



The Lionfish in ACA Markets

By Greg Fann

There's nothing wrong with enjoying looking at the surface of the ocean itself, except that when you finally see what goes on underwater, you realize that you've been missing the whole point of the ocean.
—Dave Barry

I have done most of my scuba diving in the Caribbean Sea and the Florida Keys. I can't complain. The water is clear, the temperature is comfortable, and the fish are abundant. If you are not a diver, you can probably surmise that the experience is both highly visual and eerily quiet. If done with friends, it's 30 minutes of sharing excitement via spontaneous hand gestures.

A memorable moment of every dive is climbing back into the boat and sharing stories with dive mates and the boat crew. Barring any serious technical mishap, the first query is always "What kind of fish did you see?" It's a required gesture of hospitality, but it's rarely a serious inquiry. Most amateur divers have no skill identifying the hundreds of species feeding on coral reefs. Above the surface, the barefoot locals, whose "daily grind" is on a boat floating on crystal clear salt water, have a better idea of what's swimming underneath than the tourist divers below.

There is an exception to the rule. There is a fish that most divers never see, but they know what it is if they ever see it. You guessed it. It's the lionfish. Every diver in the region is educated about the dangers of lionfish in non-native waters. For frequent divers, it's a repeated lesson akin to oxygen mask deployment aboard an airplane. Divers know what to do if they see a lionfish. They have been told many times.

INVASIVE SPECIES

The lionfish is not inherently bad. It's a fish that behaves like a fish. It causes few problems in its native environment. It may even comfortably adjust to new environments as well. The problem is the havoc it causes when introduced to an ecosystem it should not be in.



It is what the scientific community calls an invasive species. An invasive species is environmentally problematic to the habitat and poses threats to the native species in the ecosystem. Invasive species refer to both plants and animals, and the problems they cause cannot be solved until they are understood and identified. Fortunately, invasive species and the associated damage are easily identifiable in the biological world. However, in the health insurance ecosystem, the paradoxical dynamics of the Affordable Care Act (ACA) may allow an invasive species to go undetected and abide in a market and be misconstrued as a helpful part of the ecosystem.

What would an invasive species look like in a specific health insurance market? It would operate remarkably similarly as it would in other markets, but by doing so would cause market damage in the specific market and endanger existing insurers. Simple competition itself may endanger existing insurers, but competition catalyzes price efficiency and improves markets for consumers. Invasive species don't improve markets; they make things worse for consumers and harm markets.

Isn't competition good for markets? How can a lionfish-style insurer make things worse for health insurance consumers? Follow along as we dive below the surface and explore the subsidy and price dynamics in the ACA individual markets.

ACA MARKET CHALLENGES

Enrollment in ACA markets has been less than originally anticipated and the national uninsured rate still hovers around 10 percent. Unsurprisingly, high cost is frequently mentioned as a reason why more people don't procure health insurance. As the ACA has struggled, proposed solutions have often



focused on reducing costs or providing lower cost options in markets. Proposed adjustments have taken several forms, from reinsurance to care management to narrow networks and lower cost providers. Due to the mechanical dynamics, straight cost reductions do little to improve markets and stakeholders are now [seeking changes](#) in subsidy formulas rather than cost reductions.

A problem in ACA markets across the country is akin to the impact of invasive species. The lionfish in ACA markets is an insurer with a cost structure well below traditional insurers and incumbent health plans. Sometimes, its efficient cost structure is achieved by less favorable dynamics such as a network of fewer providers or perceived as lower quality. In fact, the lionfish insurer may require such a price advantage to compete with higher cost insurers thought to be more attractive and have stronger networks.

The problem arises because the lower-cost insurer doesn't really provide lower costs for many consumers. It only increases the costs to purchase insurance from other carriers, and it may also increase consumer costs for its own plan. A highly appropriate question at this juncture would be, "What you talkin' about Willis?" This logic doesn't make any sense. How do lower costs lead to higher prices? A numerical illustration is useful to understand the dynamics.

SUBSIDY DYNAMICS

Premium subsidies are the [lifeblood](#) of ACA markets. There is a lot of chatter about mandates, outreach and consumer protections, but the ACA would not survive without premium subsidies. A proper understanding of how the subsidies work is imperative to understand the success and challenges in ACA markets. A demonstration of the effect of a low-cost insurer entering a market will illustrate the impact.

