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# ASPE RESEARCH BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

# LONG-TERM CARE INSURANCE

## Background

Long-term care includes a range of services and supports individuals may need to meet their health or personal needs over a long period of time. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called "Activities of Daily Living" or ADLs. There is a high likelihood that individuals who survive to older ages will need assistance with these ADLs, which can include: bathing, dressing, toileting and eating. The assistance is costly and there are limited sources of third party funding.

- Almost seven out of ten people turning age 65 today will experience, at some point in their lives, functional disability and will need some paid or unpaid help with basic daily living skills. On average, they will require such help for 3 years (3.7 years for women, 2.2 years for men).[1]

- Of the average 65 year old American's projected 3 years of lifetime need for long-term care, about two-thirds of that time would be spent at home and one-third in either a nursing home or assisted living facility.[2]

- Accordingly, Americans who live to age 65 and beyond would need to set aside or have set aside for them and invested approximately $50,000 to cover the cost of their long-term care during the remainder of their lives. However, this figure represents average expenditures across a highly skewed distribution. About half the cohort will have no long-term care expenditures; whereas approximately 16% would be expected to incur at least $100,000 and 5% to incur at least $250,000 in long-term care costs.[3]

- Formal services are expensive. While private pay costs for nursing home care vary widely, they average about $87,235 per year for a single occupancy room and $78,110 per person, double occupancy. Assisted living costs average $41,724 annually. Home care costs approximately $20 per hour. Accordingly, 10 hours of weekly home care would cost $11,400 annually and 8 hours of daily home care would cost $58,240 annually.[4]

- Medicaid covers long-term care costs only for chronically disabled elders with limited financial means. Under Medicaid nursing home care is an entitlement,

but access to home care is not universally available to all who meet the financial eligibility and medical/functional need requirements. Older Americans with incomes above poverty or with savings of more than $2000 typically qualify for Medicaid coverage only when they enter a nursing home and "spend-down" by exhausting all other resources. In the 2004 National Long-Term Care Survey (NLTCS), only 17% of chronically disabled elderly living in the community who received any paid help cited Medicaid as a payment source. (However, some respondents may confuse Medicare and Medicaid coverage and under-report the latter).[5]

- Strictly speaking, Medicare's coverage of skilled nursing facility (SNF) and home health agency (HHA) services are considered "post-acute" not long-term care. However, unlike the SNF benefit, a prior hospital stay is not required for HHA coverage and, whereas SNF coverage is limited to 100 days and subject to a deductible and co-payments after the first 20 days, HHA coverage is exempt from beneficiary cost-sharing and can continue indefinitely so long as a physician recertifies medical necessity every 60 days.

- Chronically disabled elderly who reside in the community use more Medicare home health services than their non-disabled counterparts. Home health services users must be homebound; that is, they must be at least temporarily disabled with regard to mobility. They must also require "skilled" care provided by a licensed nurse, physical therapist, or other qualifying rehabilitation therapist. Those with functional disabilities may also be approved to receive help with ADLs from home health aides. Medicare beneficiaries with chronic disabilities tend to use more home health services over longer periods of time than non-chronically disabled beneficiaries' whose need for home health services is associated with recovery following a hospital stay. In the 2004 NLTCS, 25% of chronically disabled elderly living in the community who used any formal home care services reported Medicare as a payment source.[6]

- According to the 2004 NLTCS, 53% of chronically disabled elders living in the community who received any paid home care paid out-of-pocket. Whereas two-thirds (64.6%) of all chronically disabled elders living in the community and receiving human assistance relied exclusively on informal (i.e., unpaid help) provided primarily by spouse and adult children, those at risk of nursing home placement (those requiring help with three or more basic ADLs) were less likely to do without formal services (56%).[7]

- Seventy-two percent of elders at greatest risk of nursing home placement live with others who provide them with, on average, 47 hours of weekly unpaid help supplemented by about 8 hours of paid assistance.[8] At average private pay home care agency rates this supplemental paid assistance costs $160 per week or $11,320 annually. However, if all 54 hours of assistance per week had to be paid for out-of-pocket at these private pay rates it would cost $51,160 annually.

