Status of Long-Term Care Financing Products in Minnesota

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HUMPHREY SCHOOL
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Table of Contents

Executive Summary

Minnesota expenditures for long-term care (LTC) services through the Medical Assistance (MA) program are unsustainable. In 2010, Minnesota spent approximately $1.281 billion annually on LTC through MA.[1] The influx of baby-boomers needing LTC in the near future will only add to this growing budget. As part of a response to this problem, Minnesota is undertaking a public awareness campaign called Own Your Future (OYF).

This report provides an update to the Minnesota Department of Human Services' 2005 report to the Legislature, "Financing Long-Term Care for Minnesota's Baby Boomers." It also offers a springboard for discussion, analysis, and decision-making within the OYF leadership team as the team seeks to address the problem of financing LTC.

Product Analysis

The products reviewed in this report are divided into three categories:

1. Private insurance: Includes long-term care insurance, the Partnership for Long-Term Care, life insurance with long-term care, and long-term care annuities;
2. Savings and borrowing: Includes health savings accounts and reverse mortgages; and
3. Public insurance: Includes the 2010 federal CLASS Act and the Hawaii CarePlus Program.

Each product is evaluated using the following criteria: cost to the consumer, level of coverage, flexibility, eligibility, and consumer protection. This research drew on a variety of sources including academic and scholarly publications, government reports and documents, industry data, interviews with industry experts, and meetings with state government staff.

Recommendations

Each product is unique and provides certain benefits. However, this analysis uncovered several themes to all the products analyzed in this report. All of the products exhibit some degree of complexity, most of the products have wide variation in payment structure and/or benefits, and most are heavily impacted by an individual's age and health status.

These themes inform the following recommendations for the OYF campaign:

1. Expand access to and transparency of product information for consumers.
2. Provide or facilitate access to individuals or organizations that can assist the OYF target population in understanding and choosing products that suit their needs.
3. Consider products that have multiple benefits.
4. Consider individual motivations for purchasing LTC.
5. Continue to encourage cross-agency collaboration.

Introduction

Medicaid is a funding partnership between the federal and state governments. The purpose of the Medicaid program is to provide health care coverage for low-income individuals who otherwise would not be able to afford care. In Minnesota, the Medicaid program is known as Medical Assistance, or MA. The cost split between the federal government and the state government of Minnesota is typically around 50-50, however in 2009, the federal government picked up a larger share of the programs cost changing this ratio to 60-40.[2] The program is the state's largest publicly funded health care provider and offers coverage for over 600,000 low-income individuals every month.[3]

In 2009, all MA spending for Minnesota totaled roughly $7.4 billion, but over 40 percent of spending, approximately $3 billion, went toward coverage for Minnesotans receiving LTC.[4] There are a number of types of LTC services available to those needing care such as hospitals, mental health facilities, nursing homes, assisted living facilities, and in-home care. In Minnesota, MA expenditures for LTC were heavily weighted toward home health care (nearly $2 billion or 65 percent of all spending) and nursing home care ($852 million or 28 percent of all spending).[5]

These spending levels below reflect the market costs of LTC in Minnesota. Although costs vary depending on where care is received – metro area vs. rural – the average individual can quickly incur tens of thousands of dollars worth of care even if he or she does not reside in a nursing home:[6]

Minnesota	Average Daily Nursing Home Rate: Private	Average Daily Nursing Home Rate: Semi-Private	Average Monthly Cost in Assisted Living Facility	Average Hourly Rate Home Health Aide	Average Hourly Rate Homemaker Services	Average Adult Day Services Daily Rate
Minneapolis/ St Paul	$180	$146	$3,063	$25	$21	$71
Rochester Area	$140	$124	$2,909	$30	$25	$54
Rest of State	$150	$131	$2,829	$29	$21	$67
State Average	$154	$134	$2,961	$28	$22	$66

Problems with Current Financing Structure

The most significant problem with Minnesota's current MA spending for LTC is its unsustainable growth. The state's share of MA spending was nearly $2.8 billion for FY 2010, and 46 percent of that spending was directed toward various types of LTC services.[7] Additionally, with LTC costs growing at a rate of 4.7 percent to 6.6 percent per year,[8] we can

only expect that MA spending will continue to take up a greater share of the state of Minnesota's budget.

Compounding the problem is the coming influx of baby-boomers who will need LTC. According to the 2010 Census, Minnesota's population 65 years and older was 689,487.[9] In 2010, the Minnesota State Demographer's Office estimated in 2035, approximately 1.4 million individuals in Minnesota will be age 65 or older.[10] This increase is particularly concerning as 70 percent of people over 65 will utilize some form of LTC.[11] (See Appendix I, page 39).

Unfortunately, many aging Minnesotans do not have the resources to pay for their own LTC needs. Up to 30 percent of baby boomers in Minnesota report that they have insufficient resources as they head into their retirement years.[12] This funding gap means that baby boomers may not be able to afford to pay for nursing home, assisted living, or in-home care. Instead, they would need to rely on either help from family members or publicly-funded care, like MA, as they spend down their assets.

The "spending down" of assets leads to the problem of perverse incentives. When the family members of elderly Minnesotans either cannot or are not willing to provide care for their loved ones, individuals are left with no other option than to pay out of pocket for LTC. In this scenario, elderly individuals needing LTC spend down assets to the MA eligibility limit of $3,000 – essentially living in poverty – in order for the state to pay for the cost of necessary LTC services through MA.

The financial implications of this scenario are bleak. Currently, many baby boomers provide caregiving services informally for their own parents or other family members, the value of which is estimated to be about $8.2 billion annually in Minnesota, a significant cost savings to the state.[13] As today's baby boomers age and eventually need LTC services, it is likely that a greater percentage of them will not receive informal care, as there are more boomers requiring care than the available supply of informal caregivers.[14] Instead, they will rely more heavily on professionals to provide their care, which may result in increased MA spending overtime. .

Minnesota's Response: The Own Your Future Campaign

The State of Minnesota, through the Department of Human Services, is responding to the anticipated increased demands on its MA funding system through the Own Your Future (OYF) campaign, which launched in March 2012. The centerpiece of the campaign is personal responsibility as it urges Minnesotans to develop a financing plan for their LTC needs. In order to accomplish this, the campaign takes a threefold approach. First, it seeks to raise awareness about the need for LTC planning. Second, it will identify LTC financing products that are accessible for middle-income individuals before they begin to need LTC services. And third, the state will collaborate with the federal government to change MA's LTC provisions to encourage private payment for LTC[15].

The campaign will target the "tweener" population. Tweeners are defined as individuals between the ages of 40 and 65 who are middle income. In 2010, the median household income in Minnesota was $57,243.[16] The tweener population is well-positioned to both plan for and finance their potential future LTC needs. They are part of an age group that generally does not anticipate

using LTC services in the immediate future, they may have assets they are interested in protecting, and their level of current income and assets may mean that LTC financing products are affordable.

This report fits into the second phase of the campaign: identifying and developing LTC financing products. This report provides an update to the Minnesota Department of Human Services' 2005 report to the Legislature, "Financing Long-Term Care for Minnesota's Baby Boomers." The Minnesota Department of Human Services selected the eight financing products analyzed in this report. These products were identified by the OYF campaign as products the leadership team was interested in considering in the product development phase of OYF. This report also offers a springboard for discussion, analysis, and decision-making within the OYF leadership team as the team seeks to address the problem of financing LTC.

The eight financing products are divided into three categories:

Private Insurance
1. Long-term Care Insurance
2. Partnership for Long-Term Care
3. Life Insurance with Long-Term Care
4. Long-Term Care Annuities

Savings or Borrowing
5. Health Savings Accounts
6. Reverse Mortgages

Public Insurance
7. CLASS Act
8. Hawaii CarePlus

A number of these private financing products already exist to help individuals pay for LTC. The two public options have been explored at the federal and state levels, but neither was fully implemented. All eight LTC financing products are described in greater detail and analyzed using five evaluative criteria.

Methodology

The criteria used to evaluate each of the LTC financing products are: cost to the consumer, level of coverage, flexibility, eligibility, and consumer protection. The criteria selected are similar to the 2005 report, but provide further description than the previous report. The goal in looking at each product with a common set of criteria is to make it easier to compare the advantages and disadvantages of each product.

The cost to consumer criterion includes premiums, loads, fees, and other costs the consumer faces at the time of purchase and throughout the life of the product. Cost matters because tweeners fall somewhere above low income and below high income. The cost of the product may affect the ability of the tweener group to afford it.

The level of coverage criterion explains inflation protection and the average benefit one would receive from the product. The level of coverage is important because it measures if the product will be enough to cover LTC costs. It is difficult to capture level of coverage for each product because within each there could be several options for consumers. Due to this problem, ranges are given when the average could be misleading.

The flexibility criterion describes the types of care covered, level of portability, and potential use for non-LTC needs of each product. The types of care covered are important because of Minnesota's focus on self-directed services and the availability of options for care outside of the traditional nursing home. Portability is the ability to retain the product if an individual changes jobs or moves to another location. Finally, the ability to use the product for non-LTC needs is important for some individuals because not everyone will need to use LTC benefits.

The eligibility criterion explains who is eligible for the product based on age, health status, income, etc. Eligibility is important because the target age group for OYF is 40 to 65 years of age. Some products require an individual to be a certain age and some are less expensive to purchase when younger because health status is better.

The consumer protection criterion describes the complexity to the consumer, potential for fraud and abuse, market stability, and measures in place to protect consumers for each product. Consumer protection is important because all of the financing products highlighted in this report are complex, so it's possible for a person to buy the wrong product if he or she does not understand it well.

This research drew on a variety of sources, including academic publications, government documents, industry data, and expert interviews. One limitation of the research was gaining access to accurate and reliable data for all of the products. It was difficult because many of these products are sold in the private market and information available varied based on how they are regulated.

Overview of Product

Long-term care insurance (LTCI) is private insurance that is purchased to cover future LTC.[17] If care is needed, the insurance company pays benefits as specified in the policy.[18] LTC includes home and institutional care in a nursing home or assisted living facility.[19] LTCI policies cover either an individual or two people, if purchased as a joint policy for a married couple. Group policies also exist and are usually offered through an employer, where an insurance company will offer voluntary private LTCI to a group of employees.