Starting with a simple example of one existing health plan (we'll call it Littlefish Health), sample gross premiums are provided in Figure 1.

Figure 1
Gross Premiums

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	600	850	800	900
Littlefish Health HMO	540	765	720	810

Most market enrollees are subsidized. Assuming a net contribution of \$200 for a given income level, Figure 2 displays the net premiums after adjusting for premium subsidies of \$650 (\$850 minus \$200, more detail on calculations [here](#)). Net premiums equal the maximum of \$0 and the gross premiums minus \$650.

Figure 2
Net Premiums

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	0	200	150	250
Littlefish Health HMO	0	115	70	160

Littlefish Health and its consumers are doing fine. Bronze plans are available for free and low cost-sharing Gold plans are available at a [lower price](#) than Silver plans. Watch what happens when an invasive plan (we'll call it Lionfish Health) arrives in the market. Lionfish Health brings a more efficient cost structure to the market. It is of no consequence whether the efficiency is related to care management, lower administration costs, or more aggressive provider reimbursement rates. The market

impact is the same simply because the price is lower. In our example, we assume Lionfish Health has 30 percent lower cost than Littlefish Health. Figure 3 illustrates the gross premium comparisons.

Figure 3
Gross Premiums With Lionfish

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	600	850	800	900
Littlefish Health HMO	540	765	720	810
Lionfish Health PPO	420	595	560	630
Lionfish Health HMO	378	536	504	567

Littlefish Health’s gross premiums are unchanged. Their unsubsidized consumers, the shrinking minority of the market, have the option of selecting a lower cost plan or sticking with their current plan option.

What about the majority of individual market enrollees, the lower income subsidized population? Lionfish’s entry into the market disrupts the subsidy calculation by offering the new benchmark plan. The \$200 maximum premium contribution is now calibrated to the Lionfish PPO Silver premium of \$595 rather than the Littlefish PPO premium of \$850. That reduces the premium subsidy available by \$255 from \$650 to \$395. Figure 4 shows the new resulting net premiums with Lionfish in the market.

Figure 4
Net Premiums With Lionfish

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	205	455	405	505
Littlefish Health HMO	145	370	325	415
Lionfish Health PPO	25	200	165	235
Lionfish Health HMO	0	141	109	172

Figure 5 shows the net premium change due to Lionfish’s market entry. As expected, the Littlefish net premiums are significantly higher. It is less intuitive that most of the plans offered by Lionfish Health are more expensive than the plans offered by Littlefish Health before the presence of Lionfish. In a sense, the environment

is less welcoming for the invasive species. These results are driven by leveraging of premium subsidy dynamics. As benchmark premiums levels change and premiums for other benefit levels change proportionally, the difference between the two narrows.

Consumers enrolled in plans with prices below the benchmark benefit from higher costs. Historically, this was intuitively all Bronze plans and the lowest cost Silver plan. Beginning in 2018, the defunding of Cost Sharing Reduction payments necessitated an increase in Silver plan premiums. The result of this dynamic is Silver plans being priced higher than Gold plans, but the market is in transition and current pricing relationships vary across the country. In our example, you can see that the price of the lowest cost plans increased except for the high-priced Platinum PPO.

An illuminating insight here is that the majority of individual consumers are subsidized in all states and very few of them are enrolled in Platinum plans. It is conceivable that the majority of current ACA enrollees would benefit from price increases and would be harmed by price reductions. It’s incredibly non-intuitive, but it’s the reality of ACA math.

Figure 5
Net Premium Change due to Lionfish

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	205	255	255	255
Littlefish Health HMO	145	255	255	255
Lowest Cost PPO	25	0	15	-15
Lowest Cost HMO	0	26	39	12

Let’s push the numbers a little more and see what happens. In response to the new competition, Littlefish becomes more aggressive and reduces premiums by 10 percent. Figure 6 shows the resulting gross premiums.

Figure 6
Gross Premiums With 10 Percent Price Reduction

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	540	765	720	810
Littlefish Health HMO	486	689	648	729
Lionfish Health PPO	420	595	560	630
Lionfish Health HMO	378	536	504	567

As the benchmark plan rates haven’t changed, the subsidy remains the same and the net premiums for Littlefish are lower

than they were before the price reduction. However, even after a 10 percent price reduction, the Littlefish net premiums are still much higher than they were before Lionfish entered the market. The results are shown in Figure 7.

