THE CASE FOR LONG-TERM CARE INSURANCE

by Mark R. Meiners

Prologue: Total national expenditures for nursing home care grew tenfold between 1965 and 1980. Now the Department of Health and Human Services estimates that such expenditures will more than quadruple by 1990, reaching some $82 billion. The median age of a nursing home patient is eighty-one years; thus, not only are most nursing home residents on fixed incomes, but their resources have largely dwindled by paying for institutional care. This set of circumstances poses a dilemma for the nation’s health care system, a dilemma which Mark Meiners discusses in this paper. Meiners, who holds a Ph.D. in economics from Georgetown University, heads efforts at the National Center for Health Services Research to examine long-term care issues. The center’s work has gone on under Democratic and Republican administrations. As a repository of knowledgeable economists and analysts, the center serves as an important policy resource for the office of the secretary of the Department of Health and Human Services. Interest in the subject of long-term care insurance also is increasing in the private sector. One reflection of this increasing activity is a long-term care task force created by the Health Insurance Association of America. Meiners articulates a “reasonable case” for the market potential for long-term care insurance. His proposal comes at an interesting time, with the population aging and thus the need for long-term care increasing. Also, a Republican administration that favors private-sector solutions is in power and, with a staggering federal deficit already looming, little in the way of new public monies is likely to be made available anytime soon. But there would be potential benefits for consumers, too. Now, there are really only two options open to elderly consumers who need long-term care. One is to expend resources down to the level necessary to qualify for Medicaid, and the other is to transfer assets to qualify for Medicaid. Though the second option has been the preferred route, changing government policies may soon close it off. In the face of this prospect, new private sector options must be more closely examined.
Financing long-term care for the elderly is one of the most challenging health care problems facing us today. The dramatic increase in health expenditures for long-term care is straining public budgets and the spectre of a rapidly aging population suggests that the problem will become worse. Frequently overlooked, however, is the fact that financing long-term care is also a significant drain on private resources and that the options for privately insuring against such expenditures are extremely limited. Elderly persons with resources who need long-term care must pay for such services out of pocket. Since such care can be quite expensive, particularly if it is at a level that requires a nursing home stay, people who need it become candidates for the Medicaid rolls.

This paper examines the potential for relieving this dilemma through privately financed long-term care insurance. The reasons for the underdeveloped market are outlined. Medicare and private coverages are reviewed. A prototype policy is formulated and cost estimates are presented as a basis for suggesting the factors which could serve to overcome the resistance to such a market. Barriers associated with insurance regulation and Medicaid are assessed and the private capacity to finance long-term care insurance is examined. The paper concludes that the availability of private long-term care insurance may serve to relieve some of the current pressures on the Medicaid system by providing the elderly with an acceptable alternative to poverty and Medicaid nursing home entry. Suggestions for stimulating the growth of such a market are also provided.

Reasons for Underdeveloped Market

The reasons for the lack of development of a private insurance market for long-term care for the elderly are not entirely a mystery. Bishop, for example, bases her argument for a compulsory national long-term care insurance program on the desirability but unavailability of individual private coverage. She suggests that private coverage is unavailable for a variety of reasons, most notably, the discrepancy between income and the cost of such coverage and the availability of public long-term care programs as a “safety net” for those who are poor or may become poor. Other problems that tend to reinforce private insurers’ lack of interest in covering long-term care are the traditional insurance concerns of adverse

The author wishes to thank Ross Amett, Christine Bishop, Pamela Farley, Judy Feder, Charles Fisher, John Gable, Judy Sangl, and Gail Wilensky for their helpful reviews. The paper also benefited from numerous discussions with Gordon Trapnell and the research assistance of the Actuarial Research Corporation. The views and ideas expressed in the final product, however, are the sole responsibility of the author and no official endorsement by the National Center for Health Services Research is intended or should be inferred. An earlier version of this paper was presented at the Annual Meeting of the American Public Health Association, November 14-18, 1982, Montreal, Canada.
selection, insurance-induced demand, administrative economies, and premium pricing difficulties due to inflation.

Individuals in the insurance business added a number of additional and perhaps overlapping concerns. Meaningful limits for long-term care were felt to be too difficult to establish. Some insurers fear that people who need such care will need it for the remainder of their lives, resulting in an open-ended liability. Traditional thinking within the health insurance field is that nonmedical services are not insurable. Since long-term care is often defined to include personal and social services such as homemaker care, nutritional services, and respite care, along with medical and rehabilitative care, this is thought to have stymied innovation. As a result, targeting coverage on the basis of level of care is felt to be arbitrary and open to challenge. Furthermore, there has been an absence of reliable data on which to base estimates of utilization and costs, particularly data that reflects actual experience with such insurance. Finally, regulation was cited as a barrier.

Evidence also exists that elderly consumers simply do not understand their insurance coverage, or the health care risks they face, enough to effectively demand coverage for long-term care. Some elderly believe that they are already adequately covered for such services under Medicare. Others think they have coverage for long-term care with their purchase of a Medigap policy that includes nursing home benefits.

There also is a preference on the part of most consumers for “first dollar” coverage and the elderly are no different in this regard. Currently, gap-filling insurance products dominate the private health insurance market for the elderly, possibly because of an expressed preference on the part of the elderly or because of an effective marketing campaign on the part of the industry. This may limit the amount of money available for other insurance products such as coverage for long-term care.

What is clear from this discussion is that there are a number of significant concerns that, if accepted, would deter private health insurers’ involvement in covering long-term care services for the elderly. Perhaps the most compelling deterrent at this stage is that there has been, until just recently, little interest in investing in the research necessary to challenge the legitimacy of these concerns and whether they can be feasibly overcome. Nonetheless, it appears there may be some clear benefits from doing so. In particular, the availability for long-term care could provide the elderly a better choice in guarding against catastrophic long-term care expenses and this could reduce the growing pressures placed on the Medicaid system by the elderly needing this care.

