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THE ROLE OF PRIVATE INSURANCE IN FINANCING LONG-TERM CARE

By Howard Gleckman*

Introduction

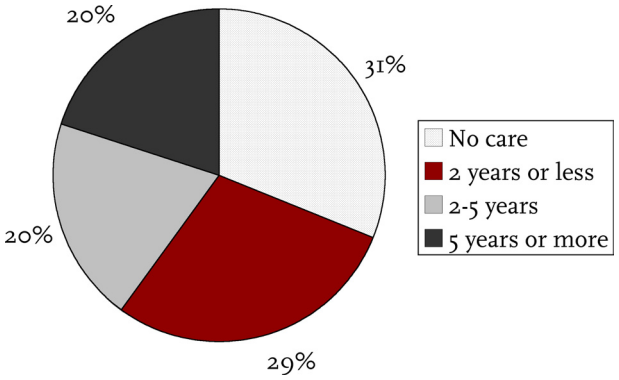
Private insurance currently plays a small, but potentially important role in financing the long-term care of the elderly in the United States. Some believe it can be a significant element in a restructured long-term care financing system. However, to date, the demand for such insurance has been modest. This *brief* will discuss the potential benefits of long-term care insurance, review its current structure and status, and explore possible explanations for low takeup rates. Finally, it will consider future issues surrounding the role of this product.[1]

Overview of Long-Term Care

In contrast to acute medical care, long-term care is aimed at assisting those with chronic illnesses manage their daily lives in relative comfort and security. Such care is provided to both the aged and the disabled, and may include assistance with eating, bathing or toileting, cooking or eating. It may be provided at home or in a nursing home or assisted living facility. Today, about 10 million Americans receive some form of long-term care.

About two-thirds of those over 65 will need some long-term care in their lives, and they will require assistance for an average of 3 years. However, the distribution of need is quite broad. About one-third of older Americans will require no long-term care at all while one-fifth will need it for 2-5 years, and another fifth will need it for more than 5 years (see Figure 1).[2]

Figure 1. Projected Need for Long-Term Care for Individuals Who Turned 65 in 2005



Source: Kemper, Komisar, and Alecxih (2005).

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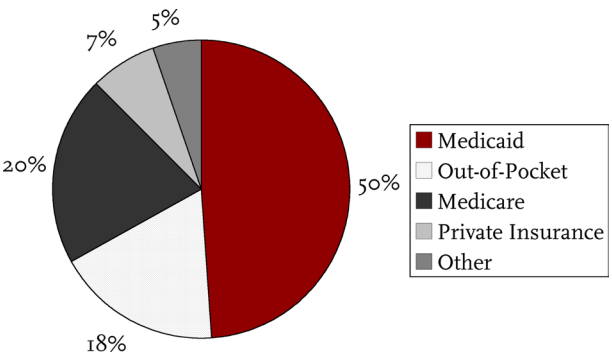
Figure 2. Funding Sources for Long-Term Care, 2005



Source: Komisar and Thompson (2007).

Long-term care can be extremely expensive. A private room in a nursing home costs an average of $75,000 per year. Home health aides cost an average of $18/hr.[3] Therefore, the 40 percent of the older population who will require long-term care for more than two years, and especially those needing assistance for more than 5 years, face potentially severe financial burdens and might well benefit from affordable insurance.

In 2005, families, states, and the federal government collectively spent more than $200 billion for long-term care. About half of paid long-term care is funded by Medicaid, the joint federal-state health program for the poor.[4] Medicare, the near-universal health program for people 65 and older, covers home health or nursing home care in very limited circumstances. However, it does not pay for long-term personal care services.[5] Families pay 18 percent of long-term care costs out of pocket, while private insurance pays only about 7 percent (see Figure 2).[6]

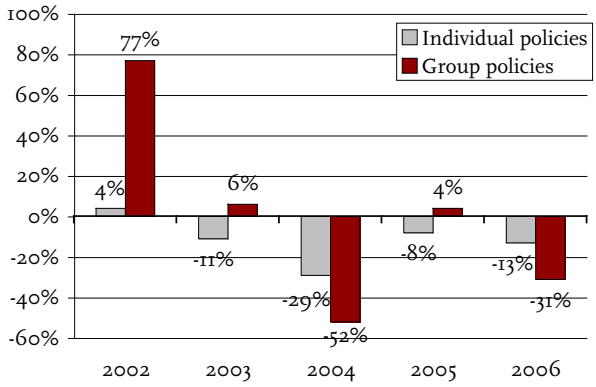
Potential Benefits of Long-Term Care Insurance