Private LTCI policies are available to purchase in Minnesota. There are currently 22 licensed companies actively selling new LTCI policies in Minnesota.[20] In 2004, there were 67 licensed companies selling LTCI in Minnesota.[21] Although the LTCI market in Minnesota is contracting, many companies with a large portion of the total LTCI continue to sell in the state. Many companies have left the market due to lack of sufficient profits and others have consolidated.[22] At the end of 2010, an estimated 199,397 Minnesotans were insured by a LTCI policy.[23] At the end of 2008, this number was 194,208.[24] Minnesota ranks 12th highest in the number of individuals with LTCI.[25]

LTCI products are marketed as individual or group policies and are either offered by an employer or purchased in the private market. Most employers do not buy LTCI for their employees, instead offering LTCI as a policy their employees may elect to participate in.[26] Either the employee must pay the entire LTCI premium, or the employer will subsidize a policy by either contributing to the premium or offering a base level plan allowing the employee to purchase more comprehensive coverage. In either case, because individuals must usually self-select to purchase LTCI through an employer, there is potential for the risk pool to be skewed by more people who are at a higher risk for needing LTC benefits, leading to adverse selection.

It is estimated that approximately 7 percent of eligible individuals hold a LTCI policy in the United States. In Minnesota the penetration rate is estimated to be 9 percent for individuals over 45 years of age.[27] This suggests there is potential for greater market penetration in Minnesota. One possible explanation for the generally low take-up rates is that MA may "crowd out" demand for private insurance.[28] LTCI provides a benefit that would otherwise be partially covered by MA.[29] In this way, MA is an "imperfect but free substitute" for LTCI.[30] "Private insurance premiums must in part pay for benefits that are redundant of MA," something sometimes referred to as an "implicit tax." Although one advantage of LTCI is asset protection, the MA "crowd out" can perversely incent individuals who could otherwise afford to purchase a LTCI policy to spend down or hide their assets in order to qualify for MA.[31]

There are several other possible explanations for why take-up rates for LTCI are low. At the time of purchase, many individuals do not know what their future LTC needs will be. This makes it difficult for individuals to know what kind of policy to purchase. Because LTCI policies can be fairly complex, this may deter individuals from purchasing a policy at all. Finally, individuals

may be concerned about the long-term sustainability of a company providing LTCI, as many companies have already left the market.

Because LTCI is considered a third party liability, MA only pays for expenses not covered by private insurance.[32] Although MA is the payer of last resort, this does not preclude an individual from using MA.[33] If there is a difference between the daily benefit of a LTCI policy and the daily cost of care, often this difference is considered an out-of-pocket expense, unless the individual is eligible for MA. An individual would need to pass an asset test and meet all other MA eligibility requirements. Then, if the individual does have an income, they may be required to contribute a portion of their income toward their LTCI costs. Usually, a LTCI benefit is not considered income. If there are still remaining LTCI costs, the individual may participate in MA.

If individuals purchase a low-cost LTCI policy with limited coverage, "these same individuals are unlikely to have additional income and assets to supplement their private insurance and will likely rely on MA." [34] This is why it is imperative that individuals purchase a policy with a benefit structure that suits their needs, which is one that considers the individual's ability to pay, health status, and coverage needs.

Product Analysis

Cost to Consumer

LTCI premiums vary widely depending on the product coverage, age, and health status. In 2010, the average yearly premium for an individual LTCI policy in Minnesota was $1,700.[35] By age alone, annual LTCI premiums range from a couple hundred dollars a month if purchased in one's 40s to a couple thousand dollars when purchased in one's 60s. LTCI policies often have an elimination period, the period of time between an insurance claim and when the policy pays out a benefit. The elimination period is essentially a deductible or waiting period. The typical elimination period is 90 days.[36] Longer elimination periods require a larger upfront cost, but reduce premiums.

The State of Minnesota offers a $100 LTCI tax credit per person for policies that have a minimum lifetime LTC benefit of $100,000 and meet other requirements as outlined in statue.[37] In 2010, the Minnesota Department of Revenue granted 59,862 credits, totaling $8.48 million and averaging $139 per credit.[38] The average age of those who received the credit was 65. Of those who received the credit in 2010, 36 percent had an annual income between $50,000 and $99,999, while 32 percent had an income between $100,000 and $249,000.[39] This suggests those who claimed the credit had a considerably higher income that the state median household income of $57,243.[40]

Tax credits are used to incent the purchase of LTCI by making policies more affordable and research suggests tax incentives do, to a small degree, encourage individuals to purchase LTCI policies. However, those who take advantage of LTCI tax credits are typically high-income individuals and this makes LTCI tax incentives regressive. [41] This is indeed the case in Minnesota. Research suggests that "tax incentives are unlikely to substantially reduce the proportion of the population that does not have adequate private insurance coverage for long-

term care," as those who claim LTCI tax credits are likely to purchase LTCI regardless of the credit. [42] This suggests that a LTCI tax credit may not reduce the number of individuals using MA for LTC, as the individuals who utilize the credit would not have used MA anyway.

Level of Coverage

LTCI provides coverage for the cost of LTC as specified in the policy purchased, usually up to a lifetime maximum benefit measured either in days covered or in dollars. There are three main ways in which a LTCI policy pays out: the insurer may pay a cash benefit directly to the policy holder, it may reimburse the policy holder for specific services, or it may provide direct payments to the LTC service provider.[43] It is most common for LTCI policies to reimburse policyholders for the specific services they consume.

In Minnesota, LTCI policies must cover "diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care series" provided in either a home or institutional setting.[44] Policies must also provide a fixed dollar benefit for LTC expenses, subject to certain policy limitations, such as elimination periods or maximum benefits as outlined in the policy.[45]

In insurance, policy benefits are often measured by their "load." The "load" of an insurance policy is "a standard method of comparing how much individuals pay in premiums relative to how much they can expect to receive in benefits.[46]" An actuarially fair policy has a load of zero, meaning "the measure of benefits paid out by the insurance company is equal to the measure of the premiums that the individual will pay."[47] In other words, "the higher the load, the lower the expected return on the policy."[48] It is estimated that the typical LTCI policy has a load of 0.18, that is for every dollar spent in premiums, the policyholder will receive only 82 cents in benefits.[49] This high load estimate suggests that LTCI policies are priced at an actuarially unfair level.

Flexibility

As stated earlier, LTCI can be used in a variety of settings, but can only be used for LTC. Most LTCI policies are comprehensive, in that they cover nursing, assisted living, respite, hospice, and adult day care.[50] This gives policyholders greater choice about what kind of LTC they wish to utilize.

Eligibility

In purchasing a LTCI policy, individuals must go through an underwriting process where their risk level is analyzed based on their medical history and lifestyle. Positive living habits, such as eating well and exercising regularly can lower an individual's risk level during underwriting.[51] The underwriting process allows the insurance company to analyze an individual's risk level based on their health status. Using this information, insurance companies decide whether or not to grant coverage and how much the premium will be. Individuals in poor health are more risky to cover, as they are more likely to need LTC. These same individuals will also experience higher premiums based on their increased likelihood of needing LTC. For these reasons, the

underwriting process may exclude individuals in poor health, either because the individual is denied coverage or their premiums are unaffordable.

Consumer Protection

Minnesota requires LTCI policies to cover at least one year of LTC and Alzheimer's disease only if the disease is a preexisting condition.[52] The state also requires that LTCI polices include a 30 day cancellation policy and a clause that states a policy cannot be cancelled unless the premium is not paid. One important consumer protection feature is Minnesota's requirement that all LTCI policies offer policyholders an option to purchase insurance with annual compound inflation protection. Inflation protection increases one's benefit amount over time to keep pace with increasing LTC costs. Inflation protection can either be simple, compound, or indexed to the Consumer Price Index, for example. Because inflation protection often increases the premium cost, some LTCI consumers choose to forgo this feature and in effect, limit their future benefit.

One visible trend in LTCI is the magnitude of recent large, unexpected premium increases. LTCI premiums have increased for two primary reasons: low interest rates and higher than expected claims.[53] The Minnesota Department of Commerce reviews all requests for premium increases submitted by insurers. The Department then has the authority approve or deny a premium rate increase. Insurers have requested premium increases of up to 100 percent.[54] These large premium rate increases make planning for LTC difficult. Some individuals may be unable to afford their premium after a large rate increase, particularly during retirement.

The complexity of LTCI policies poses another consumer protection challenge to those interested in purchasing a policy. Minnesota requires that insurers provide customers with a document that explains the policy's benefits, limitations, and exclusions. Although the state requires insurers to explicitly outline the elements of a policy, when individuals shop around for the policy that best fits their needs, often LTCI policies differ in very nuanced ways. Often times, "the complexity of insurance products requires the individual-level attention and guidance of a sales agent or other consumer advisor."[55]

Advantages	Disadvantages
▪ Flexibility to purchase a policy that fits individual needs: cost and coverage. ▪ Flexibility to chose either home or institutional care. ▪ Predictable benefit. ▪ Allows insured to protect their assets.	▪ Can be complex to the consumer, as the terms and features of products vary widely. ▪ Premiums can be expensive and must be paid consistently. ▪ No control over large, unexpected premium increases. ▪ Medical underwriting may exclude individuals with poor health status. ▪ Inflation protection not required.

Product 2: Partnership for Long-Term Care

Overview of Product

The Partnership for Long-Term Care (Partnership) provides financing for long-term care in the form of a public-private partnership between MA and private LTC insurers. States are given authority to sell Partnership products through state plan amendments submitted to, and approved by, the Centers for Medicare and Medicaid Services (CMS). Information regarding the Partnership is readily accessible – more so than for other LTC financing products – due to required federal reporting for insurers.