- According to the 2004 NLTCS, the 15% of disabled elders who qualify for and are at great risk of nursing home placement because they live alone rely primarily on paid home care (receiving, on average, 30 hours of paid help per week and 15 hours of unpaid help).[9]

- Private mechanisms (including long-term care insurance (LTCI), whole life insurance or life insurance riders, reverse equity mortgages, and annuities) are available to help people plan ahead to pay for their future care. LTCI, by far the most popular private option available, can be costly and difficult to purchase for those with insufficient resources and/or pre-existing health conditions or disabilities.

Private LTCI is currently being purchased primarily by middle aged and older Americans with higher than average incomes, who are healthy enough to pass underwriting, and who plan ahead.

- There are approximately 7.7 million LTCI policies currently in force in the United States.[10]

- Individual policies make up two-thirds of in force policies (58% of new sales).[11]

- The average age of purchase for individual policies is 57; purchasers of group (employer-sponsored but seldom employer-subsidized) policies are younger (63% are age 54 or younger).[12]

- In 2008, 12.4% of Americans age 65 and older and 8.8% of Americans age 55 and older had private LTCI.[13]

- About one in five Americans age 55 and older with annual income of $100,000 or more had private LTCI -- more than twice the percentage of those with annual household incomes between $20,000 and $50,000.[14]

| Percentage of Adults Age 55 and Older with LTCI | |
|---|---|
| Less than $20,000 | 3.3 |
| $20,000 to $50,000 | 8.8 |
| $50,001 to $100,000 | 13.8 |
| More than $100,000 | 19.3 |

- Among Americans age 55 and older with annual incomes under $20,000, 3.3% have private LTCI. At this income level, they could qualify for Medicaid, if they have less than $2,000 in savings; it is possible that they purchased the LTCI policy to protect a higher amount of assets or that they purchased the policy earlier.[15]

- Whites are four times more likely than Blacks and six times more likely than Hispanics to have private LTCI.[16]

- Private LTCI is more likely to be purchased by people: with college or higher degrees; who engage in financial planning for retirement; and whose close relatives have required paid long-term care.[17]

- However, because of their higher socio-economic status, Americans most likely to purchase private LTCI are at lower risk than non-purchasers of becoming severely disabled.[18]

Private LTCI differs in important ways from health insurance.

- Private LTCI originated about three decades ago largely as nursing home insurance as part of insurers' health line of business.

- LTCI, however, is a long-term contract with a level premium, and the insurer promises to pay benefits that, for most, are in the distant future. In this respect, LTCI is more like whole life insurance than health insurance, which typically is an annual contract.

- Initially, like health insurance, the main criterion for receiving benefits for LTCI was medical necessity. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) changed this, requiring that the benefit trigger be based on disability to qualify for special tax treatment (see below), introducing a feature of disability insurance.

- National Association of Insurance Commissioners model regulations for LTCI evolved over time. In 2000, the model regulations shifted from requiring fixed medical loss ratios (of 60%) to requiring that actuaries certify the adequacy of premiums. A loss ratio is defined as the total claims paid divided by the total premiums collected.

- A limitation of basic LTCI products from a consumer's perspective is that they rarely include non-forfeiture benefits (where the company pays back a consumer's premiums as a benefit if the consumer lapses (stops paying) or cancels the policy), although insurers are required to offer these for an additional premium.

- In sum, private LTCI has evolved to be a hybrid product that has features of health insurance (the benefits); disability insurance (the benefit trigger); and life insurance (the level premium).

## The Market for and Cost of LTCI

- Based on LIMRA data, only eight companies that reported more than 100,000 LTCI policies in force in 2008 are still actively selling. Six companies that reported 90,000 or more in force policies in 2008 have left the market.[19] This does not necessarily represent a decrease in the number of policies sold, but there is clearly a smaller number of companies in the market.

- The average annual premium for private LTCI policies sold in the individual market in 2010 was $2,283.[20]

- These policies cover both facility-based (nursing home/assisted living) and home care (only 1% cover nursing home care only); have a $150 a day benefit for 4.8 years, on average; and provide inflation protection (74%).

