

IS PRIVATE LONG-TERM CARE INSURANCE THE ANSWER?

By Richard W. Johnson and Cori E. Uccello

Introduction

As the population ages, more Americans than ever before will need long-term care. The cost of providing services is already straining government and family budgets, and costs are expected to soar in a few decades when the Baby Boomers begin to reach their 80s. One option often touted as a possible solution to the looming crisis is to promote private insurance coverage of long-term care needs. This brief describes private long-term care insurance and some of the advantages and limitations of coverage. Despite ongoing efforts to promote private long-term care insurance, widespread coverage faces a number of important hurdles, including affordability, uncertainty about future premium increases, and the disincentives created by the Medicaid safety net.

What Is Long-Term Care?

Long-term care encompasses a wide range of services for people who need assistance on a regular basis because of chronic illness or physical or mental disabilities. Unlike most health services, long-term care is not generally designed to treat an illness or condition. Although it can include skilled nursing care, it consists primarily of help with basic activities of daily living (such as bathing, eating, dressing, and using the toilet) and with tasks necessary for independent living (such as shopping, cooking, and housework). Although two-fifths of long-term care recipients are under the age of 65, this brief focuses on services provided to older Americans.¹

Older people with the most serious disabilities generally receive round-the-clock care in nursing homes. Only about 5 percent of Medicare enrollees age 65 and older, or about 1.6 million seniors, resided in nursing homes in 2002.² However, 44 percent of 65-year-olds can expect to live in a nursing home now or at some point in the future.³

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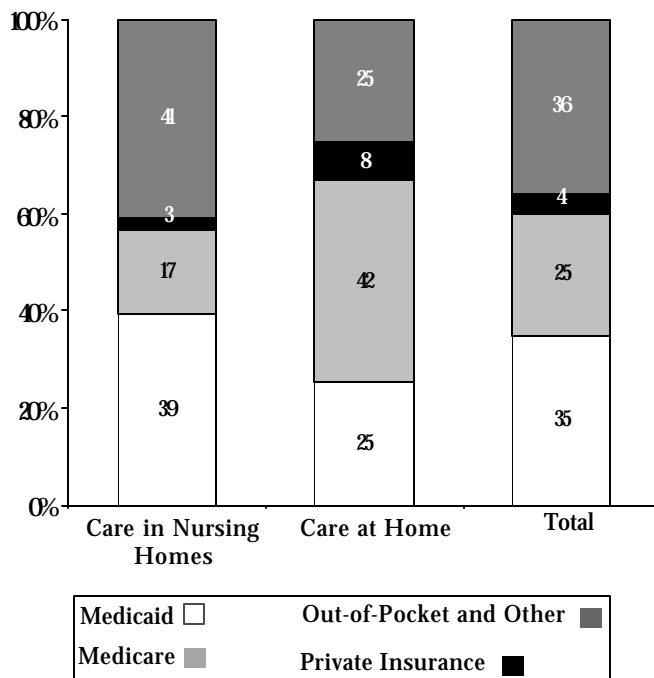
Most long-term care recipients live in their own homes or with their families. About 1.3 million seniors in the community receive care from paid helpers, who provide skilled home care or unskilled care with basic personal activities.⁴ Another 5.5 million older Americans in the community receive unpaid help from family members. The burden on family caregivers of juggling work and other responsibilities is likely to grow in the future as women — who provide most family care — continue to spend more time in the labor force.

Who Pays for Long-Term Care?

The cost of long-term care services, especially nursing home care, can be staggering. In 2004, the average daily private pay rate for a private room in a nursing home was \$192, or about \$78,100 annually.⁵ A semi-private room was nearly as expensive, at \$169 per day, or \$61,700 for the year. Home health aides who provide assistance with personal care activities charged \$18 per hour on average in 2004. At three hours per day, five days per week, annual home care costs would total more than \$14,000.