**Medicare and Private Coverage**

As a starting point for reviewing the major barriers to determine whether
they can be overcome, it is helpful to examine the market as it exists today. To do this, we must retreat from the concept of long-term care and focus on Medicare coverage for nursing home and home health care.

As many of our elderly have become painfully aware, Medicare was not designed to address the need for long-term care. Though it covers up to 100 days of skilled nursing home care, with the first twenty days completely covered and a copayment for the remainder, users of the benefit have averaged only about twenty-seven days of covered care per year. Medicare’s claims criteria are often complex, restrictive, and subject to the individual judgements of claims reviewers which can vary substantially. Also, only a portion of all nursing home beds are certified for Medicare, limiting a beneficiary’s access to covered care.

Medicare covers home health if an individual needs part-time skilled nursing, physical therapy, or speech therapy and the benefits were recently expanded from 100 visits to unlimited visits. In practice, home health users, like nursing home users, receive nowhere near the limit of care that is covered. Home health users average only about twenty-three covered visits under the old rules. Under the new rules some increased utilization of home health care is expected. However, it is unlikely to be substantial because of the continued requirement that the patient be homebound and receive primary skilled care.

The predominant involvement of private insurance in nursing home care is simply that of filling the gaps in Medicare’s nursing home benefit. Some policies provide for Medicare-defined skilled care to be covered for a fixed amount per day for those days over 100, usually for 365 days but sometimes longer. These coverages are of minimal benefit since few people qualify for much Medicare SNF care beyond the twenty free days.

Removing the requirement that the beneficiary receive care in a Medicare-certified SNF bed is an improvement. As noted earlier, requiring that care be given in a Medicare certified facility limits a beneficiary’s access to covered care. Some insurers have recognized this and require only that the nursing home be licensed as a SNF by the state.

The coverages outlined thus far represent the state-of-practice in private coverage of nursing home care. Since they rely on Medicare’s narrow definition of skilled care, it is not surprising that only 1.5 percent of the elderly’s nursing home expenditures were paid by private insurance in 1980, in spite of the fact that a recent national survey found that about 59 percent of the elderly own an insurance policy that covers nursing home care.

Some examples of improved private coverages can be found and they are suggestive of the way to proceed. One improvement is to simplify the benefit language to cover any confinement in a state licensed skilled nursing home for the purpose of receiving skilled nursing care, thus avoiding Medicare’s narrow skilled care definition. However, coverage below
the skilled level is important for the elderly.

Coverages below the skilled level are typically referred to as intermediate care and custodial care. The definitions for these types of care are difficult to pin down. The concept of intermediate care comes from the Medicaid program.\textsuperscript{14} It is intended to cover what amounts to personal care, with skilled nursing services necessary, but on a less frequent basis than would be the case with skilled care. In practice, the intermediate care definition varies greatly by state with many viewing it simply as a cheaper version of skilled care. The definition of custodial care also varies, ranging from personal care with some nursing to only personal care to simply sheltered living with no specific provision for personal assistance.

Clarifying the distinction between skilled, intermediate, and custodial care has been a major barrier to the development of nursing home insurance. A number of approaches have been used to address this problem by those few insurers who have offered coverage for care below the skilled nursing level.

One approach has been to limit the coverage to skilled and intermediate coverage only. This has the effect of assuring that the care received must be at least personal care with nursing in order to qualify for payments. This type of limitation is essentially the same as exists when custodial care is covered but only when the individual is confined to a SNF or Intermediate Care Facility (ICF).

Another approach is to make the availability of intermediate or custodial care contingent on a SNF stay. For a few liberal policies the SNF stay need only be one day. To guard against unwarranted use of the benefit, insurers have added a requirement that a physician periodically review the patient’s status and certify that no greater or lesser care is needed than is covered.

Although the market is still very limited, it is encouraging to find that some private insurers do cover long nursing home stays for care below the skilled level. Long-term home health care insurance is rare. The fear is that home care will be so much more desirable than nursing home care if it is made available that there will be excessive utilization, particularly since any further liberalization of Medicare means removing the home-bound requirement or reducing the care required below the skilled level.

Prototype Policy

As a basis for discussing the important considerations of workable long-term care insurance, I have outlined a simple prototype policy. The major features are that it focuses on nursing home care, it is sold to the elderly at age sixty-five during a limited open period, it covers a stay of up to three years after a ninety-day deductible is met, and it is an indemnity policy paying a fixed amount per day with a maximum payable limit.
The data, assumptions and calculations are summarized in Exhibit 1. Assuming the hypothetical group of purchasers follow current utilization patterns, the annual costs of the benefits paid are estimated to be about $326. Using a loss ratio of .75 for group coverage and .60 for individual policies, the annual premiums would be $435 and $543, respectively.

Exhibit 1
Long-Term Care Insurance Prototype Premium Estimates: Data, Assumptions, and Calculations

- Policy covers up to three years of care after a ninety-day waiting period.
- Policy pays $35 per day. The 1977 private pay monthly charge for those with stay of six to twelve months is $710. The December, 1981 National Nursing Home Input Price Index is 143.5 (1977=100.0). $710 x 143.5 = $1019 per month, $1019 ÷ 30 = $33.96 per day.
- Life expectancy at age sixty-five is 16.3 years.
- Forty-six percent of all nursing home residents were discharged or died after a stay of at least ninety days. Thirty percent of those persons discharged alive within ninety days went to another health facility, and may possibly have to return to continue a nursing home stay. Assuming all of those discharged to another health facility who didn't die there came back to continue their stay, a maximum of 62 percent of all discharges had a stay of ninety days or more.
- Assume that all those who have a stay of ninety days or more will remain in the nursing home at least three years.
- Assume that the lifetime nursing home admission incidence rate for the elderly is 20-25 percent.
- If 20 percent of the elderly are admitted to a nursing home and 62 percent of them qualify for full coverage under the policy, the incidence rate for full coverage is 12.4 percent. If 25 percent is the nursing home admission incidence rate, the lifetime incidence rate for full coverage is 15.6 percent. Assume a 14 percent lifetime incidence rate for full coverage.
- If 14 percent of a hypothetical population of purchasers actually use the full 2.75 years of benefits the average lifetime liability per purchaser is $35 x 365 days x 2.75 years x .14 = $4918.
- Assuming that 86 percent pay the premium for their expected lifetime (16.3 years), and that the 14 percent who are expected to be users, pay the premium an average of eight years (after which they are no longer required to pay), the weighted average payment period is 15.1 years.
- Given a lifetime liability per person of $4918 and an average payout period of 15.1 years the annual benefit cost is $4918 ÷ 15.1 = $326.
- Assuming a loss ratio of .75 for group policies and .60 for individual policies, the annual premiums would be $435 and $543, respectively.

