

The Complementarity Of Public And Private Long-Term Care Coverage

doi: 10.1377/hlthaff.2009.0920
HEALTH AFFAIRS 29,
NO. 1 (2010):
©2010 Project HOPE—
The People-to-People Health
Foundation, Inc.

ABSTRACT Discussions about long-term care financing often get mired in the false dichotomy that long-term care should be primarily either a public or a private responsibility. Our starting premise is that public and private long-term care coverage can best serve complementary roles. Therefore, public policy should focus on supporting both mechanisms to achieve efficient and equitable outcomes. The current state of the private long-term care insurance market, and the possible reasons for its modest size, provide a starting point for exploring how public policy might interface more productively with it, in the context of both existing and potential programs, such as the proposed Community Living Assistance Services and Supports (CLASS) Act.

David G. Stevenson (stevenson@med.harvard.edu) is an assistant professor of health policy at Harvard Medical School in Boston, Massachusetts.

Marc A. Cohen is president of LifePlans Inc. in Waltham, Massachusetts. LifePlans offers long-term care risk management, research, and products.

Eileen J. Tell is senior vice president of Univita (formerly the Long Term Care Group), in Natick, Massachusetts.

Brian Burwell is a vice president of Thomson Reuters in Cambridge, Massachusetts.

Discussions about how best to finance long-term services and supports can become contentious, especially when the role of private long-term care insurance is considered. Proponents and critics alike point to the current modest role of private insurance in financing long-term care. They argue, respectively, that public policies impede development of a more robust private market, and that private policies are unaffordable to most Americans and are thus unlikely to play a substantial role in providing risk protection to individuals and their families.

Often characterizing these debates is the false dichotomy that long-term care should be primarily either a public or a private responsibility and, by extension, that public policies should prioritize either development of the private insurance market or expanded public coverage for long-term services and supports. Insufficient discussion is focused on strategies to improve a combined approach where both public and private coverage play sizable roles.

We begin from the premise that public and private coverage for long-term care can serve complementary roles. This makes the key public

policy question not which approach to make central, but instead how to align incentives across public and private financing sources to create a rational, more sustainable system. Characterizing the current long-term care insurance market, and exploring the potential reasons for its modest size, can help inform discussion of how public policy might interface with this market more productively—especially in the context of Medicaid and other public programs.

Why Insurance?

A good starting point in discussing how to finance long-term care needs in the United States is to emphasize the insurability of appropriate services and supports. Most of us will need supportive services as we age. However, there will be tremendous variation across individuals in how extensive these needs will be, and in how much will be spent for them. Upon turning age sixty-five, for instance, 42 percent of Americans can expect to spend nothing on long-term care during their lifetimes, while 16 percent can expect to spend more than \$100,000.¹

Although this distribution of financial risk implies an appropriate role for insurance as an

efficient mechanism to spread risk, insurance currently plays a minor role in financing long-term care. Most of the almost ten million people who need supportive services get by at home, with unpaid help from family and friends. The vast majority of those who require paid supportive services lack coverage. Neither Medicare nor private health insurance covers long-term care, and only a modest portion of older people carry long-term care insurance. Family caregiving, out-of-pocket payments, and the means-tested Medicaid program collectively support the bulk of long-term care provided in this country.

By all accounts, the current approach does not work well. In particular, the system does a poor job in spreading financial risk, in supporting access to high-quality care in the settings where people prefer to live, and in fairly sharing financial responsibility for care across individuals and their families.

The State Of The Long-Term Care Insurance Market

Today, there are around eight million private long-term care insurance policies in force. Around one in six people age sixty-five and older, with an annual income greater than \$20,000, have such coverage.² The market's size and its complexion have not lived up to projections of a decade ago. The market grew by roughly 18 percent annually during 1987–2001, but sales growth has slowed considerably since then. Specifically, although the group market grew at an annual rate of about 15 percent during 2000–2005, sales in the individual market (which ac-

counts for around two-thirds of the overall market) declined by 9 percent per year over the same time period.³

Although market penetration has remained relatively flat in recent years, the attributes of policies sold have changed substantially (Exhibit 1). Policies sold now include expanded coverage for home and community-based care, and parity in daily benefits for facility-based and home care. A growing number include inflation protection.

The characteristics of the typical long-term care insurance buyer have changed as well. Today's buyers are younger, wealthier, and more educated than their predecessors. Since 1990, purchasers have come increasingly from the highest income and asset categories (Exhibit 2).⁴ These demographic trends are driven in part by substantial—and, one could argue, appropriate—declines in policies purchased by people with fewer financial assets to protect. More troubling is the erosion of sales among middle-income people, who ostensibly represent the market that companies and policymakers would most like to tap.