- Several studies of claimant experience found that private LTCI provides comprehensive coverage when policyholders qualify for benefits.[21]

- LTCI loss ratios are relatively low. Brown and Finkelstein (2011) estimate that the average individual policy purchased at age 65 pays out only 68 cents worth of present discounted value benefits per premium dollar paid.[22]

- Since 2002, almost all long-term care insurers have raised rates substantially on both new and existing policies.[23]

- For example, in 2009, federal LTCI policyholders were notified of rate increases up to 25%.[24] Enrollees were offered the option to downgrade their coverage to avoid the increase. The amount of the increase depended on the person's age when the insurance was purchased:

| Age at Purchase | Percentage Increase |
|---|---|
| 65 and younger | 25% |
| 66 | 20% |
| 67 | 15% |
| 68 | 10% |
| 69 | 5% |
| 70 and older | No increase |

- Insurers raised premiums because policy lapsation proved far lower than expected and, as the recession took hold, projected investment returns on premiums were lower than anticipated.[25]

## Barriers to Expansion of Private LTCI

Barriers to expansion of LTCI include underwriting, affordability, distrust of private LTCI companies, lack of awareness of the risk of needing long-term care, and, some argue, Medicaid crowd-out of LTCI.

### *Underwriting*

- About one in five applicants for private LTCI cannot pass medical underwriting (the health evaluation of a prospective applicant by the insurance company) and is denied coverage.[26]

- Failure to pass underwriting is highly related to age at application: fewer than 7% of applicants under age 45 are denied coverage compared to 44% of applicants over age 80.[27]

- Underwriting is less stringent for active employees in employer-sponsored plans.

### *Affordability*

- In 1990, 58%, and in 2010 56%, of "non-buyers" in the American's Health Insurance Plans (AHIP) private LTCI buyer/non-buyer survey (2010 AHIP study) gave "too costly" as their major reason for not purchasing coverage.[28] [AHIP studies were conducted in 1990, 1995, 2000, 2005 and 2010. "Non-buyers" are individuals who looked into purchasing LTCI but decided not to buy a policy.]

- Similarly, many participants in a focus group study said they thought that middle class Americans see a need for private LTCI and considered purchase but think it is unaffordable.[29]

### *Distrust of Private Insurers*

- Distrust of private insurers has declined since 1990 but still deters one in five non-buyers. In the 2010 AHIP study, 19% cited distrust, down from 36% in 1990.[30]

- Distrust of private insurers was lowest in 2000 (15% of non-buyers cited this motive). Premium rate hikes by almost all LTCI companies (which began in 2002) may be responsible for the increase in distrust of insurers among non-buyers by 2010.[31]

- Stories in the media about inappropriate claim denials may also have contributed. For example, articles in the *New York Times* in 2007 alleged widespread inappropriate claims denials, prompting Congressional hearings.[32] These reports, however, cannot be substantiated beyond anecdote. In fact in a study of a year's worth of claims approvals/denials from the major LTCI insurers (including those cited by the *New York Times*), independent nurse reviewers agreed with 93% of claims denials, disagreed with only 1% and found insufficient documentation in the file to approve or deny in 6% of cases.[33]

### *Lack of Awareness of Potential Long-Term Care Risk*

- Under-estimation of the risk of needing long-term care has declined over the past 20 years although it remains high.

- In the 2010 AHIP study, LTCI buyers remained more likely than non-buyers or the general public to judge their risk of ever needing long-term care as greater than 50%. Similarly, compared to earlier surveys, more Americans age 50 and older now understand that either they or their families will have to pay for long-

term care out of their own income or assets should the need arise -- 40% in 2010 compared to 25% in 2000.[34]

- The *Medicare and You* brochure for the first time in 2011 explicitly explains with respect to long-term care that "Medicare and most health insurance plans, don't pay for this type of care."

***Medicaid's Role***

- Some people have argued that Medicaid "crowds out" (i.e., reduces demand for) LTCI,[35] but the empirical evidence is mixed.

- This crowd-out could occur if many middle class people transfer assets to relatives to be eligible for Medicaid, which reduces demand for LTCI. However, the empirical evidence indicates that asset transfers are less frequent or sizable than alleged.