The Partnership began in Minnesota in 2006 and the state currently ranks second nationally in sales of Partnership products.[56] As of June 30, 2011, 24 carriers sold Partnership policies in the state, however the Minnesota's Partnership market is dominated by just a few carriers: Genworth (28 percent of all policies), John Hancock (23.6 percent of all policies), CNA (12 percent of all policies), and Northwestern Mutual Insurance (11.9 percent of all policies). The remaining carriers each have less than 5 percent of market share.[57]

Partnership policies sold in the state must be tax-qualified (according to IRS standards) and provide a certain level of consumer protection. Additionally, Partnership products sold to individuals under age 61 must provide compound annual inflation protection, and that inflation protection must continue until the individual is at least 66 years old. If the policy is sold to an individual between 61 and 75 years old, it must provide some level of inflation protection for the first five years after the policy was purchased or until age 76. After that, Partnership policies may, but are not required to, provide inflation protection.[58]

The Partnership grew out of an initiative of the Robert Wood Johnson Foundation in the late 1980s, which sought to encourage greater purchasing of LTC coverage. California, Connecticut, Indiana, and New York were the first states to implement Partnership programs in the early 1990s. Because MA dollars were impacted by Partnership programs, Congress sought to limit the policies that could be offered under the Partnership umbrella. In 1993, the Omnibus Budget Reconciliation Act prevented the expansion of the Partnership to other states. However, in 2005 with the passage of the Deficit Reduction Act, all states were given the authority to implement Partnership programs provided the policies met certain requirements for consumer protection and protection against inflation.[59] Currently, 44 of the 50 states offer Partnership policies.[60]

Partnership policies are sold most often on the individual market, rather than through an employer-based market. There are some exceptions: companies may design Partnership products specifically for large employers (such as State of Minnesota employees or University of Minnesota) since the pool is large enough to support a policy.[61]

Companies that sell Partnership-qualified policies often have deliberate marketing strategies around the asset protection aspect of the policies. Genworth Financial, for example, provides a Partnership-specific marketing booklet to applicants interested in LTCI. In addition, it provides a one-page information sheet upon purchase of a Partnership-qualifying policy. Companies also

serve as a liaison between the consumer and state government by informing the Minnesota Department of Human Services, which oversees the state's MA program, of the name of any individual that purchases a Partnership-qualified policy and of the amount of LTCI benefits they will receive under their plan. This simplifies what could otherwise be a bureaucratic process for the consumer.[62]

As of June 30, 2011, there were nearly 37,000 Partnership lives in force in Minnesota. Of those, nearly 6,500 were covered in the first six months of 2011 alone,[63] indicating a strong growth rate in the market.

Partnership policies provide LTC benefits that cover the cost of LTC by establishing a lifetime maximum benefit in either dollars or days of coverage. On average, coverage lasts 2.2 to 2.5 years.[64] All states that offer Partnership policies guarantee that if benefits under the Partnership policy do not cover the cost of care, the consumer may qualify for MA under special eligibility rules while retaining a pre-specified amount of assets (though eligibility rules for MA still apply). In addition to the amount of assets a person can keep within the asset limits of MA, the individual is allowed keep an additional amount of assets equal to the dollar amount of benefits that have been paid out by the Partnership policy.[65] This protects consumers from having to become impoverished to qualify for MA, and allows states avoid the entire burden of long-term-care costs.[66]

Product Analysis

Cost to Consumer

Premium costs for Partnership policies vary widely, from less than $500 per year to over $4,000 per year. Most policies that were active in 2011 (53.4 percent) had annual premiums of less than $2,000 per year. The annual premium for a Partnership policy is connected to the age of the policyholder. In 2011, the average annual premium for those who purchased a policy when under age 61 was approximately $1,900 compared to over $3,300 for those who waited until age 76 and older to buy a policy.[67]

The earliest available data on the cost of Partnership policies sold in Minnesota dates back to 2009. At that time, the average annual premium for those who were under age 61 when the policy was purchased was approximately $1,800. Individuals who purchased their policies when they were over age 76 paid an average annual premium of just under $3,500.[68]

There are potential tax-advantages for Partnership policy holders. Minnesota allows individuals who own Partnership policies to claim state LTCI tax credit of up to $100 per year, and if individuals itemize deductions on their federal tax returns, they may be able to deduct Partnership premiums if their total medical expenses exceed 7.5 percent of adjusted gross income over the course of the year.[69]

Level of Coverage

Partnership polices provide a reasonably high level of coverage due to the fact that many policies offer protection against inflation. In fact, 61.7 percent of policies provide inflation protection of 5 percent compounded annually and 6.7 percent provide inflation protection of 3 percent compounded annually. Another 7.4 percent of policies offer 5 percent simple inflation protection, 9.7 percent offer inflation protection that corresponds to the Consumer Price Index, and 10.3 percent offer graded inflation protection (where both the premium and the benefit amounts increase at a known and pre-set amount each year). Just 0.5 percent of all Partnership policies do not offer any protection against inflation.[70]

Partnership benefits are considered "short and fat" in that they offer a fairly limited length of coverage, but provide rich benefits.[71] Of all 36,962 Partnership policy holders in Minnesota, 30,620 chose policies with a single lifetime maximum (in dollars, not days) for all types of benefits. The average benefit amount for individuals in that group was $266,360.[72]

Flexibility

Partnership policies offer a variety of types of LTC coverage: nursing home care, other facility care, in- home health care, or comprehensive care. Of the 57 active claimants in the first half of 2011, 16 received benefits for in-home care and 14 received benefits for nursing home care. However, individuals in nursing homes received nearly double the dollar amount of benefits ($20,671 versus $10,400). The remaining claimants received cash or other benefits. As of the June 30, 2011 reporting data, no claimants had exhausted their benefits.[73]

Eligibility

The Partnership program is open to individuals of virtually all ages, although the majority of policy holders are between the ages of 51 and 65.[74] As with many types of insurance products, medical underwriting is used during the application process. Therefore, an ideal candidate for a Partnership policy should be in reasonably good health.[75]

Consumer Protection

The Partnership is unique in the level of reporting to which insurers must submit. This level of reporting translates into a high level of transparency for insurance regulators and for consumers that are considering purchasing policies to finance their LTC needs.

Minnesota must ensure that any individual who sells a LTCI policy that qualifies under the Partnership receives training and can demonstrate competency about the policy, particularly as the Partnership policy relates to other public and private LTC coverage.[76]

Another important feature of Partnership policies is their portability. The federal government is responsible for developing standards for national reciprocity among all states participating in the Partnership. If an individual in Minnesota purchases a Partnership policy, he or she can receive

asset protection when they apply for MA coverage for their LTC if they move to another state participating in the Partnership and with which Minnesota has a reciprocity agreement.[77]

Because the Partnership program is regulated federally by CMS, there are strict reporting requirements regarding details of Partnership policies. Insurers must report what benefits have been paid along with the amounts of the benefits paid. Further, the state of Minnesota can specify any additional reporting data that insurers must provide along with the format in which the data must be provided. [78]

Advantages	Disadvantages
▪ Offers asset protection up to a certain level. ▪ Policies are transparent because of federal regulation. ▪ Offers inflation protection.	▪ Medical underwriting could exclude individuals in poor health. ▪ Targets those with significant assets, not necessarily those likely to use MA.

Product 3: Life Insurance with Long-Term Care Benefits

Overview of Product

There are two types of life insurance: term and whole. Term life insurance is purchased for a period of one to 30 years, and upon the death of the insured individual, it pays out the full policy value to a beneficiary. Whole life insurance features the same death benefit as term insurance but also includes an investment fund that builds value over time. Term life insurance can sometimes be converted into whole life insurance policies although the specific processes and benefits of doing so can vary by insurer. Although life insurance coverage is often available through one's employer, the life insurance policies that feature LTC benefits are mostly purchased on the individual market.[79]

There are a number of life insurance products that provide LTC benefits (LI+LTC). The basis of any policy is typically whole or universal life insurance, that is, life insurance with benefits that are permanent over the course of the life of the policy holder. There may be provisions embedded in the policy that provide LTC benefits such as:

- accelerated death benefits (an advance against the death benefit),
- life settlements (selling the policy to a third party for more than its cash value but less than the value of the death benefit), or
- viatical settlements (which are similar to life settlements but are designed for the terminally ill).

There are multiple options for financing these types of policies. Most policies have a schedule of recurring premiums that the policy holder must pay to the insurer in order for the policy to remain active. Another option is for a policyholder to add a LTC rider to a whole or universal life insurance policy. The purchase of the life insurance with the attached riders is made through a single premium payment to an insurer. Once the payment has been made, the account value earns interest on a tax-deferred basis (usually a guaranteed rate of 4 percent). The cash value in the account can then be used tax-free to cover LTC costs, and any funds that are unused from the fund after the death of the policyholder can be passed on to heirs in the form of an income tax-free death benefit.[80]

A total of 442 companies are licensed to sell life insurance in the state; 14 of them are located in Minnesota. Most available statistics aggregate whole and term life insurance policies and it is unclear how many policies in Minnesota feature LTC benefits. However, the numbers illustrate the relevance that life insurance in general has for Minnesotans. Of the 3 million individual life insurance policies active in Minnesota, the average benefit provides roughly $140,000 worth of coverage. Statistics are not available specifically for life insurance policies with LTC benefits. Overall, Minnesotans have $595 billion in death benefit coverage available from their policies, but just a fraction of that amount, $7 billion, was actually paid out in 2010.[81] Roughly 70 percent of households in the United States have some level of life insurance.[82] In 2010, life insurers paid out benefits of over $550 billion.[83]

Despite having the option of linking other benefits such as LTC insurance to a policy, life insurance is typically seen primarily as a product that protects the policy holder's dependents rather than serving as a vehicle for LTC financing. In fact, the Minnesota Department of Commerce notes that "people who do not have any dependents and have enough money to cover their final expenses may not need any life insurance."[84]

Generally, the cash surrender value of life insurance policies is considered when determining MA eligibility. The cash surrender value of a whole life insurance policy is counted toward the MA asset limit unless it is excluded under the burial fund exclusion or if it is unavailable because it has been assigned to fund a burial arrangement or if the policy is paying out an accelerated death benefit. The evaluation of life insurance policies relative to MA is complex, and to the extent that policy benefits are only payable based on the need for LTC, they would be treated as third-party liability and would offset the MA payment. Additionally, because life insurance policies that offer LTC benefits are fairly new products, it is unclear if these types of policies actually hold a cash value when the policy holder is receiving LTC. [85]

Product Analysis

Cost to Consumer

Costs vary depending on age, benefit level, health status, and other factors. Without surveying life insurers that offer products with LTC benefits from Minnesota's market, it is difficult to obtain an average or even a range of costs.