Long-term care insurance offers potentially significant benefits to both individuals and government. For individuals, policies pay a portion of the cost of care for those not eligible for Medicaid. This coverage may allow recipients of long-term care to preserve assets for spouses or children. But if long-term care costs exceed the amount covered by insurance, the insurance may only serve to delay the depletion of a household's assets. Even so, such insurance may offer other advantages over Medicaid. For instance, an insurance beneficiary may have greater choice of care settings and providers than a Medicaid recipient. Some home health agencies and nursing homes do not accept Medicaid reimbursement. Other nursing homes limit the number of Medicaid patients they will accept at any one time and often require recipients to share a room. In addition, while Medicaid has been expanding its home care services, many recipients still only receive benefits if they are in institutional care.

For states and the federal government, private insurance may reduce the number of individuals who qualify for Medicaid, thus potentially saving significant amounts of money. Because enrollment in private insurance holds the promise of reducing Medicaid costs, government has encouraged the purchase of such coverage.

Despite the potential advantages of long-term care insurance, to date the product has not proven broadly popular. In 2005, only 6 to 7 million people were covered by long-term care insurance. And sales of long-term care policies have been flat to down in recent years (see Figure 3). The mechanics of long-term care insurance and possible reasons for the low rate of takeup are discussed below.

Figure 3. Sales of Long-Term Care Insurance Policies, Percent Change from Previous Year, 2002-2006



Note: Individual policies reflect the number of covered lives while group policies reflect the number of participants.
Source: LIMRA International (2007).

How Does Long-Term Care Insurance Work?

Long-term care policies pay a share of the cost of home care or institutional services. However, benefits are normally not paid if a claimant is merely frail. Most new policies require that a beneficiary be unable to perform at least 2 activities of daily living (ADLs), such as eating, bathing, or going to the bathroom, without assistance, or suffer from severe memory loss or other cognitive impairment. Older policies — many still in force — pay only if a claimant is unable to perform 3 or as many as 5 ADLs.

Policies normally have an elimination period of 60 to 90 days, which functions as a deductible. During this period, the policyholder is responsible for all costs. Policies also limit the amount they will pay per day, and cap the length of time during which coverage is provided. Many newer policies reduce some of this complexity by offering a "pool of money" which will pay a maximum dollar amount over an agreed-upon period of years.

A policy purchased in 2005 provided an average daily benefit of about $140 with a duration of coverage of about 5 years. Three-quarters of policies also provided inflation protection, so that benefit levels increase over time.[7]

The cost of coverage varies widely. For instance, the average annual premium in 2005 for a 60-year old who buys a popular benefit package was $1,702.[8] However, the actual cost among five companies surveyed ranged from $1,455 to $2,213.

Policies are sold individually and through groups, usually employers. Unlike health insurance, however, employers rarely contribute to premium costs. Underwriting standards may be somewhat more lax in group policies, making purchase through the workplace advantageous to those with pre-existing conditions. This flexibility, however, may also increase prices for these policies.

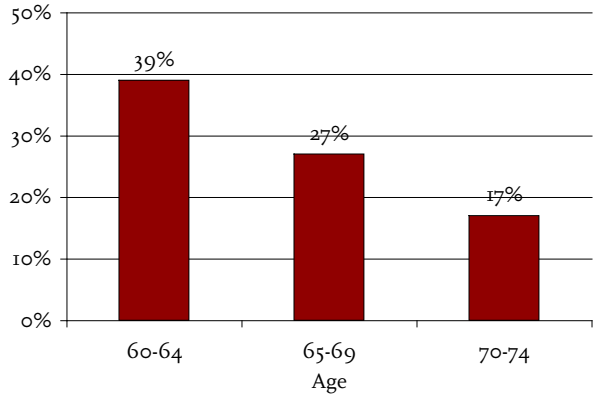
The Role of Private Long-Term Care Insurance Today

Before assessing the future role of long-term care insurance, it is helpful to consider the size of the potential market for such coverage. This assessment touches on questions of affordability, insurability, and marketability.

Affordability

Private long-term care insurance is not inexpensive. While it is far less costly than health insurance, the average annual premium of nearly $2,000 per person at age 65 means that a couple can expect to spend more than $300/a month for this coverage. Based on National Association of Insurance Commission (NAIC) guidelines, an estimated 39 percent of 60-64 year-olds could afford coverage, falling to 27 percent of 65-69 year-olds, and just 17 percent of 70-74 year-olds (see Figure 4).[9]

Figure 4. Percent of Older Individuals Who Can Afford Long-Term Care Coverage (Under NAIC Guidelines), 1998



Source: Merlis (2003).