Figure 7
Net Premiums With 10 Percent Price Reduction

	Bronze	Silver	Gold	Platinum
Littlefish Health PPO	145	370	325	415
Littlefish Health HMO	91	294	253	334
Lionfish Health PPO	25	200	165	235
Lionfish Health HMO	0	141	109	172

The dynamics of a lower cost plan entering the market and causing disruption is not theoretical. It has been the [cause for alarm](#) warning of “serious financial risk.” It is worth noting that all is not lost when a lower cost insurer enters a market. First, taxpayers save money as premium subsidies are calibrated on a lower cost plan. In aggregate in 2019 and 2020, taxpayers received a direct benefit from premium [reductions](#) or new insurers with lower cost structures entering markets. Second, while subsidized consumers are generally harmed by lower market premiums associated with lower health care costs, they benefit from lower cost-sharing if they switch to plans with lower provider reimbursements. Third, unsubsidized consumers obviously benefit from lower premiums. However, these “good news” items do not detract from the reality that cost reductions in ACA markets are really hurting those they are often [intended](#) to help.

MEANINGFUL SOLUTIONS

In a recent Congressional hearing related to ACA market challenges, a committee chair said, “The first step in reducing health insurance costs is to reduce the cost of health care.” Nobody gasped. Nobody acknowledged a profound insight. Nobody asked him to repeat the comment or wrote it down. The relationship of health insurance premiums to health care costs is naturally logical. It’s also something the committee members have heard him say many times before. But it’s not accurate. At least not for subsidized consumers in ACA markets. Reducing the cost of care doesn’t help them. It often makes things worse.

If reducing premium costs isn’t the solution, what can states do to improve ACA markets? What if I told you that the Littlefish

Health HMO gold plan that went from \$70 to \$243 courtesy of Lionfish Health was actually [free](#) in Oklahoma? It is, in 12 different counties. The circumstances in Oklahoma are a bit unusual, but states can benefit consumers (and insurers) by requiring stricter [compliance](#) with ACA rules. Opportunities abound as “a nationwide scan of premium rates reveals variances outside the bounds of effective Rate Review.” States interested in assessing their markets can determine the overall efficiency of market rates through a quantitative market optimization model.

CONCLUSION

ACA individual markets provide the last resort for Americans to procure major medical insurance. High premiums have been a deterrent to robust enrollment in ACA markets. Enrollment is skewed due to the ACA rating rules and premium subsidy dynamics. These dynamics changed with the defunding of Cost-Sharing Reimbursement payments in 2018, but many stakeholders do not fully understand the dynamics, and relative prices in many state markets are inefficient and deviate from strict interpretation of ACA guidance.

Despite the [alarmism](#) surrounding regulatory changes, ACA markets are [stronger](#) than ever and primed to be even stronger. Unfortunately, traditional cost-saving efforts offer little promise. Serious improvements in ACA markets can be achieved via a twofold strategy. First, states can optimize their markets by assuring appropriate pricing. Second, Section 1332 [waivers](#) can be utilized to [broaden](#) the allocation of enhanced subsidies to a larger consumer base. If a state has a cost saving proposal, it should be considered as part of a Section 1332 waiver. Otherwise, cost reductions only result in lower federal subsidies and higher net premiums.

The seas are now calm, so dive in and explore the underwater world of ACA dynamics. The water is deep, but it’s necessary that stakeholders responsible for decisions related to ACA markets suit up and take the plunge. While the surface may look no different than other markets, strong fins and a clear mask will reveal a different world 100 feet below. I’m usually down there and easy to find. Give me a wave or a thumbs up and let’s enjoy the beautiful opportunities now available in ACA individual markets. Just leave your pre-conceived notions of gross premium impacts (and the lionfish) in the boat. ■



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Medi(long-term)care for All: A Look Into the Future of Long-Term Care Insurance—Part One

By Stephanie Moench and Shawn Stender

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With the introduction of the Patient Protection and Affordable Care Act (ACA) in 2010, the health care industry, in particular major medical insurance, was thrust into the spotlight of national media and political campaigns. The key issue—how to make health insurance coverage available to the people who need it most. Recently, the long-term care (LTC) insurance industry has been gaining similar attention. Several recent political candidates have mentioned affordable LTC services, along with social LTC programs like Medicare for All, in their campaigns. At least one state-level government, Washington, has developed and adopted a social program that targets the need for LTC insurance.¹ Additionally, several other states have taken developmental steps to address LTC needs through similar programs or by other means (e.g., Medicaid expansion). As the topic of affordable LTC insurance comes into focus in political conversations, we often find ourselves thinking, “What is going to happen to the private LTC insurance industry going forward?”

