be most effective.

Findings Related to LTCI

The following identifies key findings that impact on determining the value of various approaches to incent the purchase of LTCI.

1. **There is a disconnect related to Medicare coverage of LTSS.**
   Public opinion surveys suggest the general public believes that Medicare will be the primary source of coverage for LTSS. In fact, Medicare will only provide limited coverage for medically necessary LTC, and generally after a hospital stay. After the first 20 days, there is also a significant co-pay for the remaining 80 days that Medicare will cover.

2. **Medicaid, not Medicare, is the 'payer of last resort' for qualified LTSS.**
   Unlike Medicare, which is a federal health insurance program paid for by employee and employer payroll taxes, Medicaid is a shared state and federal program paid for by state and federal general revenue. It is generally one of the largest state budget items, and it has been growing over time. States have significant latitude in how they structure Medicaid benefits and reimbursement rates for services, and per capita costs vary considerably from state to state.

3. **Qualifying for Medicaid generally requires a significant spend down of assets and limited income.**
   While there are exceptions made for an automobile and a house up to a certain value – and also the ability for a non-institutionalized spouse to maintain their income and assets – there are otherwise limitations on assets and income to qualify for Medicaid coverage of LTC. The asset limit is $2,000, and the monthly income limit for 2022 is $2,523. Medical expenses (including LTC) can be applied against income to get to the $2,523 limit, but the fact is that Medicaid coverage of LTC will generally reduce assets and income that otherwise might be passed along to heirs.

4. **LTCI is not a single product, and there is no 'one size fits all' answer to the question of whether individuals or households should purchase LTCI.**
   There are a variety of LTCI products, with varying tax treatments at the federal and state level. Even within the traditional LTCI product, the amount of coverage, the waiting period before claims will be paid, and features like an inflation factor will vary. The premiums will also vary by age, sex, medical history, etc.

   Beyond the traditional product, there may well be advantages to short-term and hybrid products for many individuals or households. Short-term products will generally cover the typical NF stay and significantly reduce the cost of LTCI. Hybrid products may allow an individual or household to build up a cash value to pass along to heirs in the event LTC is not needed during the policyholder's lifetime.

   Because of the cost alone, there are many households who, absent nearly complete subsidization, will not be able to afford LTCI – or they will determine that there are other more immediate funding priorities. For many of these households, Medicaid as the payer of last resort for LTC is an acceptable alternative. On the other end of the financial spectrum, there are also households with the ability to self- fund LTC, and incenting them to purchase LTCI is unnecessary, as they will be private payers should they require those services. Identifying the cohort in the middle of these extremes and determining how to incent them to at least consider LTCI is probably the wisest course of action for the state.

An example of an approach to consider would be for the Ohio Department of Insurance to incorporate hybrid insurance policies within their long-term care partnership program

5. **There are public benefits to LTCI beyond the possible reduction in Medicaid.**
While the report has noted the cost to the state from LTSS funded by Medicaid, an increase in Ohioans with LTCI would have other potential benefits as well. LTCI provides a level of financial stability and equanimity that has value, and it allows individuals and households to pass along earned wealth and assets to their heirs.

   LTCI also provides additional resources for LTC. Private pay daily rates exceed those that are paid by Medicaid. Private pay also will (should the policy provide for it) cover the costs of a private NH room; unless medically necessary, Medicaid does not cover the cost of a private room.

Findings Related to Existing Incentives for LTCI

6. **Existing incentives to purchase LTCI are tax incentives.**
The project team's research did not identify existing programs that provide a financial incentive other than tax benefits. While many tax incentives exist to induce or support activities (such as the deduction for home mortgage interest payments or childcare tax credits), in general, tax incentives tend to be less targeted than other types of incentive programs. Tax incentives may be unknown to taxpayers when making financial decisions, and they often 'incent' activity that would have occurred without the tax incentive (which touches on the incentive 'but for' question). In this respect, tax incentives are a costly way to incent new activity, since they generally also benefit those who have, in this case, already decided to purchase LTCI.

7. **Not all forms of LTCI will qualify for the incentives.**
LTCI that qualifies for a tax deduction is insurance that can be classified as a form of health insurance – which explains the federal requirement that the deduction can only be claimed when unreimbursed medical expenses exceed 7.5 percent. Hybrid LTCI policies provide, in part, health insurance coverage that may be deductible. On the other hand, the portion of the policy that provides a death benefit is not LTCI and is generally not deductible. If the incentive is an important consideration for the purchase of LTCI, that incentive will not exist for at least a portion of the hybrid policy premiums.