And while premiums are much less expensive at younger ages, competing financial demands may still make long-term care insurance difficult to afford. According to one study, as many as 76 percent of those aged 35-59 could afford coverage based on the NAIC income and asset test alone. However, only 33 percent of this age group had adequate retirement savings, health insurance, and life insurance and could also afford long-term care coverage.[10]

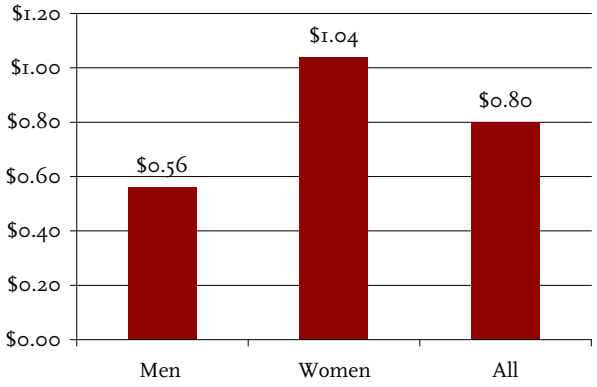
Confusion over government's role in financing long-term care may discourage some purchasers of long-term care insurance. According to one survey, nearly 60 percent of those over 45 believe that Medicare will pay for a long-term care stay in a nursing home. And half believe Medicare Supplemental (Medigap) insurance covers such care.[11] These mistaken beliefs may play a key role in consumers' unwillingness to buy private long-term care insurance.

The role of Medicaid is more complex. One study concludes that, for all but the wealthiest buyers, long-

term care insurance replaces most of the benefits that purchasers would otherwise receive from Medicaid. Thus, Medicaid creates a strong financial disincentive for many to buy insurance.[12] Given widespread confusion over Medicaid's role in paying for long-term care, it is not clear how many potential buyers actually make such a calculation.

The industry's own consumer surveys conclude that price is by far the biggest reason people do not buy their product. In 2005, 83 percent of non-buyers said that cost was an important or very important reason why they declined to purchase.[13]

Figure 5. Expected Long-Term Care Benefits per Premium Dollar



Source: Brown and Finkelstein (2004b).

Recent research suggests that private long-term care policies may be poorly priced. For a mid-range policy, a 65-year old will receive about 80 cents in benefits for every dollar paid in premiums.[14] By contrast, typical health insurance policies pay between 90 cents and 94 cents. In addition, there is evidence that while women may get their "money's worth" from these policies, men do not. Policies are not priced by sex, so that a male and female of the same age and health status pay equal premiums. However, women are far more likely to receive benefits than men, in part because they live longer. The result is that a 65-year-old male will receive only 56 cents in benefits per premium dollar, while a 65-year-old woman will receive $1.04 (See Figure 5).[15]

Insurability

Individuals purchasing long-term care insurance must submit to underwriting, so that those with certain medical issues are uninsurable or may have to pay higher premiums to get coverage. Those who suffer from diseases such as dementia or Parkinson's, or who have received either home health or nursing home care during the past year are normally denied coverage. Others with pre-existing conditions may be offered insurance at higher rates. While estimates vary, one-in-four 65-year-olds may be medically ineligible for coverage.[16]

Marketability

Both the insurance industry and government are exploring ways to encourage more consumers to buy policies. Supporters of these initiatives hope to expand the risk pool sufficiently to reduce premiums and, thus, encourage more buyers.

The industry and independent economists are devising hybrid products that combine long-term care coverage with other insurance. Ideas include tying long-term care to life or disability policies, annuities, or allowing accelerated death benefits under life policies.[17] For instance, one proposal would marry a long-term care benefit with an annuity.[18] Because healthy buyers are attracted to annuities and unhealthy purchasers favor long-term care policies, a combined product would reduce the need for underwriting because carriers could internally hedge the risk of claims against each part of the policy. However, the upfront price would preclude many 65-year olds from purchasing this product.[19] According to one estimate, 10 to 20 percent of households in this age group have sufficient financial assets to buy such a policy.[20]

In an effort to reduce monthly premiums, carriers are aggressively marketing long-term care insurance to younger people. This effort appears to have enjoyed some success. The average age of buyers has dropped from 69 in 1995 to 61 in 2005.[21] While the increase in younger buyers does put downward pressure on premium costs, it also creates other potential problems. It may be 30 years before a 55-year old goes to claim, during which time premiums may increase,[22] carriers may fail, and the nature of long-term care may change in profound but unknowable ways.