Figure 1. Medicare and Medicaid Pay for Majority of Long-Term Care Expenditures

Long-Term Care Expenditures for Aged Americans, by Source of Payment, 2004



Source: Congressional Budget Office, Financing Long-Term Care for the Elderly, 2004.

The nation spent an estimated \$135 billion on long-term care for the aged in 2004, devoting 68 percent to care in nursing homes and 32 percent to home-based care.⁶ Medicaid paid for 35 percent of all long-term care spending on older Americans, Medicare covered 25 percent of costs, private health insurance paid another 4 percent, and care recipients and their families paid out of pocket for 33 percent of costs (see Figure 1).

For those who qualify, Medicaid covers nursing home care, home health services, and non-medical home- and community-based care designed to enable persons with disabilities to remain in the community. The program pays for about 39 percent of all care received in nursing homes by the aged and 25 percent of care received at home.⁷ However, individuals must meet strict income and asset tests to qualify. Eligibility rules are complex and vary by state. Some states use the federal thresholds for receipt of Supplemental Security Income (SSI) to determine Medicaid eligibility, which in 2005 are \$579 per month in countable income and \$2,000 in countable assets for unmarried people.⁸ In other states, Medicaid pays for long-term care services for individuals with incomes up to 300 percent of the federal SSI threshold.

People with too much wealth or income to qualify initially for Medicaid can receive benefits once they have spent nearly all of their resources on long-term care services. According to one estimate, about one-third of nursing home residents ineligible for Medicaid when they are admitted deplete enough of their assets to qualify for coverage before they are discharged.⁹ Most states allow Medicaid applicants to subtract medical and long-term care expenses from income before determining eligibility, enabling people with high long-term care bills to get on Medicaid even if their Social Security and pension incomes exceed eligibility thresholds.

Medicare is the principal payer of skilled home health services for older Americans, but coverage of other long-term care services is limited. It does not pay for any non-medical home care, and covers only temporary stays in skilled nursing facilities that follow hospitalizations. Overall, Medicare funded 42 percent of the paid care older Americans received at home in 2004 and 17 percent of the care they received in nursing homes.

Much of the financial burden of long-term care falls on care recipients and their families. Individuals without private supplemental insurance who do not qualify for Medicaid must bear the cost of Medicare deductibles and co-payments, and the entire cost of services that Medicare does not cover. Private long-term care insurance, a relatively recent insurance product, funds only 3 percent of nursing

home costs for older adults and 8 percent of home health costs. Increasing private insurance coverage may reduce financial pressures on public programs and protect families from the catastrophic financial consequences of long-term care.

How Does Private Long-Term Care Insurance Work?

Like traditional medical insurance, private long-term care insurance is a financial contract whereby the insurer agrees to provide covered benefits in exchange for regular premium payments by the policyholder. The long-term care insurance market has grown steadily over the past 20 years. First sold as nursing home insurance in the 1970s, it now covers a wide range of services, including home care, adult day care, and assisted living, in addition to nursing home care. The cumulative number of long-term care insurance policies purchased has increased from fewer than 1 million in 1987 to over 9 million by the end of 2002, but still covers only a small share of the population.¹⁰

Long-term care insurance can be purchased through either the individual or group market. Group plans are typically sponsored, but not subsidized, by employers. Individual policies continue to dominate the market, but employer-sponsored plans are growing rapidly, fueled in part by the creation of the Federal Long-Term Care Insurance Program in 2002, which allows federal employees, retirees, and some of their family members to purchase coverage through the federal government. About one-third of new policies sold in 2002 were sponsored by employers. By contrast, only 18 percent of policies ever sold by 2002 were employer-sponsored plans.

The cost and adequacy of policies vary by the types of services they cover, when they start paying benefits, how much they pay, and for how long. About three-quarters of individual policies purchased today cover both nursing homes and home care.¹¹ In 1990, by contrast, nearly two-thirds of policies sold covered only nursing home care.