8. **The majority of the LTCI tax incentives are deductions that generally do not materially reduce the cost of LTCI.**
The federal government allows a deduction, with limitations on the amount of the deduction depending on the age of the taxpayer, for qualified LTCI. However, that deduction is only available for individuals who itemize deductions and only when medical expenses exceed 7.5 percent of taxable income (the 7.5 percent requirement does not apply to owners of pass-through entities), which is a high bar for many taxpayers. Given that federal personal income tax rates are significantly higher than those of the state of Ohio, this is a significantly larger benefit should a taxpayer meet the federal requirements.

   Among the states that provide a tax benefit, 22 allow some form of a deduction from taxable income for qualified LTCI, while 8 provide some type of a tax credit. Among the deduction states, several align with the federal requirements, while others (including Ohio) provide a deduction without the federal limits related to premiums based on age or medical expenses exceeds 7.5 percent of taxable income. Finally, there are other states with various limitations or exclusions.

   In the case for every state tax deduction for LTCI, it is unlikely that the size of the deduction will materially impact the decision to take out a LTCI policy, as the benefit relatively small in comparison to the cost. For the state of Ohio, an individual with income of $50,000, no dependents and no other deductions beyond the personal exemption and a LTCI policy with a $2,000 annual premium would receive a tax benefit of

approximately $65 a year from the state income tax deduction. It is highly unlikely that the $65 benefit would incent that person to purchase a policy with a $2,000 a year premium. In this case, the incentive provides little real value to the state of Ohio.

9. **LTCI state tax deductions for businesses that purchase coverage for their employees are less frequent, and the federal tax advantages are significant.**
   For most types of LTCI, a business may deduct the cost of the insurance as a business expense, which is particularly helpful for C-corporations, whose tax rate for TY 2022 is 21 percent. By contrast, the state corporate tax rates range from 2.5 percent to 11.5 percent. Only two states provide a corporate income tax deduction for LTCI premiums paid for employees. Neither of these states (Maryland and Arkansas) are among the leaders in LTCI state participation rates. It should also be noted that for pass through entities (sole proprietorships, LLCs, S-corporations) where owners income is included on personal income tax returns, there is an additional advantage, as the requirement that medical expenses exceed 7.5 percent to claim the LTCI deduction does not apply.

10. **State tax credits likely provide a greater incentive for the purchase of LTCI, but they are also more costly.**
    While a tax deduction reduces the income subject to tax, a tax credit directly reduces the income tax liability. Unless the deduction is very large and/or the credit is very small, in most cases a tax credit provides greater benefit to the taxpayer. That said, unless the credit is refundable, it may be the case that the taxpayer will not receive the full value of the credit.

    In practice, most of the states that provide a tax credit limit the amount of the credit, which varies from a low of $100 for individual filers or $200 for married couples filing jointly in Minnesota to $500 for individual filers in Maryland, Mississippi, and Oregon (although it is a one-time credit in Maryland). Two states, Colorado and New York, provide a credit of 25 percent and 20 percent respectively, although Colorado limits eligibility to those with income under $50,000 (individuals) or $100,000 (joint filers), which limits the liability for the credit, as it is not refundable. New York has the most liberal credit, with a $1,500 cap on the LTCI premium tax credit, with an income cap of $250,000 for tax years beginning in 2020.

    As the benchmarking demonstrated. New York had by far the highest average cost per resident from its tax credit, which aligns with the magnitude of its credit. At the same time, their LTCI per capita participation rate was in the middle of the benchmarked states. It is notable that two of the four states with the highest per capita LTCI participation rate are state with a tax credit. Given that only 8 of the 30 states with a tax incentive are tax credit states, this may be notable, but there are a variety of exogenous variables that cannot be controlled for in this high-level benchmarking analysis.

11. **In general, there is no obvious correlation among states with and without tax incentives for LTCI and participation rates.**
    When examining states' percentage of LTCI 'lives in force' there are states with incentives at both the high and low end of the scale. States without tax incentives tend to be found across the spectrum – of the 25 states included in the analysis, Illinois and Washington do not provide an incentive and ranked 7th and 11th in terms of participation. While the top 6 for participation all have some state tax incentive, the bottom 5 also have either a deduction or credit for LTCI.