Most life insurance policies with embedded LTC benefits offer recurring premiums, either in installments ($5,000, $10,000, or more) or over the course of the policy holder's lifetime. Annual premium amounts vary widely and are difficult to estimate since they are based on a number of factors such as the size of the death benefit, the age of the insured individual and the individual's health status. Obtaining an accurate estimate of the cost would likely require a survey of life insurers in Minnesota's market.[86]

Due to the single premium payment required to purchase life insurance with some life insurance policies with LTC riders, the cost of obtaining this product may be prohibitive for many and the market currently appeals to more affluent individuals.[87] To obtain a meaningful level of LTC benefits, a policy holder would need to pay at least $50,000. In 2011, two-thirds of life insurance policies with LTC riders that were purchased in the United States had a premium of over $100,000 per individual.[88]

Level of Coverage

On average in Minnesota, coverage from a life insurance policy would provide $140,000 in benefit, although that amount is not specific to life insurance with LTC benefits.[89] In general, however, the monthly amount for LTC benefits is derived from the premium payment for the policy. The monthly benefit for nursing home care is typically equal to 2 percent of the life insurance policy's face value. The amount available for home care (if it is included in the policy)

is typically half that amount. However, some policies may pay the same monthly amount for care, regardless of where it is received.[90]

Not all LI+LTC policies offer inflation protection, and therefore, the benefits may be insufficient to cover the cost of future LTC.[91] In most cases, the benefit amount is fixed which means that it is exhausted at a faster rate if LTC costs go up. However, Minnesota law dictates that "no insurer may offer a LTCI policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of LTC services covered by the policy."[92] Essentially, an insurer must offer at least one policy that provides for inflation protection in order to be licensed to sell insurance in Minnesota.

Flexibility

LI+LTC policies vary in terms of coverage. Some policies provide for a monthly amount that must be used for specific types of care, such as nursing home-only or in-home care-only. Other policies provide a lump sum amount for all LTC coverage.[93] Policies that have not been issued recently may only cover nursing home care.[94]

LI+LTC policies are highly portable. Policies need only to be purchased in a state where they are approved and licensed, so the policy remains active and the benefits follow the policy holder as long as he or she continues to pay for it.[95]

Eligibility

Since medical underwriting is used to determine eligibility for LI+LTC products, it is important that individuals be in good health to qualify for coverage. Also, age is an important consideration. Nationwide in 2011, 37 percent of men who purchased LI+LTC were ages 55 to 64 and 40 percent were ages 65 to 74. The data was similar for women: 34 percent were between ages 55 and 64 and 39.5 percent were between ages 65 and 74.[96]

Consumer Protection

An important benefit to LI+LTC is that the policy has value even if the LTC benefits are never exercised. In this case, a death benefit is paid out to the policyholder's beneficiaries in the same way it would be for traditional life insurance. Both the LTC benefits and death benefits arising from life insurance policies are typically tax-free.[97]

Minnesota law protects individuals against cancellation or nonrenewal of the policy based on the policy holder's age or health condition, and also prohibits an insurer from establishing a waiting period for coverage if a policy holder's existing coverage is converted to or replaced by a new policy within the same company (unless the insured voluntarily elects to increase his or her benefit level).[98]

It is possible to withdraw cash value from the life insurance portion of the policy, but doing so may result in penalties, and specific policies for early withdrawal vary from one insurer to another. For instance, withdrawals on earnings may not be income tax-free, they may result in a reduced death benefit, and they may be subject to a 10 percent early withdrawal penalty if the policy holder is under age 59 and a half.[99] However, if a policy holder decides to cancel the policy altogether, he or she may be able to receive a Return of Premium (which would not include any gains made on the initial investment).[100]

Advantages	Disadvantages
▪ Policies are portable. ▪ Policies have value even if LTC benefits are not exercised.	▪ Policies are often marketed as protection for dependents rather than as a source for LTC financing. ▪ Subject to increases in premiums.

Product 4: Long-Term Care Annuities

Overview of Product

There are two types of long-term care annuities: deferred and immediate. Both types of annuities require a single, large premium payment to be made to an insurer in exchange for LTC coverage. Deferred annuities are referred to as "combination products" or "linked benefits", meaning that they have two funds: one fund provides to an individual the regular, fixed cash stream of an annuity that grows at a guaranteed rate of three percent. The owner of the annuity must wait until a specified future point in time to access the cash benefit from the fund.[101] The other fund, the LTC rider, directly pays for LTC services or insurance, and typically grows at a high interest rate.[102] After a seven-day waiting period, deferred LTC annuities pay for up to 36 months of coverage, although an individual may be able to purchase additional months of coverage once the benefit period ends.

Immediate annuities are suited for individuals who are not able to secure LTCI due to health conditions or who are already receiving LTC. Immediate annuities often rely on medical underwriting, which allows insurance companies to decide how much to charge for a premium and to determine what the annuity's payout schedule will be. Once the payout schedule is determined, an individual's premium is converted into a fixed steady income stream that he or she receives for the rest of his or her life. [103]

In 2010, annuity considerations held by Minnesotans were valued at $4.5 billion, and a total of approximately $1 billion in annuity benefits was paid out to Minnesotans that year.[104] However, those numbers are not specific to annuities with LTC benefits. Narrowing the scope to that extent would likely require a survey of all companies in Minnesota that are licensed to sell annuities. A total of 194 companies are regulated by the Minnesota Department of Commerce as sellers of annuities in the state. [105]

Annuities are sold on the individual market. The typical individual who purchases an annuity has a high level of liquid assets due to the fact that a large single premium is required to obtain the product. At the same time, these individuals have a high expectation of outliving their resources and owning an annuity protects against this possibility.

There are no available estimates of numbers of annuities held by Minnesotans. Determining the number of annuities would likely involve surveying all companies in Minnesota that are licensed to sell annuities. Anecdotally, it seems that the market for annuities, both in Minnesota and nationally, is small due to the large upfront cost of the product.[106]

Some individuals may purchase annuities without LTC benefits with the intention to use the income stream to pay for LTC costs. For these individuals, MA eligibility functions somewhat differently than for those who own annuities with LTC benefits. For example, the income stream from typical annuities is counted toward MA income limit. Also, annuities that are still in the accumulation phase (which have not yet begun to pay out) are considered assets. People who want MA to pay for LTC services must name the state as a remainder beneficiary of annuities in

which they have an ownership interest. To the extent there is death benefit, the state is reimbursed after payments to the person's spouse, children under age 18, or a disabled child of any age.[107]

For individuals who own annuities with LTC benefits, MA interaction is more complex. On one hand, the interaction is similar to that of typical annuities: the proceeds from the income-generating fund of the annuity are still counted as income according to MA guidelines, and there is a provision in Minnesota law for making the state a beneficiary of the annuity. However, the LTC fund of the annuity is subject to the same eligibility guidelines and MA interactions as are other types of LTCI (such as traditional LTCI, the Partnership, and the LTC benefits attached to or embedded in life insurance policies).

Product Analysis

Cost to Consumer

The most significant aspect of cost for annuities is the premium. Individuals must anticipate the total cost of their LTC needs as well as their future income needs when purchasing the product. To that extent, a premium payment could easily be $100,000 or more.

In addition to the premium, there are fees and charges associated with managing the annuity's income-generating funds. These fees and charges, also known as the load, can involve contract fees (when the annuity is first purchased) or recurring charges associated with a percentage of the premium (after the annuity has matured).[108]

LTC annuities typically appeal to a wealthy demographic due to the fact that a single, large premium payment must be made to purchase the product.[109] Although this type of financing option for LTC is becoming increasingly popular, the market for LTC annuities is small.

Despite drawbacks related to affordability, LTC annuities offer tax benefits provided they are considered tax-qualified. The Pension Protection Act of 2006, which took effect in January 2010, established that LTC riders would be treated separately from the annuity itself for tax purposes. Essentially, this means that tax-qualified LTC benefits from the rider are tax-free and the original premium is eligible for an income tax deduction.[110]

Level of Coverage

Neither deferred nor immediate annuities are guaranteed to provide enough income to pay for all LTC costs, nor do they guarantee protection against inflation.[111] If an individual needs extended coverage beyond the standard 36 months of care that a deferred LTC annuity provides or if the overall benefit does not cover the full cost of LTC, this type of product may not be a suitable financing option. If additional coverage is needed after LTC benefits run out, the individual must either purchase additional coverage or rely on MA (assuming eligibility standards are met). However, the tradeoff with uncertainty of coverage is predictability of cost: due to the single, upfront premium, owners of annuities with LTC coverage will not have to respond to premium increases over the life of policy.

Flexibility

LTC annuities can provide a variety of types of LTC. Depending on how the policy is structured, the annuity can cover nursing home, assisted living, in-home care, or a combination of these types of care.[112] Additionally, deferred annuities may also offer prescription drug coverage.[113]

Eligibility

It is often easier for individuals to qualify for deferred or immediate annuities compared to securing a LTCI policy. Deferred annuities do not require underwriting (although individuals seeking this type of annuity may have to answer basic questions about health status since some conditions like dementia and Parkinson's disease prevent eligibility), and immediate annuities are open to individuals who are considered to have pre-existing conditions and who are already receiving LTC.

Consumer Protection

The tax-benefits of annuities, while significant, may be complicated for some individuals. Owners of these products could need to seek professional advice from financial or tax advisors to make sure they are compliant with tax policies.

Once a LTC annuity is purchased, an individual's money is locked into a long-term investment product. There are surrender penalties for withdrawing cash prior to the start of the annuity's payout period (penalties often occur within the first 5 to 10 years of owning the product).[114] It is typical for surrender penalties to range from 5 to 25 percent of the amount withdrawn.[115] Since annuities require a substantial upfront investment, this also means that the annuity could result in an individual having insufficient cash-on-hand.