WHY DON'T MORE MIDDLE-CLASS AMERICANS PURCHASE LONG-TERM CARE INSURANCE? Some argue that the product is simply not “affordable” to a broad cross-section of Americans. Indeed, in a study of people who chose not to purchase long-term care insurance, 53 percent cited cost as the most important reason.⁴ This finding is echoed in other analyses.⁵ Still, the concept of affordability alone is not particularly useful because it implies that there is some definable level of cost relative to income that makes a product “afford-

EXHIBIT 1

Individual Long-Term Care Insurance Policy Designs, By Purchase Year, Selected Years 1990–2005

Policy attribute	1990	1995	2000	2005
Policy type ^a				
Comprehensive (nursing home and home care)	37%	61%	77%	90%
Nursing home only	63	33	14	3
Policy duration				
2 years	23%	24%	17%	11%
3 years	12	20	23	22
4 years	15	18	14	17
5–8 years	17	8	16	27
Lifetime	33	30	30	23
Nursing home daily benefit	\$72	\$85	\$109	\$142
Home care daily benefit	\$36	\$78	\$106	\$135
Inflation protection ^b	40%	33%	41%	76%
Average annual premium	\$1,071	\$1,505	\$1,677	\$1,918

SOURCE Authors' calculations based on data from America's Health Insurance Plans. ^aA small portion of policies cover home care only.

^bNote that 6 percent of new policyholders had a guaranteed purchase option for benefit upgrades. This 6 percent is not included in the total percentage of people who purchased inflation protection.

EXHIBIT 2

Income And Asset Profile Of Individual Long-Term Care Insurance Buyers, Selected Years 1990–2005

Sociodemographic characteristics of buyers	1990	1995	2000	2005
Income status				
Average income	\$36,250	\$36,600	\$49,700	\$62,825
Less than \$20,000	29%	21%	9%	3%
\$20,000–\$24,999	13	16	8	4
\$25,000–\$34,999	20	24	19	9
\$35,000–\$49,999	17	18	22	13
\$50,000+	21	20	42	71
Total liquid assets				
Average assets	\$72,125	\$68,750	\$91,425	\$95,475
Less than \$20,000	16%	18%	6%	4%
\$20,000–\$29,999	8	10	5	3
\$30,000–\$49,999	11	13	7	6
\$50,000–\$74,999	12	10	5	6
\$75,000 and over	53	49	77	81

SOURCE Authors' calculations based on data from America's Health Insurance Plans.

able” to an individual. In fact, whether someone exercises a preference for a product is a function of the cost relative to its perceived value. Clearly, long-term care insurance is not viewed by the majority of consumers as providing sufficient value in light of its cost.

VALUE GAP There are a number of potential reasons why this perceived “value gap” exists in the long-term care insurance market. On the supply side, research has identified important market failures (for example, information asymmetries between buyers and sellers can lead to adverse selection and moral hazard) that can affect premium pricing and the comprehensiveness of policies offered in the marketplace. Analyses by Jeffrey Brown and Amy Finkelstein (2007), for instance, found that the pricing of long-term care insurance premiums has relatively high loads compared to other types of insurance—that is, a lower portion of the premium dollar translates into benefits.⁶ Yet these supply-side factors cannot entirely explain the limited size of the market, which suggests that demand-side market failures are also at play. For instance, although premiums are a relatively poor deal actuarially for men relative to women, this discrepancy has not translated into substantial differences in coverage rates by sex.

On the demand side, research has shown that people who do not buy policies generally underestimate their risk. Roughly 70 percent of those who turn age sixty-five will have long-term care needs at some point in their lives (a slightly smaller portion will require paid services). A sizable minority will face substantial financial liabilities or will place large burdens on their families for informal care.¹ Yet only slightly more

than half of nonbuyers consider themselves to be at risk for needing significant long-term care services, and most believe that they will not be liable for the costs of care (that is, the government or other health insurance would pay).⁴ At the same time, nonbuyers generally overestimate premium costs and underestimate long-term care costs, reinforcing barriers to purchase.