Alternatives and Possible Impacts

As already discussed, there is little direct evidence that existing incentives, which are entirely tax incentives, have been effective in inducing individuals or households to purchase LTCI. Some of this likely relates to the disconnect on the need for coverage, because the existing national health insurance for those ages 65 and older, Medicare, does not generally cover LTSS but the general public largely thinks it does. If this is the case, even subsidizing a significant portion of the cost of LTCI may not create an incentive for the public to make

the purchase. If the public thinks LTC will essentially be a ‘free good’ any cost associated with LTCI may not be considered of value.

For this cohort, it is likely that continued public education campaigns will be necessary. It is notable that there have been organized campaigns by both the federal government and state governments (sometimes in concert), but it is not clear that these have effectively moved public opinion. The Ohio Department of Insurance has a helpful guide for LTCI on its website, so it is unclear what, exactly, a public information campaign would look like (and is outside the scope of this report).

Keeping in mind that caveat, the following are some alternate approaches and possible impacts:

12. **Shift the State LTCI deduction for insurance premiums to a tax credit.**
    As noted in finding 8, the current Ohio personal income tax deduction is limited. In the example provided (individual with a $50,000 income and a LTCI premium of $2,000), the existing tax benefit from the deduction is approximately $65. It is unlikely that this will incent an individual or household to purchase LTCI. As an alternative, were Ohio to shift to a tax credit in the middle range of those offered, $500, there would be a tangible difference in the tax implications for the individual with $50,000 of state taxable income. In that case, the full $500 could be claimed, which would be a 25 percent discount on the $2,000 average annual LTCI premium. While the extent of the impact on consumers cannot be quantified – and isn’t necessarily supported by the benchmarking data, it is highly likely that the number of qualified LTCI policies written in the state would increase.

    One of the advantages of initiating this type of substantial change is that it signals the importance of the issue for some in the general public. A significant tax break for LTCI that did not exist in prior years will likely motivate some people to take advantage of the ‘offer’ by the state. This is often referred to as 'the psychology of discounts’ and, with effective marketing, could be a useful mechanism for the state. This will come at a cost – in the hypothetical taxpayer case, Ohio’s cost for the taxpayer is nearly 8 times the current incentive.

    As was identified in the example of tax subsidization for all eligible to purchase LTCI, the costs to the state can quickly grow into the hundreds (or even thousands) of millions of dollars. While the project team assumes this will greatly increase participation (at least at the highly subsidized levels), it is really not feasible to suggest from a state budget perspective.

13. **Allow the use of certain non-taxed assets for the payment of LTCI premiums.**
    Some forms of individual retirement accounts (such as 401k individual retirement accounts) are not taxed for state and federal income tax purposes at the time of contributions but are taxed at distribution. An alternative would be to not tax or otherwise penalize distributions when used to pay for LTCI. In essence, this would be similar to a tax credit for the purchase of LTCI, but it would allow an individual or household to spend down accumulated assets to pay the premiums. To avoid getting both this benefit and the state income tax deduction, there would have to be a reduction in the deduction to match the tax advantage from not taxing the distribution. Ohio could only make this applicable to state income tax; there would still be the requirement to pay federal income taxes on the distribution.

14. **Create a non-tax incentive program for the new purchase of qualified LTCI.**
    As has been described, the use of the tax code to incent consumer behavior is problematic for a number of reasons. First, as described, it fails the ‘but for’ test, as the tax incentive is provided to individuals who already had made the decision to purchase LTCI. In that case, there is no additional benefit in return for the foregone revenue. Second, sending signals through the tax code is often not an effective medium. The general public often doesn’t understand the tax code and may not comprehend the value of tax law changes for their finances.

A more effective approach would be to provide an incentive through a tailored, targeted program that provides cash grants to individuals who purchase LTCI for the first time. The advantage of this approach is that it can be 'fine-tuned' to fit the specific goals of the state. As was noted in the discussion of smart incentives, the state needs to determine what, exactly, it wishes to accomplish with its program, as pure subsidization for the entire eligible population is not likely to be cost effective.

With that goal in mind, Ohio could establish a limited program, and allocate some fixed amount for individuals to purchase LTCI for the first time. There are certain parameters that should be established, including:

- *What is the eligible population?* A logical approach would be to target the program at individuals ages 55 and older. This is often considered something of the 'sweet spot' for coverage, where rates do not grow precipitously from other age cohorts but close enough to the age where LTCI might be used to be cost beneficial for the individual or household. There could also be income limits to reduce participation by those who could otherwise afford LTCI premiums.