Both deferred and immediate annuities provide for death benefits if the value of the annuity is not exhausted after paying for LTC costs.[116] The death benefit decreases in proportion to the amount that was paid for LTC.[117]

Minnesota law protects individuals against cancellation or nonrenewal of the policy based on the policy holder's age or health condition, and also prohibits an insurer from establishing a waiting period for coverage if a policy holder's existing coverage is converted to or replaced by a new policy within the same company (unless the insured voluntarily elects to increase his or her benefit level).[118]

Advantages	Disadvantages
▪ Cost is predictable given the single, upfront premium. ▪ Medical underwriting may not be required. ▪ Offers a predictable income stream from a separate investment fund.	▪ Large, upfront premium may limit the market. ▪ Penalties for early withdrawal during accumulation period. ▪ Funds may not be available if care is needed prior to the payout period.

Overview of Product

Health Savings Accounts (HSAs) are tax exempt accounts tied to High Deductible Health Plans (HDHPs) that an individual can use to pay for medical related expenses. HSAs are considered an option for saving for LTC because money in the account can also be withdrawn to pay for qualified LTC services or insurance premiums. A HDHP is generally a health insurance plan with lower premiums and higher deductibles. A HDHP policyholder has the option to open an HSA.[119] Both individuals and employers can contribute to the HSA. Individual contributions are deductible from adjusted gross income and employer contributions are excludable from taxable income. Minnesota state law provides further preferential tax treatment for HSAs by allowing the same exemption from taxable income and deduction from adjusted gross income that federal law allows. Additionally, withdrawals from the HSA are non-taxable if spent on qualified medical expenses or qualified insurance premiums.[120]

Data on the number of individuals with HSAs is difficult to find. Most sources only report the number of lives covered by a HDHP, but having a HDHP does not mean an individual has an HSA. It only means that one is eligible to open an HSA. Therefore, data on the number of HDHPs is used to approximate how many individuals would be eligible for a HSA. America's Health Insurance Plans' (AHIP) January 2011 Census reported that 14.9 percent of Minnesotans with private health insurance under age 65 had a HDHP in 2011. This is the highest percentage amongst the states with a range from 0.2 percent in Hawaii to 14.9 percent in Minnesota. Using this percentage, one could estimate that approximately 507,307 Minnesotans were eligible to have an HSA in 2011.

HSAs are not counted toward an individual's asset limit for MA in Minnesota so they would not need to be spent down to qualify for MA. However, health coverage purchased with these funds would be counted as third-party liability.[121] MA is payer of last resort, so individuals with third-party liability would have to use those sources before MA would pay.[122]

A growing number of people are enrolling in HDHPs. There were 11.4 million lives covered by HDHPs in January of 2011. This is a large increase from the 1.0 million lives covered in March of 2005. [123] Large groups are making up more and more of the percentage of lives covered since 2005. Of the 11.4 million lives covered by HDHPs, 6.3 million are in group plans.[124] The increase is in part driven by employers' attempts to mitigate the increasing costs of health care for their employees. A HDHP is a type of consumer-driven health plan where the individual is responsible for more upfront costs. The rationale for these plans is that consumers will make better health care choices if they know what they are paying for. In 2009, 20 percent of Americans with health coverage through their employer were in a consumer-directed type of health plan.[125]

As mentioned previously, it is difficult to find data on the number of people with HSAs because being enrolled in a HDHP does not necessarily mean that one also has a HSA. Data on the number of HSAs must be obtained from the Internal Revenue Service (IRS). A Government

Accountability Office (GAO) report from 2008 analyzed HSAs using industry data and IRS data. The report found that "participation in HSA-eligible plans and HSAs increased significantly, but many HSA-eligible plan enrollees did not open an HSA."[126] From 2004 to 2005, they found that the number of lives covered by a HDHP increased from 438,000 to 1,031,000 respectively and the number of tax filers who reported HSA activity increased from 120,000 to 355,000 respectively.[127] Therefore, approximately one-third of HDHP holders had a HSA in 2005.

Product Analysis

Cost to the Consumer

The most obvious cost of having a HSA is the deductable associated with having a HDHP. In 2012, a plan qualifies as a HDHP if it has a minimum annual deductible of $1,200 or a maximum annual deductable of $6,050 for self-only. For family coverage, the minimum is $2,400 and the maximum is $12,100.[128] There are also a number of fees associated with a HSA. These fees include set-up fees, annual or monthly fees, per transaction fees, per check fees, traditional check fees, ATM fees, debit card fees, and closing fees. An analysis completed by Great Lakes HSA found first year fees to range from $25 to $85.[129] The cost to the consumer varies depending on how one views the payment of a deductible each year.

Level of Coverage

There is a limited amount that could be saved for LTC services or insurance given legal limits on annual contributions to HSAs. The amount an individual or an employer can contribute to the HSA depends on the type of HDHP the individual holds, his or her age, date eligible, and date the individual ceased to be eligible.[130] For 2011, an individual with a self-only HDHP can contribute a total of $3,050 (including employer contributions) and an individual with a family HDHP can contribute a total of $6,150. If an individual is 55 years or older, he or she can contribute an additional $1,000 per year for a self-only HDHP. If spouses are both over age 55 the total contribution could not be more than $8,150.[131] In 2005, these contribution limits were $2,650 for self-only, $5,250 for family, and the additional contribution for those over 55 years of age was $600.[132] Once an account holder is on Medicare, he or she cannot make further contributions to the HSA. In addition, HSA holders likely use the money in their account each year to pay for needed health care services. A 2007 AHIP Census report found that the average HSA account balance for 2007 was $1,382 and the average amount spent was $1,083.[133]

Assume a 55 year old woman contributed $4,050 (the maximum self-only amount plus the additional $1,000 in 2011) to her HSA each year for ten years without withdrawing any funds for other medical expenses. After ten years at 1 percent interest rate, she would have $42,371. At a two percent interest rate she would have $44,348.[134] While this is a large sum of money, it is small compared to the average yearly nursing home cost of $56,210 for a private room in Minnesota.[135] Further, people use their HSAs to pay for medical expenses each year, so the roll-over amount from year to year is very small.

Flexibility

Key features of the HSA are that the account rolls-over from year to year and it is portable. While the HDHP may not be able to move with an individual, his or her HSA will.

However, HSAs are somewhat limited in flexibility because withdrawals have to pay for qualified expenses. Qualified expenses are usually medically related. HSA withdrawals can also be made to pay for qualified LTC services and qualified LTCI premiums. The IRS defines qualified LTC services as: "…necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services … that are: 1) Required by a chronically ill individual, and 2) Provided pursuant to a plan of care prescribed by a licensed health care practitioner.[136]

A qualified LTC contract is one that provides only coverage of LTC services. It also needs to meet the following criteria:

1. Be guaranteed renewable;
2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed;
3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits; and
4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes *per diem* or other periodic payments without regard to expenses.[137]

If withdrawals are made for non-qualified expenses the amount withdrawn is subject to income tax and an additional 20 percent tax.[138] Once an individual with a HSA turns 65 there is a little more flexibility with the account. After 65 years of age, an individual can withdraw funds from the HSA for non-qualified expenses without facing the 20 percent tax. However, the funds withdrawn for non-qualified expenses would become subject to income tax. Funds in the HSA account can be used to pay for Medicare premiums and other health coverage, with the exception of Medicare supplemental policies like Medigap.[139]

Eligibility

An individual is not eligible for a HDHP with HSA if he or she has other health coverage, such as a spouse's plan, unless the spouse's plan is also a HDHP. In addition, an individual is not allowed to make contributions to a HSA if he or she is claimed as a dependent on another person's tax return.[140] Finally, HSAs cannot be opened in conjunction with Medicare and contributions cannot be made to an existing account when an individual becomes eligible for Medicare.[141]

Consumer Protection

Consumer protection issues are more relevant to the HDHP than to the HSA. These issues become important since an individual needs to have a HDHP to open a HSA. Generally, HDHPs

and other consumer-directed plans have a cap on out-of-pocket expenses and they waive the deductible requirement for qualified preventive services which provides a level of consumer protection. RAND conducted a study to analyze the effects of HDHPs and consumer-directed plans impact on health care cost savings and use of preventive services. They found cost savings for those enrolled in these types of plans, but they also found moderate reductions in the use of preventive care.[142] The RAND study authors suggest that the reduction in use of preventive care could have resulted from three scenarios:

1. People might have been deterred from seeking care for a health problem that would prompt a referral for a preventive screen because of the high deductible.
2. Individuals could have sought care outside their plan.
3. They might not have understood that y preventive services were not subject to the deductible due to the complex nature of these plans.[143]

Longer term studies will need to be conducted to analyze whether or not there is a continued reduction in use of recommended preventive care. If there is a reduction, this could lead to people needing LTC services earlier in life.

Advantages	Disadvantages
▪ Account has preferential tax treatment. ▪ It is portable and rolls-over each year. ▪ Market is growing.	▪ Limited amount could be saved for LTC coverage. ▪ 65 year old cannot continue to contribute to HSA. ▪ Uncertain health impact on HDHP policyholders over the long-term.

Product 6: Reverse Mortgages

Overview of Product

There are three types of reverse mortgages: Home Equity Conversion Mortgages (HECMs), proprietary, and single purpose. Reverse mortgages are loans against the equity of a person's home. They are considered an option for LTC coverage because a reverse mortgage provides an older individual with cash that could be used to purchase LTC services or to pay LTCI premiums. The HECM is the only type of reverse mortgage available in Minnesota, so analysis of reverse mortgages focuses on this product and a new variation of the HECM called a HECM Saver.

The HECM Standard and HECM Saver are U.S. Department of Housing and Urban Development (HUD) insured products. They are available to individuals who are 62 years of age or older, own his or her home outright (or have a very low balance on the mortgage), and still live in the home. They can be term or tenure with fixed or adjustable interest rates. The HECM Saver became an option for homeowners in 2010. This option allows homeowners to pay a lower initial mortgage insurance premium compared to the HECM Standard, saving on their upfront closing costs.[144] The process for obtaining a reverse mortgage is similar to that of a traditional mortgage, except that when complete the borrower will receive payments instead of making payments. The borrower can choose to receive payments via a lump sum, line of credit or combination of the two. There is not limitation on how these funds are spent.