---


individual coverage (the minimum proportion of the premium paid out in benefits as recommended by the Voluntary Certification Program, a federal effort to meet certain standards for regulating Medicare supplement health insurance policies), the annual premium would be $435 and $543, respectively. In other words, the monthly premium would be in the range of $36-$45.

These estimated premiums are not considered insignificant since they would have to be paid over the lifetime of the aged purchaser (users of the benefit are assumed to pay until the benefits begin). Nonetheless, they are an encouraging first approximation. The estimated premiums are substantially less than had been suggested during my initial conversations with individuals from the insurance industry and they are based on several assumptions that are clearly conservative. To simplify the calculations, I have assumed that all those who are in a nursing home for more than ninety days will stay the entire three years and, thus, qualify for 2.75 years of coverage. This contributes to an overestimate because people are actually discharged over the entire period. Also, the discharge data imply that some allowance for additional payments should be made to account for the fact that about 35 percent of those discharged within ninety days went to another health facility and may actually have a longer stay than can be determined from the available data. Erring on the high side again, I have assumed that all these discharges would qualify for the full benefit period. This raises the estimate of the proportion of long-stayers from 45 percent to 62 percent and raises the estimate of the incidence rate for a stay of three years from 10 percent to 14 percent.

Unfortunately, no information was found to reasonably adjust the estimates for insurance induced demand or selection factors. However, the average utilization frequencies derived from the general population, by including the large portion of patients relying on Medicaid or other public programs, do reflect some of the effect of third-party payments. Also, careful selection by insurers, such as rejecting applicants in poor health or with other characteristics that make a nursing home stay more likely, could reduce utilization below the patterns found in the general population. Average frequencies derived from data covering the entire population were used because the intent is to examine the feasibility of covering a substantial proportion of the population.

It is beyond the scope of this paper to attempt a more refined set of estimates though this work is currently underway in an effort to provide a better understanding of the trade-offs involved in alternative policy specifications. The calculations, however, do demonstrate that there are some reasonable limits that could be placed on such insurance which may be acceptable to both the buyers and sellers.

The fear that everyone who enters a nursing home will be there for a long stay is not substantiated by the best available data. A significant
proportion (38-55 percent) of people who use nursing homes are short-stayers. They enter from a hospital after an acute episode and either get better or die within ninety days. Furthermore, only about 10 percent of the people who are admitted to a nursing home are there for more than three years and only about 4 percent are there for more than five years. Thus, there are distinct, limited periods during which coverage might reasonably be sought by the elderly. For those who exceed these limits, Medicaid may be expected to be more acceptable. In the following sections further elaboration on some of the important features to be considered in structuring insurance coverage for long-term care is provided.

Service Benefits

Though the prototype policy focuses on a nursing home stay, it is not my intent to limit the benefit to only nursing home care. Rather, the allowable cost of the nursing home stay serves as the basis for the upper limit of the insurance company’s liability. The services to be covered should include home health care along with the other services which can be provided in the home to substitute for care in the nursing home. Broadening the coverage to these other services would avoid a bias toward institutionalization and provide the beneficiary the opportunity to shop around to obtain the maximum benefit for his premium dollar. In some circumstances noninstitutional care will cost more than the nursing home care, in which case only an amount equal to the nursing home stay would be paid and the beneficiary would have to pay extra for choosing a preferred, but more expensive, set of services.

It would be best if eligibility for home care benefits could be determined prior to institutionalization. We would like to be able to screen individuals on the basis of a set of criteria (for example, need for assistance in activities of daily living, such as feeding and going to the bathroom) which would be limited in scope so as to keep administrative costs down, reliable enough to determine whether a person would otherwise need institutional care, and that would stand a legal test. This is a difficult challenge and potentially controversial in light of the state of the art in preadmission screening but we are moving in the direction of developing such screening devices. With this kind of assessment, the insurer could feel more comfortable in approving home care as a substitute for nursing home care prior to any institutionalization. The most likely first step for insurers, however, is to allow the home health services after a covered nursing home stay begins. This is the safest approach because it provides some assurance that the beneficiary is in need of nursing home care.

Home care benefits are also likely to be important for purposes of marketing this type of insurance. There is a general distaste for nursing homes on the part of the elderly. Allowing for consumer preferences may serve
to assist in selling the idea to the elderly. Insurers will also benefit if beneficiaries seek out care packages which cost less than a nursing home stay. The one area where cost savings appear to be captured when alternative long-term care services are offered is in the context of insurance plans where substitution of one level of care for another can be directly encouraged by the provisions of the policy.17

The amount of coverage offered for home health care is not directly addressed in the prototype policy. Relatively little is known about utilization patterns for home health care and, as noted earlier, there is an understandable wariness on the part of insurers to cover such services at all, much less for an extended period. There are several possible approaches to this problem. One is to limit the period of coverage, another is to limit the amount of visits, and a third is to limit the amount paid per visit. Any of these would reduce the insurer’s potential liability. For the consumer, the most acceptable approach would be to limit the number of visits per week. Since it is reasonable to assume that someone who chooses to be cared for at home can get along on intermittent care, a maximum of three to four home visits could be specified. Leaving the maximum allowable period of coverage in the prototype as three years of either home care or nursing home care or some combination, we could actually reduce the estimated cost because some of the people we assumed might stay the full three years will be able to go home. Even if the beneficiary required care for all of the remaining benefit period and we agreed to pay up to $35 per visit, the visit limit would substantially cut benefit costs.