- *What is the size of the subsidy?* Psychology of discounts research suggests that for purchases over $100, a 'dollar off' discount works better than a percentage discount. One discussion noted that for a $1,000 computer, a $200 discount was perceived more favorably than a 20 percent discount. An advantage of a 'dollar off' approach is that it also limits the tendency to 'over purchase' to get a larger cost reduction. Given the average price of LTCI, a discount of $250, with a $25 million grant fund, would have the potential to generate approximately 100,000 new policies (if totally subscribed). Given that current policies in Ohio with LTCI cover approximately 200,000 lives, that would be a significant increase.

  While it is not known whether that would be sufficient to 'move the needle' to purchasing LTCI, it would have several advantages over a tax incentive. First, it would only incent new purchasers, so there would be more confidence in answering the 'but for' question. Second, there could be data to support who was incented by the program. Finally, it could be more effectively marketed. It would be time limited, first-come-first served, with a waiting list should it be over-subscribed. This creates a situation where people are motivated to act.

- *How would it be administered?* There would have to be an application process, which would include verification from an insurance policy that a new qualified LTCI policy had been written. The individual would have to affirm that they had not previously had LTCI, and it would also require providing their age and family income. To reduce opportunities for fraud, it is recommended that payment be made either after the completion of 12 months of the LTCI or at least a payment after one month and a subsequent payment at the end of the 12-month period. There would have to be an appropriation made sufficient to establish and administer the program.

- *How long would it last?* This could be established as an ongoing program, with only new policies (and evidence of no lapsed policies) eligible from year to year. That could be a decision made after demonstration of the effects/efficacy of the program. It is probably better to initially establish it as a one-time program.

One of the concerns about this type of program is the additional general fund cost. One of the reasons that tax incentives are often established (rather than grants) is that there is no additional general fund spending – in fact, it reduces general fund tax collections. An alternative to address that would be to make it a more tailored tax reduction program.

15. **Create an insurance premium tax credit for new LTCI policies.**
    This approach could be structured similar to the prior one, the difference being that participating

insurance carriers would agree to reduce the LTCI premiums by a set amount in return for an insurance premium tax credit of the same amount. In this case, insurance carriers could carry forward the credit if they did not have tax liability. It would also be done on a 'first come, first served' basis.' Insurance carriers would receive the credit after payment of 12 months of the LTCI premiums.

This would require the cooperation of the insurance carriers, and it would create some administrative burden for them. On the other hand, the opportunity to have a significant reduction in premiums (and, based on elasticity of demand, the likelihood of additional new business) should be attractive.

One concern with this approach would be how to curtail consumers from ending an existing policy and taking out a new policy with another carrier. There are risks associated with that from the consumer's perspective, but it would be more difficult to enforce, as the incentive is not a 'contract' between the state and the policyholder.

There would likely be a significant advantage, as it would be expected that the insurance carriers would actively (and perhaps more effective than the state) market the program to those likely to purchase LTCI. That sort of 'public private partnership' has been effective in other areas and could be here as well.

Non-incentive Approach to Increase LTCI

16. **The Ohio Department of Insurance should advocate for the incorporation of hybrid insurance policies within their long-term care partnership program.**
Consumers have not always had a positive view of traditional long-term care insurance. Continuing premium increases have led consumers to either lapse such policies or not purchase them at all. The disconnect between the need for long-term care insurance and the cost of such coverage has led carriers and policymakers to look for alternatives that provide coverage that is not traditional in nature but provides some form of benefit payment be that upon death of the insured or payment for long-term care services should the insured qualify.

Hybrid policies that provide consumers with components of both life insurance (with a death benefit) and long-term care service payments are an alternative that should be incorporated into current state long-term care partnership program. While premium costs may be slightly higher, the consumer is provided protection for the premiums in the form of a death benefit should they never need to access long-term care services. Consumers would be given an opportunity to shield assets in the event of triggering long-term care service yet also provide for a death benefit payment to survivors.

At this time hybrid policies are not authorized as part of the Partnership Program. The Federal Deficit Reduction Act of 2006 only provides for traditional long-term care insurance products to be allowed under the Program. However, this is an opportunity to provide greater flexibility and options for consumers. Ohio could become a leading advocate for adding new products to the Partnership program through the structure of the National Association of Insurance Commissioners (NAIC). The Senior Issues Working Group of the NAIC could work in concert with federal regulators to seek opportunities to amend the program for the addition of new and creative policies for inclusion in the Partnership. The State of Ohio could also seek support of their U.S. congressional delegation membership to urge changes to the program to reflect new types of policy forms. Granted this would be a long-term project, but it would add an additional option for consumers in the future.