Policyholders cannot collect benefits until their disabilities reach the levels specified in their contracts. Nearly all plans now sold use the triggers specified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to qualify for tax breaks.¹² These plans require that beneficiaries need substantial assistance with at least two out of six activities of daily living and that their disabilities are expected to last 90 or more days, or that they need regular supervision because of severe cognitive impairment.

About three quarters of all individual plans

purchased in 2000 also delay benefits for a period of time after the onset of a qualified disability.¹³ More than two-thirds of plans that delayed benefits required policyholders to wait between 90 and 100 days. Only 4 percent stipulated waiting periods longer than 100 days.

Policies limit how much they pay for each day of care and for how long. The average daily benefit for both nursing home and community-based care was about \$100 for individual policies purchased in 2000.¹⁴ Since policyholders often purchase coverage decades before they receive benefits, the growth in nominal long-term care costs can erode the value of the policy over time. Only about 4 in 10 new policyholders in 2000 purchased inflation protection, although the rate was higher at relatively young ages.¹⁵ Inflation protection generally takes the form of a fixed percentage increase per year, typically 3 or 5 percent, so some policyholders may end up with less coverage than they expected if prices of long-term care services rise especially rapidly. In addition, rather than providing lifetime benefits, about two-thirds of individual policies pay benefits for only a limited number of years, generally between two and five years.¹⁶

Soaring long-term care costs could strain government and household budgets.

In addition to charging higher premiums for more comprehensive plans, insurance companies generally price policies based on the age and health of the policyholder at the time of issue. Premiums do not generally differ by gender, even though women tend to use more long-term-care services than men.¹⁷ Some plans offer discounts to married policyholders, especially when their spouses are also covered.

Most insurers classify applicants into three broad health categories: preferred, standard, and substandard. Policies are guaranteed renewable, and rates cannot rise in response to declining health. Instead, premiums remain fixed in nominal terms over the life of the contract. However, premiums can rise for an entire class of policyholders if insurers can demonstrate that their costs exceed premium revenue, and rate increases have been common in recent years.

Premiums increase rapidly with age at issue (see Figure 2). The average annual premium in

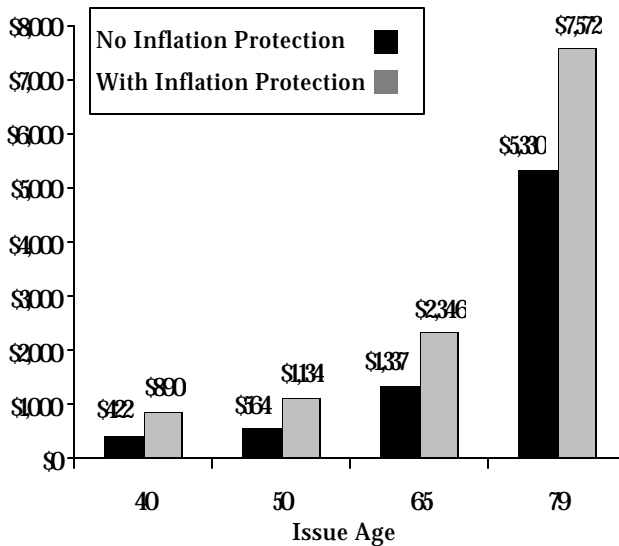
2002 for a policy providing up to four years of benefits, with a \$150 daily benefit and a 90-day waiting period but no inflation protection, was \$422 among 40-year-old purchasers. The average annual premium for the same policy was \$564 at age 50, \$1,337 at age 65, and \$5,330 at age 79. For policies purchased at ages 40 and 50, inflation protection that increases benefits by 5 percent per year, compounded annually, more than doubles the annual premium. For coverage purchased at age 79, inflation protection increases premiums by less than half.

Who Purchases Private Long-Term Care Insurance?