Waiting Period

The choice of ninety-day waiting period for benefits to begin has considerations worthy of note to both buyers and sellers. About three months in a nursing home tends to be the critical break between whether a patient is going to be a long-stayer or a short-stayer.18 It is the long-stayer who needs protection from catastrophic long-term care expenses. Without such protection, the likelihood of having to go on Medicaid because of heavy medical expenses is greatly increased. Though a stay of three months in a nursing home will cost at least $3,000, some of this expense may be covered by Medicare if the care needed is continuous and skilled. However, since Medicare tends to cover only between twenty to thirty days of care per beneficiary, the policy owner might expect to have to pay several thousand dollars for their own care before their private insurance benefits begin. There is no question that this is a significant amount. In fact, it is the situation now faced by an elderly person needing extended nursing home care. The benefit to the consumer and his family, however, is that there is a foreseeable limit to how much they may be liable. For
the insurance company, the ninety-day waiting period represents a significant deductible which should serve to deter unwarranted utilization of benefit and one which the elderly beneficiary is unlikely to want to fulfill unless it is really necessary.

Associated with the specification of the waiting period is the issue of whether there should be a link with prior utilization, such as the Medicare requirement that a skilled nursing facility stay be preceded by a three-day hospital stay for the same injury or illness. There has been considerable debate on the value of such a clause. The intent is to limit utilization to services that are clearly medically necessary. Critics argue that it simply increases the cost of care by imposing an expensive hospital stay when the patient could have been directly placed in the skilled nursing facility. A recent evaluation supported the latter claim, but the research has been criticized by the Department of Health and Human Services (DHHS) as overestimating the amount of excess hospitalization that occurs.\footnote{19}

With a ninety-day elimination period it is questionable whether such a clause is necessary. However, I expect the level of care covered would have to involve, at least, the need for intermittent nursing care and not be solely custodial care. If purely custodial care were offered, it would be reasonable to make it contingent on receipt of a higher level of care for at least some portion of the elimination period. Similar issues would have to be considered for a home health benefit waiting period. As mentioned earlier, the most acceptable first step would be to link the benefit to a covered nursing home stay.

### Length of Coverage

The three years of coverage specified in the prototype policy is an arbitrary choice intended to encompass a reasonably large portion (90 percent) of all nursing home stays. The National Center for Health Statistics (NCHS) data indicate that if the coverage had been for two years, 85 percent of the stays would have been covered, and that if coverage would have been for four or five years the proportion of stays covered would be 94 percent or 96 percent, respectively. Even allowing for some underestimation of actual length of stay for those who were discharged to another health facility and ultimately continued their nursing home stay, coverage for up to three years would substantially reduce the likelihood of an individual ever having to use Medicaid. The other options for length of coverage could also be offered with appropriate adjustments to the premium. For those beneficiaries whose stay exceeds their benefit period, Medicaid would act as the payer of last resort.
Indemnity Benefit

Most health insurance sold in this country is designed to pay the “reasonable and customary” charge for specific services when they are actually provided and billed to the policyholder. The prototype policy does not follow this approach. It is an “indemnity policy” designed to pay a fixed amount for each day of covered service. There are a number of good reasons for using the indemnity benefit approach for long-term care insurance.

The most obvious reason is that it is a simple way to limit the insurers’ liability and reduce the risk of providing insurance. Service benefit policies are much more open ended. With insurers already hesitant about their ability to put limits on long-term care coverage, this additional risk should probably be avoided.

The indemnity benefit approach may also serve to hold down costs. Open-ended service benefits in health insurance policies have been criticized as a primary contributor to the rapid inflation in health care costs. By removing much of the financial risk from the beneficiary and paying whatever providers usually charge for services, there is little or no incentive on the part of any of the important decisionmakers to hold down costs. The indemnity benefit approach, by setting definite limits on the amount that will be paid, will encourage the beneficiary to be cost conscious and signal providers that their patients do not have unlimited resources available for their care. With this spelled out in advance, providers should be able to work with the patient and their family to plan an affordable long-term stay in a nursing home, should it be necessary.

The choice of $35 as the daily benefit in the prototype policy represents an estimate of the amount necessary to cover 100 percent of the current average daily charge. In some areas of the country this will be too high and in other areas too low. The amount necessary will also vary depending on the level of care actually received, which itself may vary over the period of coverage. It is relatively easy for an insurer to offer a choice of alternative daily benefits at the time of purchase. It is not so straightforward to provide for protection against inflation.

Adjusting the indemnity benefit for inflation clearly seems necessary. Nursing home costs have been the fastest growing component of our national health accounts and the largest portion of that rise has been attributed to inflation. While the recent estimates show signs of diminishing growth in nursing home expenditures and the general inflation rate has dropped, optional inflation protection is likely to be an appealing and worthwhile feature of long-term care insurance.

One approach would be to offer an annual inflation adjustment. The additional coverage would be optional, limited in amount, and require only that the beneficiary pay the increased premium. This type of option
has become fairly common with life and disability insurance plans. Large increases in coverage could be offered but probably would have to require that the beneficiary fulfill the same requirements as in the original application for coverage and also fulfill an additional pre-existing condition waiting period before the increased benefits could be paid.

Another consideration is that the indemnity benefit approach is likely to be more acceptable to long-term care providers than for most other health care providers. Because of the heavy involvement of Medicaid in financing nursing home services and the fact that most states use reimbursement systems with limits that effectively amount to flat rate payments adjusted for inflation, the nursing home industry is already heavily reimbursed using what amounts to an indemnity benefit approach similar to that being suggested.

This is not to say that the nursing home industry is particularly satisfied with Medicaid reimbursements. Private pay patients tend to be preferred because they can be charged what the market will bear, and nursing homes are selective about the Medicaid patients they admit. They prefer to take the lighter care patients first so as to maximize coverage of their costs. Nonetheless, nursing homes do depend on Medicaid payments for about half their patient revenues. In the current environment of limits and the spectre of cut-backs in government funding, providers are concerned about encouraging additional private funding. Providers may well view a private indemnity payment at the level of what Medicaid covers in their state as a preferred alternative, particularly if it leads to a reduction in the uncertainty and paperwork associated with the public programs.