- The 2005 Deficit Reduction Act (DRA) eliminated loopholes that previously allowed individuals with assets above Medicaid allowable limits to qualify by transferring assets to family members or by setting up trusts. Home equity value (traditionally exempt from asset testing) is now capped, and estate recovery (to recoup benefits paid after beneficiaries die) is now mandatory.

- Even before the DRA's anti-asset transfer rules went into effect (2006), Urban Institute researchers Waidmann and Liu analyzed Health and Retirement Survey (HRS) data and found little evidence of sizable asset transfers among survey respondents who became Medicaid nursing home residents. They concluded that even the most aggressive pursuit of transferred assets would recover only about 1% of total Medicaid spending for long-term care.[36]

- Economists, including Pauly (1990) and Brown, Coe, and Finkelstein (2007), have modeled the extent to which Medicaid, as a potentially available alternative source of long-term care financing, reduces demand for LTCI, concluding that some crowd-out exists.[37] In contrast, Kim (2010) found that Medicaid had very little effect on demand for LTCI.[38] The results of these studies are highly dependent on modeling assumptions and methods.

- In a 2008 study of Medicaid and lifetime earnings history, Johnson and Mermin found that nearly 40% of older adults with Medicaid-financed nursing home stays between 1993 and 2006 fell into the top three-fifths of the *lifetime* earnings distribution, adjusted for household size, and nearly 20% fell into the top 40% of the distribution.[39] Some in the higher income group might have been able to purchase LTCI during their working years.

- On the other hand, nursing home residents who did not purchase LTCI even though they could have afforded it earlier in life did not necessarily plan to rely on Medicaid instead. In a recent poll by Harvard Professor Robert Blendon only

10% of pre-retirees and 7% of retirees said they expect Medicaid to pay for any long-term nursing home care they might need after age 65.[40]

- Medicaid is an imperfect substitute for LTCI because income eligibility standards are very low and some long-term care providers (particularly assisted living facilities) do not accept Medicaid.[41] The recent U.S. Department of Health and Human Services (HHS) National Survey of Residential Care Facilities (which includes assisted living facilities) found that 60% of such places do not serve Medicaid beneficiaries.[42]

## Efforts to Expand the Role of Private LTCI

### *Tax Incentives*

- The 1996 HIPAA clarified that private LTCI insurers did not have to pay taxes on reserves, that LTCI benefits paid out under HIPAA-qualified policies would be tax free to claimants, and that taxpayers could count premiums for private LTCI (HIPAA-qualified) as deductible medical expenses if their total medical expenses exceeded 7.5% of adjusted gross income (a standard few people meet).

- Twenty-four states have tax deductions or credits for purchase of LTCI. State tax subsidies reduce the after tax cost of LTCI by 5% on average. These increase private LTCI purchase by an estimated 2.7 percentage points, a roughly 30% increase relative to the rate without this incentive, but as the initial rate is so low, these incentives do not appear to make a substantial difference in the percent of the total population covered by insurance. Furthermore, most of the impact is concentrated among high income and asset-rich individuals who are not likely to rely on Medicaid.[43]

- Brown and Finkelstein note that the "largest response to the tax incentive comes from individuals at the high end of the wealth and income distribution groups that are most expensive to tax subsidize (due to higher marginal tax rates) and least likely to rely on Medicaid even in the absence of insurance." This finding suggests that, to be cost-effective, tax incentives would need to be targeted and, perhaps, phased out at higher income levels.[44]

- Additional federal tax subsidies to encourage private LTCI purchase have not been enacted.

### *The "Long-Term Care Insurance Partnership"*

- In the early 1990s, four states (Connecticut, New York, Indiana, and California) received demonstration grants from the Robert Wood Johnson Foundation to launch "Long-Term Care Partnerships" between state Medicaid agencies and private LTCI companies.

- In 1993, Congress passed legislation that allowed the original four states to continue their programs but banned other states from offering similar Medicaid asset protection to LTCI purchasers. This ban was repealed in the 2005 DRA and 40 additional states now sponsor Partnership policies.[45]

- Partnership plans are designed to encourage lower income Americans to purchase affordable coverage of limited duration (e.g., 1 or 2 years) by allowing them to keep more assets if and when they use up their LTCI benefits and transition to Medicaid.