The government is also attempting to develop the market for long-term care insurance. One effort is expansion of the Partnership Act. This program, which was introduced in four states in the late 1980s and enhanced in 2005, offers long-term care insurance buyers a trade-off. Currently, unmarried seniors become eligible for Medicaid long-term care benefits only after they spend down their assets to $2,000

(excluding a principal residence, a car and certain other personal property). A purchaser of a partnership long-term care policy is permitted to retain assets equal to the value of the policy and still become eligible for Medicaid. Thus, someone with a policy valued at $200,000 could preserve $202,000 and still qualify for Medicaid benefits.

As many as 22 states planned to participate in the enhanced program in 2007.[23] However, early evidence suggests that Partnership policies are not likely to reduce state Medicaid costs significantly. In the four original states,[24] only 218,000 policies were purchased over nearly 20 years. And simulations in one study suggest that as many as 80 percent of purchasers would have bought long-term care policies even without the Partnership provisions. Because the law exempts more assets for Partnership buyers, those individuals become eligible for Medicaid sooner than if they had purchased traditional long-term care policies, thus increasing government costs for these policy holders.[25]

Both the federal government and at least 24 states also provide tax incentives for the purchase of long-term care insurance. In 2007, individuals between the ages of 60 and 70 may deduct up to $2,950 in premium costs for certain long-term care policies from their federal taxes.[26] However, this benefit is limited, since it is permitted only if total medical costs exceed 7.5 percent of Adjusted Gross Income. Benefits paid through long-term care policies are generally tax free. Individuals may be somewhat more likely to purchase a policy in a state that offers a credit or deduction than in one that does not, but the impact appears to be quite modest.[27]

In another attempt to build a market for these policies, the federal Office of Personnel Management began offering long-term care coverage to 20 million federal employees in 2000. While coverage is quite generous, only about 5 percent of eligible employees enrolled in the federal plan — a take-up rate similar to that of the market as a whole.[28]

Questions for the Future

Like all insurance, long-term care coverage is based on an implicit trade-off: the richer the benefits, the higher the premiums. In recent years, carriers have made a conscious effort to improve benefits by increasing daily limits, offering more flexibility for home-based care, easing claims eligibility standards, and offering generous inflation protection.

The result has been a substantial increase in premium costs, which has been only partially offset by expanding the number of younger purchasers. Given the reluctance of many consumers to buy, industry executives may be rethinking this trend towards better benefits for a price. One survey of industry professionals reported that 35 percent felt that the best way to improve market penetration is to make policies more affordable.[29]

Some carriers are already moving in this direction. Typically, policy riders have provided a 5 percent annual compounded increase in coverage amounts to protect against cost inflation for both nursing homes and home care. However, in an effort to hold down premium costs, some new policies have tied inflation protection to the Consumer Price Index, which has averaged 3 percent over the past 20 years.[30] Actual nursing home costs increased at twice that annual rate over the same period.[31]

Another critical issue for the future is the potential impact of the growing use of genetic testing. As science allows us to know more about the genetic predicates of our future health status, it threatens to make the current underwriting structure untenable. To the degree that insurance companies are aware that certain potential customers are more likely than others to suffer from diseases such as Parkinson's or Alzheimer's, the population most likely to need long-term care coverage will be underwritten out of the market. On the other hand, if carriers are barred from using such information (as is already the case in several states), buyers will have the upper hand. This pricing advantage will be brief, however. Ultimately, a market where those most in need disproportionately buy will suffer from ever-rising premiums. As those costs rise, only those with the greatest need will buy, further driving up premiums — a phenomenon known as a death spiral.

Conclusion

Given ongoing public reluctance to support a universal government program for long-term care, private insurance will continue to play a role in financing such assistance. As fiscal pressures on government payers grow, so will interest in such private insurance. However, without major structural changes and a dramatic expansion in the pool of buyers so risk can be spread more widely, it is not likely that this insurance will ever play more than a niche role in financing long-term care.

Endnotes

1 This piece updates several issues that were addressed in Johnson and Uccello (2005).

2 Kemper, Komisar, and Alecxih (2005).

3 Metlife (2006).

4 Many middle-class seniors spend down their assets paying out-of-pocket for long-term care and, once impoverished, qualify for the program. In most states, an individual is allowed to retain only $2,000 in stocks, bonds, bank accounts, and other liquid assets. A couple may keep $3,000 if they are living together. If one spouse is in a nursing home, the other is allowed half of the couple's assets, up to $101,640. Couples are also allowed to retain one car, personal jewelry, other household goods, and their home. However, they are not eligible for Medicaid if their home equity exceeds $500,000. States are permitted to increase that level to $750,000. See Department of Health and Human Services (2007).