**Financing Mechanisms**

Up to this point the discussion has focused on the insurance coverage of the prototype policy. The financing mechanism for such coverage can be viewed as a separate issue with several alternatives. The suggested approach is modeled after whole life insurance where the purchaser agrees to pay a fixed annual premium over the life of the policy in return for a lifetime guarantee of benefits at the agreed upon level. It is assumed that people buy the policy at age sixty-five and pay for it throughout their remaining life except when they are actually receiving benefits. This involves a shifting of the costs from those in their eighties to the relatively young elderly.

It might be asked why someone in their eighties would continue to pay the premiums? The answer is that it is for those people that the premium is the best buy relative to their expected risk. The current rate of institutionalization in a nursing home rises from 4.8 percent for those sixty-five and over to 10.3 percent for those seventy-five and over to 21.6 percent for those eighty-five and over.21 The expectation is that, barring unforeseen
circumstances, the elderly who purchase the policy would plan to maintain their protection. An optional version could be to structure the payments so that the benefit would be fully paid by a certain age. Also, there is no technical reason why the policy could not be sold to older age groups with appropriate premium adjustments, although there are probably age limits beyond which there may be too many practical difficulties.

Implicit in the level premium approach is the potential for the insurer to earn interest on the excess reserves accumulated in the early years of a policy. The value of these earnings are not factored into the premium estimates provided earlier but they could be used to further reduce the cost or increase the benefits of the plan.

The excess reserves do amount to forced savings, the return on which will be determined by the insurer. In the case of whole life insurance, the rate paid on these savings has been a source of controversy because it is often difficult to know the actual rate of return and some feel that individuals could do better by simply buying term insurance and investing the remainder on their own. An alternative approach then would be to structure payments along the line of term life insurance where the premium payments increase with age to reflect the increasing risk.

There may be several reasons for preferring an increasing payment schedule to fixed payments. One has to do with marketing. It may be difficult to get the “young-old” to purchase the coverage if they feel that the risk of needing it is low. Premiums structured to reflect actual risk at a certain age rather than the expected lifetime risk might be more acceptable and serve to encourage greater participation in the insurance plan in the younger age groups. The problem with this approach is that as people age, their income tends to be inversely related to their expected risk of needing long-term care. What is likely to happen is that the healthiest people will decide to drop their insurance when they reach the higher cost age groups leaving only those who probably will use the benefit as policy holders. This in turn would push costs up, effectively making people uninsurable at the time when their need for such coverage is the greatest. The fixed premium approach avoids this problem and can be structured to have similar incentives for early participation if policies are offered at various ages with the premium cost set at the time of purchase to reflect the age at purchase.

A more compelling argument for the term approach, with its increasing payment schedule, could be uncertainty of government involvement in financing broader benefits through either Medicare or Medicaid or some other national program. If consumers felt there was some chance of expanded public coverage of their long-term care needs, they may well prefer to buy insurance that did not require forced savings. This, as well as concerns about the rate paid on those savings, could be addressed in the level premium approach by allowing for greater sharing of both the
risk and return between the insurer and insured such as exists in universal life insurance. Universal life insurance is being marketed currently as a better alternative to the whole life approach because it provides a clearer separation between the savings and insurance component of the agreement. Though there are some features that may be worthy of consideration in structuring the long-term care insurance payment mechanism, those issues are beyond the scope of this paper.

Other possible funding mechanisms include a single premium approach modeled after an annuity and a prefunded approach modeled after Individual Retirement Accounts (IRAs). These approaches overlap in that a lump-sum payment could be made from funds accumulated in an IRA or from any other pension funds or personal savings. The major difference would be that the insurance would be purchased with a lump-sum payment rather than over the life of the policy, (this may entail some adjustment of the premium to reflect the elimination of the risk of withdrawals from the plan). Such preretirement funding has the advantage of reducing the annual payment by spreading the cost over a longer period and minimizing adverse selection because people commit themselves to owning such insurance before they could reasonably predict their need for the benefits. Another possibility is to have long-term care insurance included in employee fringe-benefit packages that can be continued into retirement years.

Each of these suggestions for prefunding benefits, however, should be recognized as worthy of attention now as potential mechanisms for financing long-term care for the elderly in the future. They do not address the problem as it exists today. Furthermore, barriers to such prefunding do exist. Unless the tax benefits exceed those currently available with an IRA, any such retirement account for long-term care is likely to receive lower priority in consumer savings decisions because it is less general in terms of the uses to which those funds may be put. Since IRA funds can be used to buy long-term care insurance or anything else, the market for a long-term care insurance account is likely to be limited to those few individuals who can afford to save more than the $2,000 allowed under the IRA program.

Including long-term care insurance as an optional employee benefit may also not accomplish the goal of broader population coverage of long-term care needs. Younger, healthier individuals are likely to choose health insurance policies without such benefits since their risk is so small and they have other options such as disability insurance and greater family resources to draw on. This would result in the situation as it exists today with little or no insurance for anyone for long-term care.

By assuming a targeting of the policy to newly retired elderly, we focus on those most likely to recognize the need for long-term care services at a time when they are considering their options for supplementing Medicare.
It can be argued that this will result in too short a time frame for expenses to be reasonably spread. Perhaps this is true (though the estimates don’t confirm it), but the specifics of this argument cannot be clarified until we know more about the actuarial cost, the specific commitment of consumers to continue to participate, and the characteristics of the pool of individuals over which the expense might be spread. Spreading the risk over a broader population is an obvious alternative. Preretirement marketing, however, will probably be most effective if it is targeted for people who are at least fifty. It is around this age that family resources for child rearing expenses begin to be freed-up and the time when adults may begin to consider their own potential need for long-term care as they recognize the effect of the aging process on their parent’s health care needs.