The need for LTC services has been fairly well documented since the inception of the private LTC insurance industry in the 1980s. The U.S. Department of Health and Human Services launched an LTC-focused social marketing campaign in 2005 known as Own Your Future.² This campaign was aimed at encouraging people to actively plan for their LTC needs. In 2010, the national nonprofit campaign 3in4 Need More was started with a similar goal of raising awareness around the importance of planning for future LTC needs. These programs



highlighted the fact that around 70 percent of people age 65 or older will require LTC services at some point in their lives. However, many Americans still rely solely on the coverage from existing social programs (i.e., Medicare and Medicaid) and/or self-funding to cover LTC services. Based on estimates from 2014, only 11 percent of adults ages 65 and older living in non-facility care settings were covered by private LTC insurance.³ It is estimated that 50 million people will be 65 or older by 2020, and almost 50 percent of them are expected to use formal, paid LTC support and services during their lifetime.⁴

Beyond awareness, another potential complication in addressing the LTC need in the United States is that the number of insurance companies offering traditional (stand-alone) LTC coverage has decreased since the product was first introduced. A survey conducted in 2000 by America's Health Insurance Plans (AHIP) showed that there were 125 insurers selling stand-alone LTC policies.⁵ While the AHIP survey has not been repeated since 2002, Broker World estimates that there are fewer than 15 companies selling stand-alone LTC policies as of July 2019.⁶

In an effort to tackle some of the concerns regarding the growing need for LTC services, the ACA originally included coverage for LTC benefits in the form of the Community Living Assistance Services and Supports (CLASS) Act. This component of the ACA would have created a federally administered insurance program to help individuals pay for home care services. However, after the ACA was introduced, the CLASS Act was eliminated due to difficulties in finding a financially viable solution to its implementation.⁷

The need for LTC is not going away, especially as the population continues to age. With this in mind, this article explores three possible future paths for LTC insurance funding and the

associated implications for the private LTC industry. The scenarios outlined below are not intended to be a political stance but merely provide considerations for the future of LTC given the recent spotlight (political and otherwise) on the industry. All considerations regarding the future evolution of the LTC industry are speculative, and actual events may unfold materially differently under any given future path.

SCENARIO 1: STATUS QUO

One possible future path for the LTC industry is that there are no substantial changes in how LTC services are funded. That is, LTC benefits for those not eligible for Medicaid or Medicare continue to be primarily self-funded or covered via private insurance. While we assume that no federal social insurance programs are introduced to cover LTC services in this scenario, additional jurisdictions may implement their own social LTC programs, similar to what was enacted by Washington state in May 2019.⁸

Assuming no unforeseen or material changes in the environment, the “status quo” may still mean considerable evolution for the LTC industry, as has been the case in recent years. It is possible that in this future scenario, the number of carriers selling private LTC insurance will continue to shrink or new sales of stand-alone LTC may cease completely. There may also be additional reserve strengthening as companies continue to work to stabilize their in-force business. LTC carriers have generally taken steps to reduce the riskiness of their LTC business, and this is likely to be the case going forward. With this in mind, we anticipate the following trends under this scenario:

- The market for combination and hybrid LTC products (i.e., LTC insurance combined with an annuity or life insurance) will continue to expand as an alternative to stand-alone LTC insurance.
- New LTC product designs may be introduced as a more affordable alternative to stand-alone or combination LTC products. For example, more LTC carriers may explore the use of copays and deductibles as a potential cost-sharing option to make LTC insurance more affordable by having consumers share more in the risk.
- The number of policy features available may be further reduced to eliminate those features that present additional risk to insurers due to policyholder behavior (e.g., long benefit periods, short elimination periods and limited payment terms).
- Carriers will likely continue to pursue premium rate increases on closed blocks of LTC business as a risk mitigation strategy. However, the premium rate increases pursued on more recently priced LTC products will likely be limited as original pricing assumptions generally reflect more conservatism compared to earlier LTC products.
- Predictive analytics may also be used to facilitate preventive care and more efficient care management as a risk mit-

igation strategy in lieu of, or in addition to, premium rate increases. Additionally, carriers may pursue landing spots, buyouts, or mergers and acquisitions as a means of offsetting LTC losses and mitigating future risk.