5 For example, Medicare pays for a portion of the costs of a skilled nursing facility for only up to 100 days following a hospital stay.

6 Komisar and Thompson (2007). This estimate includes costs paid by both long-term care insurance and health insurance. It is not possible, using current government data, to know what share is paid by long-term care insurance alone. The long-term care insurance industry estimates that it paid between $3.5 billion and $5.8 billion in claims in 2005. Those estimates, however, may be incomplete, since they are based on voluntary self-reporting by carriers.

7 America's Health Insurance Plans (2007). It is important to note that these averages are for plans purchased in 2005. Many earlier plans, which remain in force, are less generous.

8 The benefit package cited here provides a $100 daily benefit for three years, 90 day elimination period and 5 percent compound inflation (U.S. Government Accountability Office, 2006).

9 Merlis (2003). The NAIC guidelines discourage carriers from selling to those with financial assets of less than $35,000 and for whom premiums would exceed 7 percent of income.

10 Merlis (2003); and Feder, Komisar, and Friedland (2007).

11 AARP (2006). This same survey also reports that nearly one-third of all respondents think they have private long-term care insurance, which is three times the percentage of those who have actually purchased such coverage.

12 Brown and Finkelstein (2004a). Individuals are not eligible for Medicaid until they have exhausted their wealth. In addition, Medicaid is a secondary payer for long-term care services after any private insurance. As a result, many individuals will pay premiums for private insurance that provide benefits that Medicaid would otherwise have paid. Brown and Finkelstein estimate that 60 percent of the private insurance benefits due a male with median wealth would be paid by Medicaid if that person had no insurance. For a woman, the amount of such redundant coverage is 75 percent.

13 America's Health Insurance Plans (AHIP) (2007). It is important to note that these non-buyers were individuals who had some contact with an insurance agent. AHIP did not survey the public at large.

14 Brown and Finkelstein (2004b). Gold, Vanderlinden, and Herald (2006) reached similar conclusions.

15 This return may be even lower when correcting for policies that are allowed to lapse before they go to claim. Brown and Finkelstein (2004a) estimate that a 65-year old man has a 27 percent chance of ever entering a nursing home, while a 65-year-old woman has a 44 percent chance.

16 Murtaugh, Kemper, and Spillman (1995) projected that between 12 percent and 23 percent of 65-year olds do not meet underwriting standards. Spillman, Murtaugh, and Warshawsky (2007 forthcoming) estimate as many as 28 percent would not qualify for coverage. Brown and Finkelstein (2004b) estimate that 15 percent of those aged 60 to 70 suffer from medical conditions that might disqualify them from coverage. There appear to be no credible widespread industry experience data publicly available to test these estimates.

17 Freiman (2007).

18 Warshawsky (2007); and Murtaugh, Spillman, and Warshawsky (2001).

19 For example, Warshawsky (2007) estimates that an inflation-protected policy that pays $1,000 per month in retirement income, with an additional $2,000 to $4,000 (depending on disability level) if the buyer becomes disabled, would cost a 65-year-old more than $225,000.

20 Feder, Komisar, and Friedland (2007).

21 America's Health Insurance Plans (2007).

22 Although carriers have promoted the promise that they will not raise premiums once a policy has been purchased, many have. According to the California Dept. of Insurance, more than 30 carriers nationwide have increased rates since 1990, including 8 carriers still writing policies. See State of Calilfornia (2007).

23 Urban Institute and Kaiser Commission on Medicaid and the Uninsured (2006).

24 New York, California, Indiana, and Connecticut.

25 U.S. Government Accountability Office (2007).

26 Tax-qualified policies must meet certain basic consumer protection standards. More than 95 percent of all policies sold in 2006 were tax qualified.

27 Cramer and Jensen (2006). While the authors did not specifically look at the impact of tax subsidies, their analysis of *Health and Retirement Study* data found that the demand for coverage is relatively price inelastic. They concluded that even a 25 percent price discount — far more than is available through tax incentives — would increase demand by only 11.2 percent.

28 U.S. Government Accountability Office (2006).

29 LIMRA International (2006).

30 Bureau of Labor Statistics (2007).

31 Cost of a private pay nursing home bed. Center for Disease Control, National Center for Health Statistics, author's calculations.

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