**Regulation as a Barrier**

Health insurance policies sold to the elderly are subject to a complex array of regulatory requirements covering topics ranging from the solvency of the company to the size of print used in advertising materials. Because insurance regulation is traditionally a state function, the requirements often vary from state to state. In such an environment it is not surprising to find regulatory barriers to a new product such as long-term care insurance.

The most interesting case is in Wisconsin where the State Insurance Commissioners’s office established a set of specific standards for nursing home insurance that effectively eliminated the sale of all such policies in the state except for one policy with very high premiums which probably should be viewed as experimental. Four key provisions caused concern. First, coverage could not be limited to only certain levels of care. Second, coverage must be for any care received while a resident of any licensed nursing home. Third, coverage cannot be limited to care received after a hospital confinement. Fourth, that policies could be subject to a deductible of no more than sixty days per lifetime. Since the Wisconsin definition of a nursing home is quite broad, including very small boarding homes where only personal care was provided, insurers felt that they were being asked to bear unreasonable risk. The Wisconsin regulations were implemented as a direct response to what was viewed as an inability on the part of elderly consumers to adequately understand the coverage they were purchasing and the potential for abuses arising from the lack of knowledge. Unfortunately, the effect may be to stifle innovation.

More typically, insurers find that they must conform to existing insurance regulations, many of which are not applicable to a long-term care policy. Since such insurance is sold to persons over age sixty-five, it is common to find it subject to the regulations of a Medicare supplement policy even though this may not be appropriate. The New York insur-
ance law, for example, has been interpreted to require that insurance companies must make coverage available to holders of Medicare supplemental insurance for copayment amounts for nursing home confinements covered by Medicare. Regulations of this sort act as barriers to long-term nursing home benefits because they force consumers to spend their limited insurance dollars on gap rather than catastrophic coverage. The New York law actually puts direct limits on the amount of nursing home care that can be offered by requiring a direct trade-off of two nursing home days for one hospital day, not to exceed the number of covered days of hospital care provided under the contract in a benefit period.

Even the recently instituted Voluntary Certification Program has provisions that may hinder the development of long-term care coverage. In addition to encouraging all such policies to fill the deductible and copayment gaps for hospital services in Medicare Part A, the program calls for pre-existing condition clauses of not more than six months and minimum loss ratios of 60 percent for individual policies and 75 percent for group policies.

Clauses for pre-existing conditions are included in policies to protect the insurer from having to pay benefits for people who purchased the policy because they were virtually certain of needing the covered services. While the purpose for such clauses is legitimate, there have been abuses which have prompted regulatory attention. For long-term care insurance, it is not so clear that a maximum six-month, pre-existing clause is appropriate. Given the potentially large liability of such coverage and the difficulties to use it, longer pre-existing waiting periods may be warranted. The resulting reduction of risk for the insurer should lower the cost to consumers and encourage wider availability of such coverage.

Loss ratios, the percentage of premiums returned to the policyholder, are one way to measure the relative value of an insurance policy. Regulatory attention has focused on this measure because some Medicare supplemental policies have been found to return very little to the beneficiary. In the case of long-term care insurance as structured in this paper, we would expect low loss ratios in the early years of the life of a policy to compensate for the higher loss ratios in later years when payouts increase. As such, it would not be feasible to meet a fixed annual loss ratio requirement until the policy had been sold for a reasonable length of time. Regulation must be flexible enough to allow for differences between long-term care products and Medicare supplemental products.

Long-term care insurance could also benefit from regulatory flexibility in the handling of the reserves for tax purpose. Currently, regulations for health and disability insurance make no special provisions for the earnings on reserves. As a result, about half of the earnings are paid in taxes. In contrast, the earnings on reserves in whole life insurance policies are tax exempt to the extent that they are used to cover premium payments.
Part of the problem is that the regulatory statutes for health and disability insurance are separate from those for other types of insurance, and there is a tendency to be rigid in applying the standards. If state regulations were adjusted to allow long-term care insurance to establish a schedule of reserves that included an earnings factor, the Internal Revenue Service might be encouraged to permit the same tax benefits currently available on whole life insurance.

**Medicaid As A Barrier**

An important factor encouraging growth in Medicaid long-term care expenditures is eligibility criteria that permit a large portion of those persons needing nursing home care to be reimbursed through the Medicaid program. The core group of aged Medicaid eligibles in every state are recipients of Supplemental Security Income (SSI), a cash welfare program for the aged, blind, and disabled. State programs may also choose the option of covering the “medically needy,” those persons whose income exceeds the SSI income standard, but whose medical expenses exceed the difference between actual income and the state medically needy income standard. Thirty-one programs have elected this option, which enables a large portion of a state’s nursing home population to be eligible for Medicaid. Most states without medically needy programs have spend-down provisions for institutional long-term care. These allow persons to deplete their assets and income to become eligible for Medicaid.

The elderly who become eligible for Medicaid through the spend-down process must first exhaust most of their assets. The resource limits are often quite restrictive. Frequently, they follow the SSI criteria which puts limits on the value of personal resources of $1,500 ($2,250 for a couple) and on the total equity value of personal effects and household goods of $2,000. Other restrictions can also apply. The assets criteria for Medicaid eligibility are complicated and they vary by state and sometimes by county. Only after a person fulfills the assets criteria do income spend-down provisions take effect.

The elderly who become eligible for Medicaid through the spend-down process must pay the majority of their income toward the cost of care but they are protected from nursing home expenses that exceed their income. Thus, Medicaid functions as a safety net in this country for many persons needing nursing home care. Since the elderly are potentially eligible for basic protection under the Medicaid program, some private insurers and long-term care analysts have hypothesized that long-term care insurance cannot compete with the influence of the existing safety net.

The complexities of the process by which Medicaid eligibility is established, however, can be enormous. After their in-depth review of the process, Davidson and Marmor point out that “any attempt to answer a
question as broad as ‘who is eligible?’ is complicated by the numerous
and frequently subtle variations found in both the medical and cash-
assistance programs.” They go on to conclude that “the effects of spend-
down are subtly punitive: an older person does not become eligible for
medical assistance until he has been struck by serious illness and has
depleted income and assets to a point of total dependency.”