About 9 percent of adults ages 55 and older (or 5.3 million people) had private long-term care insurance coverage in 2002 (see Figure 3).¹⁸ Only 7 percent of those ages 55 to 64 had coverage, but coverage rates among the working-age population are likely to increase as more employers offer long-term care insurance. Men are just as likely to report coverage as women, even though they are less likely to use long-term care services.¹⁹

Figure 2. Premiums for Long-Term Care Insurance Increase Rapidly with Age at Initial Purchase

Average Annual Premiums by Issue Age, 2002

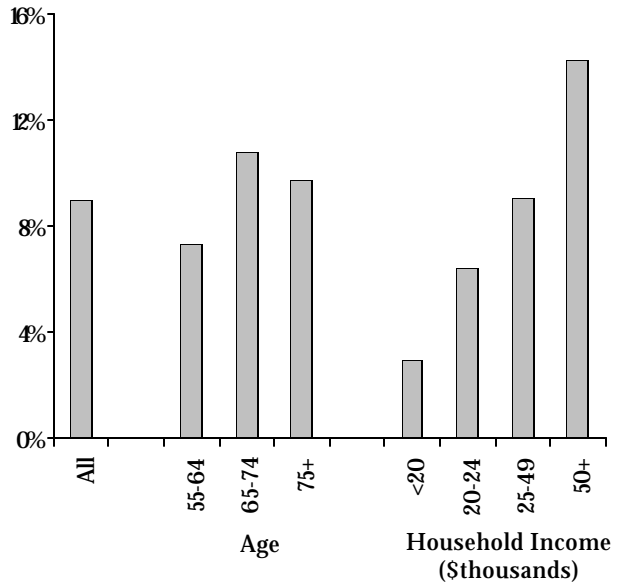


Source: America's Health Insurance Plans, Long-Term Care Insurance, 2004.

Note: The policy provides up to 4 years of long-term care benefits, with a \$150 daily benefit and a 90-day waiting period. The inflation protection option increases benefits by 5 percent per year, compounded annually.

Figure 3. Few Older People Currently Have Private Long-Term Care Insurance

Percent of Adults Ages 55 and Older with Private Long-Term Care Insurance, 2002



Source: Authors' calculations based on the 2002 HRS.

The likelihood of private long-term care coverage increases with income and wealth, because affluent adults can better afford insurance premiums and they would have to deplete their assets to qualify for Medicaid. Only 3 percent of older adults with incomes below \$20,000 and 4 percent with financial assets below \$20,000 had coverage in 2002, compared with 14 percent of older adults with incomes above \$50,000 and 18 percent of those with financial assets above \$100,000. More than half of policyholders had incomes exceeding \$50,000 or financial assets exceeding \$100,000.

What Are the Advantages of Promoting Private Insurance?

Raising private long-term care coverage rates and reducing the current reliance on Medicaid could improve the efficiency and fairness of long-term care financing. Medicaid imposes a 100 percent tax on most assets for those who receive long-term care through the program, penalizing those who save for their old age. The savings rate in the United States is notoriously low, and most Americans do not accumulate much non-housing wealth outside of Social Security and employer-sponsored pension plans.²⁰ By requiring policyholders to set aside funds in the form of premium payments each year, private insurance can raise national savings and thus promote economic growth.

Unlike private long-term care insurance, Medicaid is not designed to protect the assets of those receiving long-term care services. It leaves them with nothing to pass on to their heirs and impoverishes those who return to the community after temporary nursing home stays. Recent Medicaid reforms have increased the level of income and assets that are reserved for spouses, in an effort to provide better financial security for the community-dwelling husbands and wives of nursing home residents. However, these reforms do not appear to have substantially improved the economic security of spouses remaining in the community.²¹

Expanding private long-term care insurance could help make services more affordable.