- Since the early 1990s, a cumulative total of 747,487 Partnership policies have been sold of which 640,897 are currently in force (about 9% of the estimated 7.7 million private LTCI policies in force nationally).[46]

- During 2005-2010, Partnership policy sales accounted for 12% of all LTCI sales (14% of individual and 6% of group policies).[47]

- It is challenging to track the Medicaid impact of Partnership policies because LTCI policyholders typically do not go into claim until much later in life and Partnership policyholders have to use their entire private policy before incurring any Medicaid claims. For example, over the first 18 years of the Connecticut Partnership Program, a total of 53,064 policies were purchased; to date only 1,311 claims resulted; and, so far, only 95 claimants have exhausted their private LTCI benefits and gone onto Medicaid.[48]

- It is not clear that the Partnership has caused an increase in total sales of private policies or that the program has reached the target audience of lower income Americans. Although 12% of the policies now sold are Partnership policies, the income profile of Partnership policyholders and the coverage purchased looks similar to traditional private LTCI.[49]

### *Long-Term Care Awareness Campaign*

- Over the past 10 years, HHS has launched Long-Term Care Awareness Campaigns ("Own Your Future") in select states, funded with appropriations Congress put into the 2005 DRA for this purpose.

- While the primary purpose of the Campaign was to raise general awareness about the prospect of needing long-term care among baby-boomers, LTCI was presented as one of many possible planning options. However, LTCI is difficult to explain in awareness materials because the product is complex and many purchasers need time to understand what they are buying.

- An evaluation found that the media and direct mail campaign was effective in generating requests for long-term care planning kits: About 8% of those targeted ordered kits. This is a more favorable rate than the 5% response rate generally

seen in social marketing campaigns and much higher than typical response to LTCI industry direct mailings.[50]

- A survey carried out in connection with the first LTC Awareness Campaign found that 8% of those targeted by the media and direct mail campaign who subsequently ordered planning kits, purchased LTCI. Individuals who received the planning kit were nearly twice as likely to buy LTCI after the campaign as those who did not request the kit. They were also more likely to take other planning actions, including evaluating their existing insurance coverage to see if it covered long-term care, consulting with a financial planner or agent, or looking into a reverse mortgage.[51]

- A study conducted by a major long-term care insurer found that responses to insurer advertising and sales of policies increased during the "Own Your Future" campaigns. The lift in sales was seen over an 11 week period with the highest peak coming in a 2-4 week period.[52]

## Cross-National Experience

Almost all European Union countries have universal public long-term care programs (benefits not restricted to the poor) -- but these programs vary greatly.[53]

France is the only European country with substantial voluntary LTCI take-up -- probably because private LTCI "wraps around" a modest public benefit that is income-adjusted.

- France has 5.5 million private LTCI policies in force -- enough to cover one-third the population age 60 and older (60 is the average age of purchase).[54]

- French people purchase private LTCI to supplement the universal public "personal autonomy allowance" (APA) -- an income-adjusted cash benefit for dependent elders aged 60 and older.

- The average monthly APA benefit is modest ($771 per month).

- Private LTCI (termed "dependency insurance") in France is affordable because most people purchase coverage that pays out only a little more than the average monthly APA benefit. In 2008, the average cost of a policy that would pay $840 per month purchased at age 60 was $420 per year.

- APA beneficiaries must prove they spent their benefits on long-term care, whereas private dependency insurance benefits are also paid in cash but no subsequent accountability is required.

- More employers sponsor group dependency insurance coverage in France than in the United States, and a sizable minority of employers contribute toward the cost (while the individual remains employed).

## Endnotes


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10. Data compiled November 2, 2011 for ASPE by Eileen Tell, V.P. at Univita Health, Natick, MA based on LIMRA reports and other Univita data.

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This Research Brief describes the long-term care insurance industry; in particular, it covers who buys the product, how much it costs, what the market looks like, and foreign experience.

This brief was prepared through intramural research by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. For additional information about this subject, visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the authors Pamela Doty, Ph.D., or Samuel Shipley at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Pamela.Doty@hhs.gov or Samuel.Shipley@hhs.gov.

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