Appendices

Appendix A: Project Approach and Activities

Via a competitive RFP process, PFM was selected in June 2022 to conduct the study, which commenced in July 2022. The PFM team was complemented by two highly qualified subcontractors: Ellen Harpel, PhD, founder and president of Smart Incentives; and Susan Voss, JD, former State of Iowa Insurance Commissioner and President of the National Association of Insurance Commissioners (NAIC). The collective project team's approach to completing the study relied on a variety of methods in developing findings and recommendations and drafting the final report. Key project activities included:

- **Analysis of data and information.** The project team undertook a comprehensive review and analysis of information supplied by the state as a result of a preliminary information request. PFM also reviewed relevant state statutes and rules related to insurance, tax credits and incentives, and social services programs that may be impacted by changes.

- **Interviews with internal and external stakeholders and subject matter expert interviews.** PFM worked with the state project manager to identify key internal stakeholders and subject matter experts with knowledge of the programs and their administration, as well as external stakeholders. The project team then scheduled and conducted a series of interviews with those identified to further its knowledge of the programs and factors that may be unique to Ohio.[92]

- **Comprehensive benchmarking analysis.** PFM identified states that have some form of incentive (tax credit, tax deduction or otherwise) related to LTCI and analyzed whether offering such incentives is resulting in the desired result of increased use of LTCI. This provided useful information for determining similar effects for the state of Ohio.

- **Identification and analysis of incentive options.** PFM analyzed a variety of methods that may be used to incent the use of LTCI, including personal income tax credits, cash rebates or grants, and incentives for employers for covering all or some portion of the cost of LTCI for employees.

- **High-level findings.** Once all data was gathered and analyzed, interviews were completed and options were contemplated, the project team developed high-level findings to provide a frame of reference and discussion with the state. This served as an opportunity to dialogue about the data and findings and as needed, to develop a plan for conducting additional research or analysis – effectively serving as a roadmap for execution for the remainder of the project.

- **Draft and final reports.** In accordance with the timeline established in the state's RFP, PFM provided an initial report to the Department of Insurance in November 2022, and the following final report was transmitted to the Department in December 2022. As required by statute, the Departments of Insurance and Medicaid will issue a completed study to the General Assembly and the Governor no later than June 30, 2022.

Acknowledgments

The PFM project team wishes to thank the Ohio Department of Insurance, Department of Medicaid, Department of Taxation and the Department of Aging for their assistance with the report. Any errors or omissions within the report are entirely the responsibility of the project team.

[92] A comprehensive list of interviews conducted is provided in Appendix C.

Appendix B: Glossary of Terms and Acronyms

Financial and Government

AGI: Adjusted Gross Income

BEA: Bureau of Economic Analysis, U.S. Department of Commerce

CAGR: Compound Annual Growth Rate

CMS: Federal Centers for Medicare and Medicaid Services

COLA: Cost of Living Adjustment

CPI: Consumer Price Index

DRA05: Deficit Reduction Act of 2005

FLEC: Financial Literacy and Education Commission

FFY: Federal Fiscal Year

FY: Fiscal Year

GDP: Gross Domestic Product

IRS: Internal Revenue Service, U.S. Treasury

NAIC: National Association of Insurance Commissioners

OBM: Ohio Office of Budget and Management

ODI: Ohio Department of Insurance

ORC: Ohio Revised Code

RFP: Request for Proposals

TY: Tax Year

USC: United States Code

Industry

AARP: (Formerly) the American Association of Retired Persons

ADL: Activity of Daily Living

AALTCI: American Association for Long-Term Care Insurance

FFS: Fee for Service

FMAP: Federal Medical Assistance Percentage (for Medicaid)

HCBS: Home and Community-Based Services

HSR: Health Services Research Journal

HRS: Health and Retirement Study

IADL: Instrumental Activity of Daily Living

ICFs/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities

LTC: LTC

LTCI: LTCI

LTCP: LTC Partnership

LTSS: Long Term Services and Supports

MACPAC: Medicaid and CHIP Payment and Access Commission

MCO: Managed Care Organization

NIA: National Institute on Aging

OAA: Older Americans Act

SNAP: Supplemental Nutrition Assistance Program

SSA: Social Security Administration

TANF: Temporary Assistance for Needy Families

Appendix C: List of Stakeholder and Subject Matter Expert Interviews

- Ohio Department of Insurance
- Ohio Department of Aging
- Ohio Department of Taxation
- Ohio Department of Medicaid
- Ohio Long-Term Care Research Project at the Scripps Gerontology Center at Miami University of Ohio
- Ohio Jewish Communities
- Nationwide Insurance
- AARP