In Minnesota, the number of endorsed HECMs increased from 693 in 2005 to 1,038 in 2011, representing a nearly 50 percent increase.[145] An endorsed HECM is one which has been approved for Federal Housing Authority (FHA) mortgage insurance. Currently, there are fourteen FHA lenders that offer HECMs in Minnesota. Twelve of the fourteen lenders are located in the Twin Cities metropolitan area and all have completed a HECM in the past 12 months.[146] There are many more "loan correspondents" or brokers who as of 2009 must be sponsored by an FHA lender in order to offer HECMs.[147]

For MA purposes, a reverse mortgage is considered a conversion of one asset to another. A person's homestead is generally an excluded asset in the MA program if the person, person's spouse, or other dependent relative lives in the home as his or her principle residence. If the asset is converted to cash through a reverse mortgage, the payment is not counted in the month it is received because it retains its exclusion status. However, if the proceeds from the reverse mortgage remain the next month, the amount retained is counted toward the MA asset limit.[148]

Since 2005, the number of HECMs made nationally has increased from 43,082 to 73,131 in 2011. During this period there were three years where the number of HECM loans endorsed reached over 100,000.[149] Meg Burns, director of FHA Single Family Program Development, said that the growth is steady and gradual relative to the base.[150] The amount a borrower could take out with a reverse mortgage was changed in 2008 from the FHA limit based on the area the property was located in to the conforming loan limit for the Federal Home Loan Mortgage Corporation (Freddie Mac).[151] The average age of a HECM borrower in 2011 was 72.2 years of

age. This is a slight decline from 2005 when the average age was 73.8.[152] The take-up rate of reverse mortgages is low with only 1.4 percent of elderly homeowners using one. In their paper, Nakijama and Telyukova determined that the low take up rate is due to bequest motives, moving shocks, and house price fluctuations. They also found that the introduction of the HECM Saver option has led to an increase in demand for reverse mortgages.[153] Reverse mortgage payments are nontaxable and generally do not impact Social Security or Medicare benefits. The funds are nontaxable because they are considered a loan and not income. Individuals who receive Supplemental Security Income (SSI) may have their benefits reduced if they do not spend their reverse mortgage payments each month.[154]

Product Analysis

Cost to the Consumer

Costs to the consumer are generally high upfront; however, most can be paid with proceeds from the loan. Costs for a HECM are based on the value of the home. They include upfront costs and the costs over time from paying interest on the loan. Upfront costs include: loan origination fee, third party fees (appraisal, inspection lender title policy, etc.), FHA mortgage insurance premiums (MIP), servicing fees, and counseling fees.[155] HECM origination fees range from a minimum of $2,500 to a maximum of $6,000. They are based on the value of the home. MIPs are 2 percent for the HECM Standard option and 0.01 percent for the HECM Saver option.[156] The HECM Saver allows an individual to save on the upfront costs of the loan with the lower MIP. The costs over time are based on interest accruing on the loan balance each month. This means the total debt one owes will increase over time. Most have fixed rates, but some can have variable interest rates that fluctuate with the market.[157]

For example, a borrower utilizing the HECM Standard option with a fixed interest rate for a home valued at $250,000 could face upfront costs of $11,486 and an interest rate of 4.5 percent for the life of the loan. The upfront costs include: a $4,500 origination fee, a $5,000 upfront MIP, and $1,986 in other fees. The comparable HECM Saver option with a fixed interest rate would require upfront costs of $6,511 and an interest rate ranging from 4.5 percent to 6 percent for the life of the loan (See Appendix II, pages 40 and 41).

Level of Coverage

The level of coverage with a HECM could be high. In 2011, the average principal limit (loan amount) for a HECM was $138,837 and the average home value (maximum claim amount) was $220,121 in Minnesota.[158] Nationally, the average initial principal limit was $161,139 and the average maximum claim was $249,105 in 2011.[159] The principal limit is determined by multiplying the appraised value of the home or FHA national loan limit by a principal limit factor. This factor is based on the age of the borrower and the mortgage interest rate. The average maximum claim is the lesser of the property value or the FHA national loan limit.

On its face, the average loan amount, or benefit, in Minnesota of $138,837 seems large enough to cover expected LTC costs or LTCI premiums. However, whether or not that benefit is enough depends on the level of care one might need and for how long. Since reverse mortgage proceeds

can be used for anything, it also depends on how the individual might use the funds for other expenses like home maintenance costs, property tax, insurance, or medical care.

Flexibility

A HECM reverse mortgage is very flexible because a borrower can use the funds for anything as long as he or she remains living in the home. A borrower could use the funds to pay for shorter stays in a nursing home or medical facility since the borrower could live in a nursing home or medical facility for 12 consecutive months without having to repay the loan.[160] If the person moves, the loan becomes due.

Eligibility

Eligibility is fairly simple to understand. An individual is eligible for a HECM reverse mortgage if he or she 62 or older, owns his or her home outright, resides in the property, and completes counseling from an approved counselor. Properties that qualify include: single family homes, a one to four unit building with one unit occupied by the borrower, HUD-approved condominiums, manufactured homes, and homes on leased land.[161]

An important point to make is that HECM eligibility does not include health status, like many other LTC products do. Right now, it also does not include an income or credit check. Industry representatives believe HUD will require a financial assessment in the near future to assure that borrowers have the ability to pay insurance and property taxes.

Consumer Protection

Recent actions by HUD requiring lenders to report the number of delinquent HECMs suggests that there may be a delinquency issue with reverse mortgages. The decrease in housing values and increase in financial burden on seniors may have led seniors to stop paying property taxes or insurance premiums. If individuals default on these payments, the loan becomes due. If seniors cannot pay the loan, they may face foreclosure.[162] Industry articles indicate that there could be as many as 46,000 borrowers in default. These articles suggest that defaults occur because there is not a requirement to check credit scores or income and older homeowners were using reverse mortgages as a last resort.[163] HUD is working to remedy the situation by providing guidance to lenders on options for seniors and more funding for counselors.

Most HECMs have a nonrecourse clause. This means that you will not owe more than value of your home when the loan is due and the house is sold. If your heirs want to keep the home, they would have to pay back the loan in full.[164]

The Minnesota Attorney General's office advises seniors to be extremely cautious of salespeople who suggest that a reverse mortgage be taken out to purchase another product, such as LTCI because the cost of the reverse mortgage may be greater than the benefit received from other products.[165]

Counseling from a HUD approved HECM counselor is required before a loan is processed. A new rule in effect September 2009 requires training and testing for HECM counselors.[166] NeighborWorks America hosts a website strictly to supply resources to HECM counselors. The website provides information about the new training and exam requirements for HECM counselors.[167]

Advantages	Disadvantages
▪ Does not require one to be healthy. ▪ Allows older adults to cash in on the equity in their homes while still living in them. ▪ There is great flexibility in the use of funds.	▪ Upfront costs might scare potential borrowers. ▪ Complexity. Older adults may need financial planning assistance. May face foreclosure if do not keep up with maintenance and taxes. ▪ Older adults have less equity with the decrease in home values.

Product 7: CLASS Act

Overview of Product

In 2010, Congress enacted the Community Living Assistance Service and Support (CLASS) Act, Title IIIX of the Patient Protection and Affordable Care Act (ACA).[168] The CLASS Act established a national voluntary LTCI program mandated to last at least 75 years.[169] The CLASS Act aimed to provide greater access to LTC at an affordable cost and provide individuals with the ability to choose the services and supports to fit their needs. There was also an emphasis on community-based services. CLASS would have provided a cash benefit to individuals who need assistance with at least two or three Activities of Daily Living or who have a substantial cognitive impairment.[170] The Congressional Budget Office estimated that CLASS would reduce the federal deficit by $86 billion between 2012 and 2021.[171] The Centers for Medicare and Medicaid Services estimated the CLASS program would result in $37.8 billion in federal budget savings between 2010 and 2019.[172]

This product is not available in any state. In October 2011, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced the Obama Administration would suspend its implementation of CLASS.[173]

HHS developed an extensive marketing plan for CLASS. Because CLASS was voluntary, the program needed to be marketed heavily, not unlike private LTCI products. As consequence, these high marketing costs would likely increase the administrative costs of CLASS. HHS focused on several marketing strategies, including developing a LTC awareness survey and campaign, conducting qualitative research through in-person focus groups, developing a strategic "brand" for CLASS, and researching employer LTC offerings.[174] Like most other insurance products, HHS identified two primary customers for the CLASS program: individual consumers and employers. Most of their initial marketing research was incomplete at the time CLASS implementation was suspended. Like state level Own Your Future campaigns, this national marketing effort aimed to increase consumer awareness of the need to plan for LTC.

Because participation in CLASS was voluntary, the Centers for Medicare and Medicaid Services (CMS) estimated that by 2015, 2.8 million individuals would participate in the program, representing only 2 percent of eligible participants.[175] In the private market[176] CMS identified several factors influencing low participation rates in CLASS, including the program's voluntary participation, lack of a federal subsidy, minimum $5 premium for low-income individuals, relatively high premium for all other participants, and the availability of lower-priced LTCI options in the private market.[177]

The CLASS program was to be financed solely by participant premiums, as the legislation explicitly stated that no federal funds were to be used to pay for individual benefits.[178] In this way, CLASS was essentially a privately financed but publicly administered program.

The CLASS program was designed to work in combination with other public insurance programs that offer LTC benefits, such as MA, Medicare, Social Security, and disability programs.[179] An

individual's eligibility for the CLASS program would have no effect on their eligibility and participation in another state federal public insurance program. The CLASS Act stated that the benefits received through the program were meant to supplement, but not supplant, other health care benefits provided by MA or any federally funded program.[180] If an individual were eligible for both the CLASS program and MA, CLASS would be the primary payer of LTC, offsetting some MA costs.[181] Further, CLASS benefits would coordinate with any supplemental coverage purchased through the health insurance exchanged established in the ACA.[182]

Product Analysis

Cost to Consumer

The CLASS program was to be financed by premium contributions paid for by employed individuals 18 years of age and older, collected either through payroll deductions or direct payments. The HHS Secretary was charged with determining premium amounts, setting the rate high enough to maintain solvency for 75 years.[183] The CLASS Act gave the HHS Secretary the authority to adjust monthly premiums as necessary to keep the program solvent.