To investigate whether a significant number of the elderly are not pro-
tected by the Medicaid program, we can begin by using the income stand-
ards in the most generous state programs as of 1980. Of the states with
“medically needy” programs, Rhode Island provided the highest level of
income protection for families of one person and Wisconsin provided the
highest level of income protection for families of two persons, $4,400 and
$5,544 respectively. Medical expenses which push the family income
below these levels may qualify for coverage by Medicaid. Assuming the
annual cost of nursing home care was about $12,000, all aged individuals
with income over $16,400 and all aged couples with income over $17,544
would be ineligible for any Medicaid nursing home subsidies.

In addition to those who would be ineligible for Medicaid because
their income is too high, there are those who would not view Medicaid as
a reasonable substitute for insurance because it would pay only a portion
of their bills. The income level at which Medicaid is perceived as an
adequate substitute for private insurance is an arbitrary choice subject to
individual judgment. Two possible criteria would be the proportion of
income protected and the proportion of the bill paid. For example, if we
assume that people would want Medicaid to protect at least 35 percent of
their income (the approximate cost of maintaining a home), our example
would yield an income maximum of $12,571 for an individual and $15,840
for a couple, beyond which people would be interested in long-term care
insurance. If we assume that people would want Medicaid to pay at least
50 percent of the nursing home bill, our example would yield an income
of $10,400 for an individual and $11,544 for a couple.

Based on these three criteria, the number of elderly who would not
view Medicaid as an adequate replacement for private coverage would
range from 500,000 to 1.3 million one-person families and from 2.2 to 4.0
million couples (7 to 17 percent and 30 to 54 percent of elderly individu-
als and couples, respectively) according to 1980 income estimates from the
US. Census Bureau. Though these calculations are rough, it is safe to
view them as conservative. They are based on income standards that are
substantially more generous than exist in other states and the additional
eligibility requirements relating to limitations on assets are not considered.

On the basis of income alone, it seems clear that a significant number
of the elderly would not view Medicaid as a reasonable insurance alternative.
Other factors such as Medicaid’s institutional bias and uncertainties about
who can expect to receive benefits reinforce this view and serve to ex-
pand the pool of persons potentially interested in long-term care insurance.

Private Capacity to Finance

Not all elderly consumers will find private long-term care insurance attractive. Some already will be eligible for Medicaid and others will be either too poor to pay the premiums or have income and assets so limited in amount that they would not rationally view such insurance as a good buy. To establish the potential size of the market, we must determine the private capacity to finance long-term care insurance.

Income, savings, and the value of liquidated assets are the potential sources of the necessary funds. However, it is discretionary income defined in the broadest sense on which we need to focus. Long-term care insurance, or any other new product or service for that matter, is not likely to be purchased until the standard necessities such as food, housing, clothing, transportation, personal care, and medical care are adequately covered. Annual budget estimates for a retired couple that include these items at three levels of living are made by the Bureau of Labor Statistics. Recent estimates, adjusted to include personal income taxes, indicate that in 1980 retired couples living in lower, intermediate, and higher financial circumstances would have annual budgets of $6,850, $10,150, and $14,450, respectively. On the basis of these estimates, we can assume that a retired couple would need an annual income above these levels before they would consider purchasing long-term care insurance. Comparable estimates are not available for retired individuals, but a reasonable approximation would be to set the levels for individuals at 75 percent of the above levels or $5,138, $7,613, and $10,838 for the lower, medium, and higher budgets, respectively.

The value of personal assets such as savings, stocks, bonds, and most importantly for the elderly, a home, are also potential sources of funds for long-term care insurance. Income from dividends and interest is indicative of asset holdings and increases with higher income groups. In an ongoing analysis, Moon has found that dividend and interest comprise a substantial share of income of those in the upper brackets indicating that higher income individuals and couples are relying on assets for much of their income. In particular, individuals with income above $10,000 and couples with income above $15,000 have substantial assets on which to draw.

Using dividend and interest income as a basis for estimating net worth, Moon’s calculations imply that income for elderly individuals and couples could be increased by about 24 percent by converting those assets into an annuity. The annuitized value of a house has an even more significant effect on personal resources, particularly since the 1980 census figures indicate that 70 percent of the elderly own their own homes. Moon’s
estimates imply a 31 percent increase in income for elderly individuals and 36 percent increase in income for elderly couples from this source. This suggests that estimates of the potential market for long-term care insurance based on income alone may be substantially on the conservative side. In any case, since the levels of income and assets tend to be positively related, it is reasonable to assume that elderly individuals with income above $10,000 and elderly couples with income above $15,000 would be able to pay for long-term care insurance and perhaps be more willing to buy it for the protection of wealth it provides. In 1980, 1.3 million elderly individuals (18 percent of the one-person families) and 2.8 million couples (37 percent of the two-person families) had incomes above these levels.

Given the limited development of long-term care insurance options, evidence on consumer demand is lacking. However, several studies are underway and the preliminary results suggest that the elderly are interested.

### Who Would Benefit

Consumers and government payers as well as providers and insurers may benefit from the development of private long-term care insurance. Consumers who buy such a policy would have protection from having to go on Medicaid. Potential benefits are that they will have their homes to return to, an important ingredient and incentive for getting better; their spouse will not have to dramatically change their lifestyle to pay for care; assets can be passed along to family rather than being liquidated and spent-down; access to care may be improved because providers view private patients as preferable; and once the insurance premiums are paid, the remaining personal resources can be more comfortably spent knowing this important risk is covered. Providers would benefit by having their pool of private payers expanded and reducing their dependence on public financing. Insurers, looking for new products which capitalize on the aging population demographics and which offer a policy for elders that may receive endorsement from consumer groups for providing important new insurance protection, may view this as a product that can benefit their current operation and have substantial growth potential.