Another disadvantage of the current system is that Medicaid tends to distort the choice between home- and institutional-based care. Most older adults prefer to remain in their own homes, instead of moving to nursing homes. But despite recent improvements, Medicaid rules still make it difficult for frail older adults to receive subsidized care at home. Federal law stipulates that special Medicaid initiatives to provide home- and community-based services to people with disabilities must not increase Medicaid spending, forcing states to limit eligibility for these services and impose other requirements to keep costs down. As a result, some Medicaid enrollees cannot afford to remain in the community because the monthly stipend that the program allows is too small to cover their living expenses.

The current system also imposes substantial burdens on state governments. Medicaid is a joint federal-state program, with the federal government paying a majority of the costs. Nonetheless, states end up financing a sizable portion of Medicaid expenses. Medicaid now consumes more resources than any other single item in overall state budgets, including elementary and secondary education.²² Long-term care services for the aged accounted for 19 percent of all Medicaid spending in 2002, a share that is likely to rise in the future as the population ages.²³ Increases in private long-term care insurance coverage could reduce the strain on state Medicaid programs.

What Are the Barriers to Private Insurance Coverage?

Despite the advantages of private long-term care insurance, widespread insurance coverage faces a number of substantial obstacles. First, many older adults are simply unable to afford long-term care insurance. For example, 12 percent of married couples and 44 percent of unmarried adults ages 55 to 61 received less than \$25,000 in income in 2000.²⁴ Affordability is an even more serious problem for those who delay purchasing coverage until older ages, when annual premiums are much higher. At ages 70 to 74, 29 percent of married couples and 62 percent of unmarried adults received incomes below \$25,000 in 2000. Some studies have found that only 10 to 20 percent of older adults can afford long-term care coverage.²⁵

Some policyholders are unable to maintain their premium payments and let their policies lapse. Although data on lapse rates are scarce, one study suggests that nearly one in five new policyholders drop their coverage within three years.²⁶ Unexpected rate increases, which can occur when insurers initially price coverage for an entire class of policyholders below cost, can lead to even higher lapse rates. Many plans lack nonforfeiture benefits, which provide partial benefits for those who let their policies lapse. As a result, some who fail to renew their policies receive nothing in return for their premium payments, because most policyholders do not use long-term care services until very late in life.

Those with health problems have special difficulty purchasing long-term care insurance. Private insurers are generally reluctant to write policies for those in poor health, and as many as 15 percent of applicants are denied coverage because of health problems.²⁷ When those with health problems are offered insurance, medical underwriting raises their premiums, making their coverage even less affordable.

A related problem is adverse selection, which can undermine the private insurance market. At a given premium level, those who expect to use many services are more likely to purchase coverage than those who anticipate lower usage. As high-cost users dominate the pool of policyholders, insurers need to raise premiums to cover their claims. But raising premiums discourages more low-cost users from purchasing coverage, leading to even higher premiums. This cycle can lead to a premium “death spiral,” as it is sometimes called, causing private insurance markets to break down.²⁸

The final, and perhaps most important, obstacle to higher rates of private long-term care insurance

is the presence of Medicaid coverage for long-term care needs. Although it is obvious that the Medicaid safety net discourages those with limited financial resources from purchasing private insurance, it can also dampen coverage rates for more affluent people.²⁹ Insurance protects the assets of nursing home residents, but people can not really enjoy their wealth while in nursing homes. People who do not value additional income while in nursing homes will be unlikely to forego income while healthy by paying long-term care insurance premiums. This argument is less compelling, however, for people who expect to be discharged to their homes or for those who attach importance to leaving bequests to their heirs.

Widespread long-term care insurance coverage faces a variety of obstacles.

How Are Policymakers Promoting Private Insurance?

Policymakers are pursuing a number of initiatives to promote private long-term care insurance, including the expansion of tax incentives. Taxpayers can now deduct premium expenses for qualified long-term care insurance plans from their federal taxable income, but only if their total medical expenses (including premiums) exceed 7.5 percent of adjusted gross income. And the amount they can deduct is capped. Many states also offer tax incentives for the purchase of long-term care insurance, and a few offer more generous tax breaks than the federal government. During the 2004 presidential campaign, President Bush proposed extending federal income tax deductions to all long-term care policyholders, not just those whose medical expenses exceed the 7.5 percent threshold.