In an attempt to keep the program affordable, the initial proposed average monthly premium was $65. Individuals at the federal poverty level or employed full-time students would pay smaller premium amounts, starting at $5 per month. Younger program participants would pay in less than older participants. Under this model, the American Academy of Actuaries (AAA) estimated with a $65 average monthly premium, the program would be insolvent by 2012.[184] Assuming an average daily benefit of $75, AAA estimated the actuarially sound average monthly premium would be $160. Still, this model would be insolvent by 2032.[185] Still, CLASS program actuaries estimated that premiums could rise to be over $200 and under some circumstances to be over $300.[186]

Level of Coverage

The CLASS Act legislation established a minimum cash benefit amount of $50 per day, depending on the degree of impairment or disability.[187] This benefit was not subject to any lifetime or aggregate limit.[188] Further, the law did not allow underwriting requirements, other than an individual's age, to determine monthly premiums or prevent an individual from enrolling in the program. A daily benefit of $50 was potentially inadequate given the high-cost of LTC care. However, the program was not designed to cover all LTC costs, but rather supplement other sources of LTC financing.

Flexibility

The cash benefit provided by the CLASS Act could be used to purchase a number of services and supports needed to maintain independence at home or in another residential setting, including modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aids, and nursing support.[189] The cash benefit was limited only to nonmedical services.

Eligibility

The CLASS program was available to all working individuals, excluding individuals outside of the paid labor force. Because there was no medical underwriting, nearly all individuals would have been eligible to participate regardless of their health status. While this program feature would have enhanced access to individuals otherwise unable to get LTC coverage, it also increased the likelihood of adverse selection with the disproportional participation of individuals more likely to require LTC.

Another limitation of the CLASS program was the five-year required vesting period.[190] Program participants were also required to work three of the five years of the waiting period. This provision would have limited certain individuals in need of more immediate LTC.

Consumer Protection

The CLASS program provided participants to advocacy services and advice counseling for coordinated care.

Advantages	Disadvantages
▪ CLASS would have provided an unlimited lifetime benefit. ▪ The cash benefit provided by CLASS gave program participants the flexibility to purchase a variety LTC services to fit their individual needs. ▪ CLASS did not require medical underwriting, making it a good option for individuals in poor health status. ▪ Voluntary participation is more politically feasible than mandated participation.	▪ The estimated $50 daily cash benefit is insufficient to cover average daily LTC costs. ▪ Participants would be required to wait five years before receiving the cash benefit. ▪ Actuarial analyses conducted by CLASS actuaries and the AAA suggested the program would have been insolvent well short of the 75-year mandated solvency. ▪ Voluntary participation would lead to adverse selection in the risk pool and higher marketing costs. ▪ Poses a financial risk to the United States in the event insolvency occurs.

Product 8: Hawaii CarePlus

Overview of Product

In 2003, the Hawaii legislature enacted the CarePlus program, a mandatory public LTC savings plan, the first of its kind in the United States. The Hawaii CarePlus program did not become law, however, as Hawaii's then governor, Linda Lingle, vetoed the legislation. Like the CLASS program, Hawaii CarePlus was designed to be an affordable LTC financing option and aimed to provide participants flexibility to use their benefit toward a variety of LTC services and supports in order to maintain independent living in their community. The program instituted a mandatory premium on all individuals 25-years of age or older.[191] CarePlus, like CLASS, would have provided a cash benefit to individuals who are unable to perform at least two Activities of Daily Living or who have a substantial cognitive impairment.[192] At this time, this product is not available in any other state.

Because the Hawaii CarePlus plan was a mandatory program, the state anticipated high participation among adults 25 and older. Individuals were required to participate regardless of work status, including homemakers, self-employed individuals, and the retired.[193] The program assumed that by spreading premiums across the entire adult population, the risk pool would be more diverse and the premiums more equitable than if premiums were only paid during working years.[194] This mandatory participation would have reduced the need to extensively market the product, lowering administrative costs. Like CLASS, CarePlus was also designed to work in conjunction with other public insurance programs. Similarly, CarePlus would be the primary payer of LTC before the other programs.

Product Analysis

Affordability

As stated earlier, CarePlus was designed to be affordable. At $10 per month or $120 per year, this product was very affordable. Premiums would have been adjusted annually in accordance with the Consumer Price Index.[195] The legislation outlined a schedule by which premiums would increase until 2011, at which point the Board of Trustees that oversees the program would recommend to the legislature any future premium adjustments.[196]

Level of Coverage

As a mandatory program, CarePlus would have offered universal or near-universal LTC coverage. The CarePlus plan defined a $70 daily cash benefit for a lifetime-maximum benefit period of 365 days. This benefit amount is insufficient to cover the LTC costs of a nursing or assisted living facility. However, the $70 daily benefit may have been sufficient to cover certain home- or community-based services, which the program encouraged. In this way, CarePlus, like CLASS, was not designed to provide complete LTC coverage.[197] The program was designed instead to cover a portion of an individual's LTC costs, approximately 75 percent of average LTC needs.[198] Offering a defined benefit provides individuals with a predictable benefit.

However, because the benefit would increase to the Consumer Price Index, the benefit amount would likely increase at a lower rate than the cost of LTC.

Flexibility

The Hawaii CarePlus program allowed individuals flexibility to use their benefit on a day-to-day or on-going basis, up to a cumulative period of 365 days.[199] If an individual moved from Hawaii, the program also allowed individuals the flexibility to take their benefits with them to another state.[200]

Eligibility

Like the CLASS program, CarePlus did not require medical underwriting. Because polices were not underwritten, all individuals would have qualified to participate, including individuals with a preexisting disability or condition. This program feature would provide access to LTC for individuals unable to gain coverage in the private market. Despite this, individuals would have to pay into the program for 10 years before they could start receiving full benefits. This feature was in place to both develop adequate reserves to fund the program long-term, but also to prevent "LTC tourism."[201] A limited benefit was available if needed before the 10-year vesting period.[202] While this is important to maintain program solvency, it limits access for individuals needing more immediate LTC.

Advantages	Disadvantages
▪ Estimated $10 monthly premium is affordable. ▪ Flexible benefit covers nursing, assisted living, in-home care, and community-based services. ▪ No medical underwriting. ▪ Mandatory participation diversifies risk pool and lowers administrative and marketing costs.	▪ $70 daily cash benefit is insufficient to cover average daily LTC costs. ▪ Benefit increases indexed to Consumer Price Index, which grows slower than the cost of health care. ▪ Required 10-year waiting period may limit more immediate needs for LTC. ▪ 365-day lifetime maximum is too short for the average individual requiring LTC. ▪ Mandatory premium is essentially a tax, which may be politically unpopular.

Decision Table

	Product	Current Market in Minnesota	Cost to Consumer (Average premium, loads, etc.)	Level of Coverage (Inflation protection, average benefit)	Flexibility (Types of care covered, portability, use for non-LTC needs)	Eligibility (Restrictions based on age, health status, income, etc.)	Consumer Protection (Complexity, potential for fraud/abuse/unsuitable products, market stability, consumer protection measures)
Private Insurance	Long-Term Care Insurance	199,000*	• Premiums vary based on age, health status, and level of coverage	• No guarantee of inflation protection • Average lifetime benefit varies	• Policies can be structured to cover nursing home, assisted living, in-home care • Policy follows owner as long as premium and fees are paid	• Must pay required premium • Individuals must complete underwriting based on age, medical history, and lifestyle	• Policies must have at least 1 year of coverage, cover Alzheimer's disease, have a 30 day cancellation clause, a guaranteed renewable clause, and option of inflation protection • Policies can be complex; risk of purchasing unsuitable policy based on ability to pay and coverage needs • No protection from premium increases
	Partnership for Long Term Care	36,962*	• Average premium ranges from $1,900 - $3,300	• Some level and type of inflation protection exists for all policy holders under age 76 • Average policy benefit is $266,360	• Policies can be structured to cover nursing home, assisted living, in-home care • Policy follows owner as long as premium and fees are paid	• No age restrictions • Must pay required premium • Individuals must complete underwriting based on age, medical history, and lifestyle	• Federal reciprocity standards ensure that asset protection exists when policyholders apply for Medicaid as long as Minnesota shares a reciprocal agreement with the other state • All agents who sell Partnership policies are required to complete training and to demonstrate competency about Partnership policies • Policies must have at least 1 year of coverage, cover Alzheimer's disease, have a 30 day cancellation clause, a guaranteed renewable clause, and option of inflation protection • Policies can be complex; risk of purchasing unsuitable policy based on ability to pay and coverage needs • No protection from premium increases
	Life Insurance + Long-Term Care	3,000,000**	• Premiums vary based on age, health status, and level of coverage • Most products have recurring premiums, some have large, upfront, single premiums • Load is usually rolled into the premium	• No guarantee of inflation protection • Average policy benefit is $140,000	• Policies can be structured to cover nursing home, assisted living, in-home care • Policy follows owner as long as premium and fees are paid	• Must pay required premium • Individuals must complete underwriting based on age, medical history, and lifestyle	• Policies must have at least 1 year of coverage, cover Alzheimer's disease, have a 30 day cancellation clause, a guaranteed renewable clause, and option of inflation protection • Policies can be complex; risk of purchasing unsuitable policy based on ability to pay and coverage needs • No protection from premium increases
	Annuities + Long-Term Care	Unknown	• Average premium varies • Typically, the single, upfront premium payment must be at least $50,000 in order to obtain meaningful long-term	• No formal inflation protection • Interest benefits accrue on long-term care rider at rate of at least 3%	• Policies can be structured to cover nursing home, assisted living, in-home care • Policy follows owner as long as premium and fees are paid	• Deferred annuities may require applicants to answer basic health questions • Immediate annuities are open to those with preexisting	• Policies must have at least 1 year of coverage, cover Alzheimer's disease, have a 30 day cancellation clause, a guaranteed renewable clause, and option of inflation protection • Policies can be complex; risk of purchasing