- New LTC services may be introduced to accommodate growing demand and capitalize on technological advances, such as the introduction of a mobile application to schedule home health care services. We note that this evolution of the industry is likely for each scenario outlined in this paper; however, services and products offered may depend on the specific future path.

As the LTC industry continues to mature, the amount of credible LTC-specific experience (company and industry) will also grow. As a result, the assumptions used in pricing stand-alone LTC insurance and LTC combination products should become more reliable. As insurers recognize the reduction in uncertainty, it is possible that the number of companies offering new LTC products may increase.

SCENARIO 2: MEDICARE FOR ALL/ SINGLE-PAYER SYSTEM

A second possible future path for the LTC industry could involve the adoption of a federal social insurance program that provides materially complete LTC coverage, similar to the programs introduced in countries like Denmark and France.⁹ This potential future represents the alternative “endpoint” to the status quo scenario. In this scenario, it is assumed that the United States implements a social LTC program under which all citizens are automatically eligible for some sort of LTC coverage. Similar to the programs implemented in countries like Denmark, this system would not publicly fund all LTC services. Rather, it would attempt to completely cover a material subset of services (e.g., home and community care), though certain services would likely require a copay or even remain completely privatized.

A key hurdle to this future path coming to fruition is the level of funding that would be needed for the social program. As noted above, the CLASS Act was removed from the ACA after it was determined to not be financially viable. It is unclear whether a reasonable and sustainable funding methodology could be developed to make this endpoint possible. If such a program were implemented, it is likely that funding would need to come from a variety of sources, such as a mix of taxes (e.g., increased sales and income taxes) and/or the redirection of government funds. Beyond funding, a plethora of other considerations and questions would need to be addressed before such a program could be implemented in the United States. They include, but are not limited to:

- Program features
- Treatment of in-force LTC insurance business and reserves



- Transition approach for policyholders currently receiving private LTC benefits
- Reimbursement for policyholders with private LTC insurance

These issues are challenging but interesting; however, addressing them is not the focus of this article. Rather, this article considers how insurance companies with large amounts of in-force LTC business might be impacted by the implementation of an involuntary, comprehensive social program that covers a material portion of individuals' LTC benefits. For example, the following provides possible considerations for the LTC industry if the government enacts a social program with comprehensive LTC coverage:

- LTC insurers could be expected to assist in the transition of current insureds to the social program, to the extent logical. This may involve transferring on-claim policyholders to publicly funded care settings, which could be a significant administrative task. Alternatively, the social program may not accept insureds currently receiving privatized benefits, such that insurers would continue to be liable for LTC services incurred by existing claimants.
- Requiring private insurers to release existing LTC reserves (even if the release was staggered over time) could be a substantial effort and a potential financial (and economic) burden, depending on the particular investment portfolio of the company. Instead, the government might have companies cede a portion of their current LTC reserves into a trust that could be used to fund the social program. In the event that a company's existing reserves are anticipated to be too low relative to future experience, this approach may actually let companies "off the hook" for a large portion of anticipated future benefits.
- As the majority of existing insureds may deem private LTC insurance no longer necessary, another possibility, likely preferred by policyholders, is that existing reserves would be used to "pay back" insureds for their private insurance premiums (less any benefits paid, of course). This approach would be similar to a return of premium provision.

- The LTC insurance market would likely evolve to meet any needs not covered by the social program (e.g., "bells and whistles" coverages) and to address any copay or "private" care stipulations associated with the social LTC program. This would create small niche markets for (1) supplemental LTC benefits and (2) richer, private care policies. Because supplemental benefits would likely be low risk (but also low demand), only a small handful of existing LTC insurers may capitalize on this emerging market. This is the case in Denmark and France, where costs and services not fully covered by the government can be insured via supplemental products sold in the private sector.¹⁰ Similarly, private care policies, which would likely have a design similar to stand-alone LTC insurance, may be offered by only select carriers (e.g., those currently marketing to the most affluent insureds).