To encourage private insurance coverage, four states recently reduced Medicaid's strict financial eligibility criteria for those with private long-term care insurance. After exhausting their private insurance benefits, policyholders in California, Connecticut, Indiana, and New York can qualify for Medicaid coverage without depleting their savings.³⁰

Linking private long-term care insurance and reverse mortgages may be another way to promote private coverage. Reverse mortgages are home loans that require no repayment until the home is

sold. Under a law passed in 2000, participants in a government-backed reverse mortgage program could avoid the upfront mortgage premium, which typically amounts to 2 percent of the value of the home, by devoting all proceeds to a qualified long-term care policy. This provision of the law has not yet been implemented, however.³¹

Conclusion

Although they have not received as much attention as the financial problems facing Social Security and Medicare, future long-term care costs are likely to place enormous pressures on government and family budgets. The current system of financing care, with its reliance on Medicaid, is neither efficient nor fair. It forces older adults into poverty before paying for any of their care, and thus penalizes savings. A system based on private long-term care insurance, which protects private assets and provides a mechanism for saving for old age, would in many ways be preferable, but the presence of the Medicaid safety net may frustrate efforts to expand private coverage rates.

Endnotes

- 1 Spector et al. (2000).
- 2 Federal Interagency Forum (2004).
- 3 Spillman and Lubitz (2002).
- 4 These estimates are based on the authors' tabulations of the 2002 Health and Retirement Study (HRS).
- 5 MetLife (2004).
- 6 CBO (2004).
- 7 CBO (2004).
- 8 SSI eligibility thresholds for couples in 2005 are \$869 per month in countable income and \$3,000 in countable assets. Countable assets generally exclude the value of owner-occupied housing, an automobile used to obtain medical treatment, certain burial funds, and up to \$2,000 in personal effects.
- 9 Wiener, Sullivan, and Skaggs (1996).
- 10 AHIP (2004).
- 11 LifePlans, Inc. (2000).
- 12 AHIP (2004).
- 13 LifePlans, Inc. (2000).
- 14 LifePlans, Inc. (2000).
- 15 Cohen, Weinrobe, and Miller (2002).
- 16 LifePlans, Inc. (2000).
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- 18 These estimates are based on the authors' tabulations of the 2002 HRS.
- 19 Spillman and Lubitz (2002).
- 20 Smith (1995).
- 21 Norton and Kumar (2000).
- 22 Health Management Associates (2005).
- 23 O'Brien and Elias (2004).
- 24 Social Security Administration (2002).
- 25 GAO (2000).
- 26 LIMRA International and Society of Actuaries (2004).
- 27 Weiss Ratings, Inc. (2002).
- 28 One possible solution to the adverse selection problem would be to integrate life annuities with long-term care insurance (Warshawsky, Spillman, and Murtaugh 2002). This product would pay an annuity benefit for the life of the policyholder, but would increase the payment upon the onset of a chronic disability or cognitive impairment. Those who are likely to use long-term care services tend to have shorter life expectancies than non-users, so the relatively low value of their lifetime annuities could offset at least part of the cost of long-term care services.
- 29 Brown and Finkelstein (2004); and Pauly (1990).
- 30 Meiners, McKay, and Mahoney (2002).
- 31 Ahlstrom, Tumlinson, and Lambrew (2004).

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CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE

About the Center

The Center for Retirement Research at Boston College, part of a consortium that includes parallel centers at the University of Michigan and the National Bureau of Economic Research, was established in 1998 through a grant from the Social Security Administration. The goals of the Center are to promote research on retirement issues, to transmit new findings to the policy community and the public, to help train new scholars, and to broaden access to valuable data sources. Through these initiatives, the Center hopes to forge a strong link between the academic and policy communities around an issue of critical importance to the nation's future.

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