			care coverage • The load also varies and can include both one-time upfront costs and ongoing charges	• Average benefit varies according to premium		conditions and those already receiving long-term care	unsuitable policy based on ability to pay and coverage needs • No risk of premium increases due to the upfront single premium payment
Savings or Borrowing	Reverse Mortgages	1,038**	• HECM Standard: $11,486 in upfront costs; 4.5% interest rate (for home valued at $250,000) • HECM Saver: $6,511 in upfront costs; 4.5% to 6% interst rate (for home valued at $250,000) • Costs include: Loan origination fee, third party fee, FHA mortgage insurance premiums (upfront and annual), servicing fees, interest, and counseling	• In MN, the average initial principal limit factor (present value of loan funds available to borrower) was $138,837 in 2011	• No restrictions on types of care covered • Loan is due if no longer living in house • Funds can be used for anything – not just long-term care	• Must be 62 or older, own home outright, and live in home • No income test currently • Required counseling	• Complex terms • Loan can become due if borrower does not pay property taxes, insurance, utilities, maintenance, fuel, and other expenses • Risk of default because no requirement for credit or income check • Loans are federally insured
	Health Savings Accounts	507,307***	• HDHP cost: Deductibles for HDHPs range from $1,200 to $6,050 for self-only • HSA fees: Small fees associated with set-up and transaction costs range from $25 to $85	• Legal limits on annual contributions • Individual limit is $3,050 in 2011 • Those over 55 can contribute an additional $1,000 per year	• Qualified long-term care services and long-term care insurance premiums • Account is portable • Can also use for medical, dental, vision and prescription drugs • Withdrawals for non-qualified expenses subject to income tax and additional 20% tax	• Adults with a HDHP (usually large groups through employers) • Not available to open through a Medicare plan	• Complex plans • Potential decrease in use of preventive services
Public Insurance	CLASS Act	None	• Voluntary premium estimated to be $65	• Estimated $50 daily unlimited lifetime cash benefit	• Nursing home, assisted living, in-home care, respite care, assistive technology, home modifications, transportation	• No medical underwriting • Available to all working individuals	• Unknown
	Hawaii Care Plus	None	• Mandatory $10 per month payroll tax	• $75 daily cash benefit for a 365 day lifetime maximum benefit period	• Nursing home, assisted living, in-home, and community services • Transferrable to other states	• No medical underwriting • Available to all working individuals	• Unknown

* May be overlap between LTCI and Partnership

** Not all policies are used for LTC

*** 507,307 Minnesotans had a HDHP which means they were eligible for a HSA

As stated earlier, this analysis of LTC financing products aims to inform the OYF leadership team as it begins the product development phase of the campaign. This phase will include engaging industry stakeholders, reviewing current product regulations, considering other consumer protection measures, and potentially developing legislative recommendations to modify existing financing products. These recommendations and conclusions aim to guide the OYF team's work moving forward.

1. **Expand access to and transparency of product information for consumers.**

   One limitation of this research was the difficulty in gaining access to detailed information on each product. This is due to the fact that many products are offered in the private market where consumer access to information is imperfect. Many of the products featured in this report exhibit some level of complexity that make a product difficult to understand in plain terms. It will be important for OYF to expand access to and transparency of product information in order to help individuals make educated decisions in financing their LTC.

2. **Provide or facilitate access to individuals or organizations that can assist the OYF target population in understanding and choosing products that suit their needs.**

   Many of the products featured in this report exhibit some level of complexity that may inhibit an individual from choosing the right product that suits their needs. Even comparing two LTCI products, for example, can be difficult. Individuals need to know what products are right for them, given their unique circumstances: age, health, and financial status. For this reason, OYF should explore ways in which the state can provide or help facilitate access to individuals or organizations that help tweeners understand products better and ensure they choose a product that fits their needs.

3. **Consider products that have multiple benefits.**

   Individuals may be incentivized to purchase products that will provide value to them even if they will not need LTC in the future. A number of products analyzed here can serve multiple purposes. For example, Partnership policies offer LTC coverage and asset protection. LI+LTC, as suggested by the title, provides both life insurance and LTC coverage. Annuities will provide an income stream, regardless if an individual requires LTC. These features may be attractive for individuals seeking LTC coverage.

   Further, because products offer different levels of affordability and coverage, it may be necessary for tweeners to consider multiple products to ensure they have a sufficient level of LTC coverage. It may be the case that utilizing multiple products will provide an adequate level of coverage for certain people.

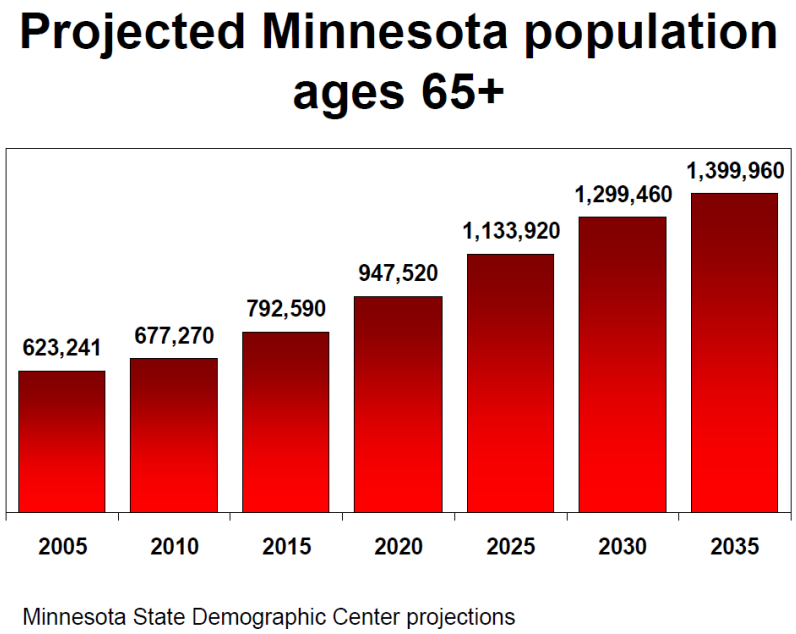
4. Consider individual motivations for purchasing LTC.

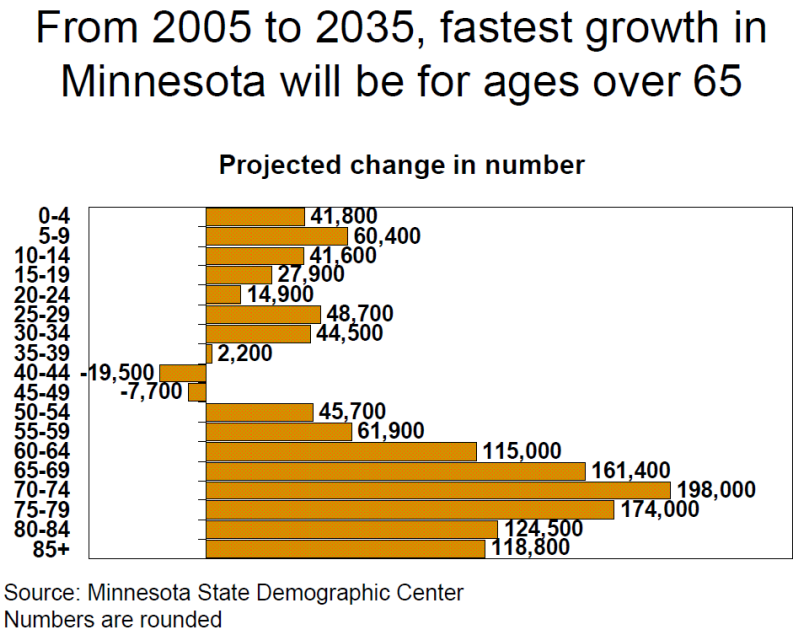
People choose to purchase LTC for a variety of reasons. Certainly, many are interested in protecting themselves against the growing costs of LTC. However, others may be interested in protecting their assets for family or charitable giving, avoiding reliance on friends and family for care, protecting their standard of living, or having greater control over the type and quality of care they eventually receive. This may heavily influence an individual's interest in certain products.

5. Continue to encourage cross-agency collaboration.

The OYF campaign is comprised of experts and leaders in the areas of health care, insurance, aging, public policy, and communications. Building a successful LTC awareness campaign and policy agenda will require sharing this expertise within the leadership team.

Appendix I





Source: Minnesota Population Projections, 2005-2035.(May 2007) Minnesota State Demographic Center. Retrieved from http://www.demography.state.mn.us/documents/ProjectionsMapsCharts2005-2035.pdf.

Appendix II

DHS Focus Group Reverse Mortgage Comparisons

HECM Standard - FIXED W/Origination Fee

Home Value	$150,000	$250,000	$300,000
Interest Rates	4.50%	4.50%	4.50%
FEES:			
Mortgage Insurance Premium	$3,000	$5,000	$6,000
Orgination Fee	$3,000	$4,500	$5,000
Other Fees	$1,507	$1,986	$2,172
TOTAL FEES	$7,507	$11,486	$13,172

HECM Standard - FIXED W/No Origination Fee

Home Value	$150,000	$250,000	$300,000
Interest Rates	4.99%	4.99%	4.99%
FEES:			
Mortgage Insurance Premium	$3,000	$5,000	$6,000
Orgination Fee	$0	$0	$0
Other Fees	$1,507	$1,986	$2,172
TOTAL FEES	$4,507	$6,986	$8,172

HECM Standard - ARM

Home Value	$150,000	$250,000	$300,000
Interest Rates	2.25%	2.25%	2.25%
FEES:			
Mortgage Insurance Premium	$3,000	$5,000	$6,000
Orgination Fee	$3,000	$4,500	$5,000
Other Fees	$1,507	$1,986	$2,172
TOTAL FEES	$7,507	$11,486	$13,172

HECM Saver - FIXED

Home Value	$150,000	$250,000	$300,000
Interest Rates	Ranges from 4.5% to 6.0% (Choice of lender to submit to varies primarily due to different underwriting requirements)		
FEES:			
Mortgage Insurance Premium	$15	$25	$30
Orgination Fee	$3,000	$4,500	$5,000
Other Fees	$1,507	$1,986	$2,172
TOTAL FEES	$4,522	$6,511	$7,202

HECM Saver - ARM

Home Value	$150,000	$250,000	$300,000
Interest Rates	2.50%	2.50%	2.50%
FEES:			
Mortgage Insurance Premium	$15	$25	$30
Orgination Fee	$3,000	$4,500	$5,000
Other Fees	$1,507	$1,986	$2,172
TOTAL FEES	$4,522	$6,511	$7,202

Source: Beth Paterson, Executive Vice President, Reverse Mortgages SIDAC.

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