While this scenario presents a very different approach to addressing the LTC need from the status quo, it may not be out of the realm of possibility. The magnitude of LTC services that are anticipated to be needed by the baby boomer generation alone presents a unique challenge, which may require a creative solution beyond that currently offered by private insurance.

SCENARIO 3: SOMEWHERE IN BETWEEN

A third possible future path would fall somewhere between scenarios 1 and 2. The United States may not be prepared to transition to a "complete" social LTC program; however, the rising LTC needs of the baby boomers could be the catalyst for a change in how LTC services are funded. It is possible that an involuntary, partial social program could be established to provide LTC coverage. The intent of this program would be to materially fund LTC benefits for a large percentage of people who need services, but these social benefits would not be enough for all people.

It is worth noting there are existing federal programs that cover LTC services. For example, Medicaid provides coverage for a large portion of the LTC services in the United States; however, to qualify for this program, an individual must spend down his or her excess assets to a specified limit, which may vary by state. A key distinction between the existing federal programs and the program envisioned in this "somewhere in between" scenario is that the social program described in this scenario would be available to all citizens regardless of financial need.

Because the LTC benefits covered by the social program in this future path would not be "complete" (unlike the program described in scenario 2), there may be considerable market opportunities for LTC insurers, such as:

- The LTC market could evolve to offer supplemental policies that provide additional LTC benefits after those covered by the social LTC program are exhausted. The product design may generally be similar to that of existing stand-alone LTC insurance, except that the benefit options

marketed would be more limited (i.e., emphasis on sales of one-year to three-year benefit periods). It is possible that insurers would also offer these supplemental plans to existing LTC policyholders as a new “reduced benefit” option not available at original issue. These products may also offer longer elimination periods (e.g., two years) as well as limited or single premium payment terms to recognize that policyholders may utilize their social benefits first. These products would be lower risk than stand-alone LTC insurance due to the lower benefit level and there would likely be a high demand. As such, it is possible that several companies would enter the market to capitalize on this opportunity.

- New LTC products intended to provide “wraparound” coverage could also be introduced. These products may look materially different from the LTC products sold today in terms of both the amount of benefits covered and risk profile. For example, companies may develop a “dementia risk” product similar in concept to certain critical illness products currently available in the market. This product would only cover costs for dementia-related claims that would otherwise quickly exhaust an individuals’ social insurance benefits.
- Given the lower anticipated risk, both the supplemental and wraparound policies may be designed as “guaranteed” premium (non-cancellable) products to attract more insureds to this market.
- Combination products would likely continue to be sold as a cost-effective option with life and annuity policies. However, the LTC benefits on combination products would likely be offered in smaller increments in light of the social LTC coverage. Awareness regarding LTC needs would likely be heightened following the implementation of the social LTC program, and it is possible that new varieties of LTC combination products may emerge (e.g., LTC riders sold with health insurance or property and casualty insurance).

We expect that in-force LTC insurance blocks would be materially impacted by the introduction of a partial social LTC program, as envisioned in this scenario, due to existing policyholders changing their coverage in light of the involuntary social benefit. Generally, a company’s aggregate risk is reduced when LTC insureds elect to lapse their policies or reduce benefits beyond what would have been anticipated in original pricing, but would this still be the case if a social program was the catalyst for the policyholder behavior? This question, along with several others, will be explored in a follow-up article. Part Two will provide a case study that examines the potential financial impact on private LTC insurers if a partial social LTC program were to be established.

CONCLUSION

This article explored three possible future paths for the LTC industry, but there are undoubtedly numerous possibilities. While a number of unknowns, including funding, would need to

be addressed by regulators and actuaries before any social LTC program could be established, it is clear that the need for LTC is not going away any time soon. Regardless of the future scenario that unfolds, the LTC industry will continue to evolve to meet this need.

Please stay tuned for Part Two of “Medi(long-term)care for All: A Look Into the Future of Long-Term Care Insurance.” ■

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ENDNOTES

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