The most intriguing benefit from the development of a private market for long-term care insurance is the potential for relieving some of the pressure of Medicaid. Government payers will benefit if private insurance replaces Medicaid and other long-term care programs for the middle class, or at least slows down the spend-down process or negates the need to divest assets. The problem is that even those persons with personal resources that are quite adequate for a normal retirement will not be able to pay for long-term care should it become necessary. There are
essentially two options open to the elderly. One is to spend income and assets down to the level necessary to qualify for Medicaid. The other is to transfer assets to qualify for Medicaid. It is not surprising that people have chosen the latter option. It is usually more appealing to pass along one’s estate to close relatives than to pay it out gradually to a nursing home when the end result in either case is that the patient will have to go on Medicaid.

In response to such practices, federal regulations regarding transfer of assets has recently been strengthened to make it more difficult to qualify for SSI and Medicaid. Resources disposed of within twenty-four months of the date of application at below market value for the purpose of establishing eligibility for SSI benefits including Medicaid will be counted in determining eligibility, and the period can be extended if the uncompensated value of the resources exceeds $12,000. The right to extend these restrictions to cover anyone eligible for Medicaid has recently been given to states along with the right to place liens on the homes of nursing home residents. While the extent to which transfers of assets occur is not known, it is clear that these proposed solutions will be difficult, costly, and unpopular to administer. The availability of private long-term care insurance would provide a reasonable alternative for people with assets worth transferring and government payers would be relieved of paying those long-term care related expenses.

Significant government savings may also result from avoiding or slowing the spend-down process. An estimated 54 percent of the elderly who enter a nursing home are not initially supported by Medicaid and most of those people pay more than 90 percent of their bill out of their own resources. The longer that individuals stay in a nursing home, however, the greater the likelihood that they will become Medicaid-sponsored residents.

Conversions from private pay status to Medicaid represent a major portion of nursing home residents supported by Medicaid. Though the available evidence is quite limited, a Government Accounting Office review of several studies indicates that conversions represent 30-38 percent of the residents supported by Medicaid. While one study showed that many conversions occur shortly after admission, the majority (59 percent) converted sometime after a six-month stay. What these figures suggest is that a significant number of those who entered the nursing home as a private payer, but converted to Medicaid, had personal resources sufficient to have paid their nursing home bills for at least six months. Individuals with personal resources of this order of magnitude could probably have purchased long-term care insurance had it been available. Had they done so, some 18 to 22 percent of those now on Medicaid may have avoided needing such government support.

Even if these estimates are off by a factor of two, the dollar savings to
the government would be substantial. In 1980, Medicaid spent $10.4 billion on nursing home care. Excluding payments to intermediate care facilities for the mentally retarded, Medicaid’s nursing home expenditures were $8.7 billion. A 10 percent reduction would have resulted in savings of $870 million. Using the same relationships, recent projections of nursing home expenditures suggest that these savings would increase to $1.9 billion by 1985, and to $3.4 billion by 1990 if current trends persist.  

Summary Discussion

The discussion in this paper constitutes a preliminary analysis of the market potential for long-term care insurance. It suggests that a reasonable case can be made for the development of such a market. Many of the barriers that are thought to preclude long-term care insurance are subject to resolution by careful policy specification. A prototype policy is outlined and serves as a basis for recommendations concerning services covered, waiting periods, length of coverage, benefit payments, and financing mechanisms.

Several important barriers that cannot be construed as simply technical in nature include regulatory restrictions and rigidness, the availability of Medicaid as a potential hinderance to the private market, and the limited capacity of the elderly to finance long-term care insurance. The substance of these issues is examined and with the possible exception of regulatory concerns, these barriers do not appear to be as formidable as is commonly thought.

It is the conclusion of this analysis that significant benefits await the development of a market of private long-term care insurance. The most intriguing benefit is the potentially substantial savings in Medicaid payments that would be gained if elderly individuals were able to protect themselves from the catastrophic expenses associated with the need for long-term care by purchasing private insurance.

The notion that there could be substantial savings to public budgets as well as benefits to consumers, providers, and insurers from the development of a viable private market for long-term care insurance suggests that there is a public role in encouraging that market. This assistance could take several forms including tax incentives, information dissemination, and regulatory relief.

Tax breaks for health insurance have recently fallen out of favor and will no longer be allowed as a separate deduction after this year. With long-term care insurance, however, it would appear that such incentives should be encouraged. The elderly people who are most able to buy this coverage have a sufficient tax liability that the incentive should help stimulate interest in this type of insurance. Also, families who purchase the
policy for an elderly relative could be made eligible for the same tax breaks.

An even more appealing opportunity for stimulating the market for long-term care insurance through tax incentives can be found in the current tax benefits for older persons. Up to $125,000 in capital gains on the sale of a home are tax free for a person who has reached the age of fifty-five. Currently, no restrictions are placed on the use of this money. The tax law could be adjusted to require that the savings from this tax windfall be used for something that would be beneficial to the government as well as to the individual. From the analysis presented in this paper, long-term care insurance would appear to be a likely candidate for such support. Using this tax incentive is particularly appealing because it would not result in any reduction in the government’s tax base.

An alternative option involving the home is to facilitate reverse annuity mortgages, perhaps giving special consideration to those who use their home equity income to finance long-term care insurance. This approach would allow the elderly homeowner to retain occupancy rights, while at the same time providing protection against long-term care expenses; an informal version of continuing care retirement community arrangements.

There is clearly substantial progress to be made in improving our understanding of long-term care and how to insure it. The lack of consumer knowledge about health insurance in general and long-term care in particular is a real barrier. Regulations regarding health insurance for the elderly have been designed to compensate for this lack of knowledge. They don’t help in many cases in spite of the good intentions. Insurers have been hesitant about the market because there is little or no private experience on which to base their estimates and the public experience with financing long-term care is only beginning to be understood. The analysis in this paper suggests that a private market for long-term care insurance can exist and that continued efforts to support that development are warranted.
NOTES


23. Ibid.


25. State of New York Insurance Department. Section 164 (7-i) of the New York State Insurance Law and the Eighth Amendment to Department Regulation No. 62.


37. Ibid.

38. Freeland and Schendler, “National Health Expenditures.”