ROLE OF MEDICAID Another demand-side theory for why people do not purchase long-term care policies is that Medicaid “crowds out” its purchase. Medicaid’s share of total long-term care costs has remained relatively stable over the past few decades at around 50 percent. Although Medicaid is not an insurance product, because it offers little explicit financial protection for long-term care costs, some have argued that Medicaid in fact does provide a degree of protection for those who are well schooled in Medicaid eligibility policy.⁷

Using simulation models, Brown and Finkelstein estimated that the implicit tax imposed by Medicaid (that part of the long-term care insurance premium that pays for benefits Medicaid would have provided in the absence of insurance) could explain why people representing more than 60 percent of the wealth distribution do not buy long-term care insurance.⁸ Importantly, Brown and Finkelstein note that reducing the implicit tax of Medicaid on long-term care insurance would likely be an insufficient mechanism to expand the market, in part because of the consumer misperceptions and supply-side failures described above.⁹

After the Deficit Reduction Act of 2005 resulted in reforms in this area, many states have implemented Long-Term Care Partnership pro-

grams to address this conundrum. People who purchase and receive benefits under a “partnership qualified” policy may be entitled to dollar-for-dollar asset “spend-down” protection under Medicaid if they use their benefits and subsequently apply for Medicaid. For example, if a person uses \$50,000 of insurance coverage, the same amount of assets (up to the policy maximum) would be disregarded if that person applies for Medicaid. Although not a direct subsidy of premiums, partnership programs give purchasers incentives to buy “shorter and fatter” policies that are more closely aligned with their individual financial risk (that is, the amount of net worth they wish to protect).

As of July 2009, thirty-six states had adopted a partnership program, and more than 100,000 new partnership-qualified policies were in force.¹⁰ At this stage, it is too early to evaluate the impact of these programs on market penetration or on Medicaid program costs.

CONSUMER CONFIDENCE An important area where demand- and supply-factors intersect is consumer confidence—namely, whether consumers trust that insurers will pay benefits when care is needed and that premiums will remain relatively stable over time. Data from claims denial reporting and independent research show low claims denial rates (more than 95 percent of claims are approved) and high rates of claimant satisfaction (94 percent of claimants report being satisfied with their experience claiming benefits).¹¹ However, there have been serious allegations that the claims practices of certain companies are suspect and designed to make it difficult for people to obtain benefits.¹²

Consumers’ concerns about rate increases also could affect demand. Some policyholders have faced rate increases of 15–50 percent, and new policies are typically priced 10–15 percent higher than comparable products were priced just a few years ago. These rate increases primarily reflect inaccurate assumptions about interest rates and about lapse rates among policyholders, and some carriers have failed to use adequate risk management strategies to assure a stable risk pool. The challenge of keeping premiums stable has led both companies and regulators to implement more-stringent actuarial standards around pricing policies. Moreover, carriers now have a broader experience base from which to draw, and there is greater agreement about the value of prudent underwriting and claims management to ensure rate stability. It is not yet clear whether these changes will achieve premium stability over the long term, but they are steps in the right direction.

The Interaction Of Public Policy And Private Insurance

Public policy affects the long-term care insurance market in both direct and indirect ways. Directly, public policy can exert influence through such mechanisms as tax policy and regulatory oversight. Indirectly, public policy can affect the market through publicly financed programs like Medicaid, and through supplemental financing mechanisms like public disability insurance (similar to what would be provided under the Community Living Assistance Services and Supports [CLASS] Act included in the health reform proposals of 2009). We focus on the latter, reflecting its centrality in creating an improved public and private financing partnership.

MEDICAID CROWD-OUT The private long-term care insurance market has developed alongside publicly financed options, such as Medicaid-financed long-term care. As described above, this arrangement has substantial limitations, with some observers pointing to Medicaid as being the primary reason for the long-term care insurance market’s modest size. We generally accept the notion that Medicaid crowds out (depresses the purchase of) long-term care insurance to some extent. However, we also posit that it is difficult to estimate the true magnitude of the phenomenon with simulation analyses alone. In our view, however, a precise estimate of Medicaid crowd-out is not required to determine a feasible way forward for policy.

Part of our rationale is pragmatic. Even if one accepts that Medicaid crowds out long-term care insurance purchase for the majority of people across the wealth spectrum, it seems neither feasible nor desirable to reduce Medicaid eligibility standards to eliminate this impediment to the private market. For instance, empirical analyses have shown that even if all states moved to the most stringent eligibility standards allowed by federal law, private long-term care insurance purchase would rise by only 2.7 percentage points.¹³ Moreover, because of Medicaid’s role as a secondary payer (that is, Medicaid pays for services only after private insurance or other resources are exhausted), crowd-out would remain even in the context of more stringent standards than are currently allowed.

PUBLIC POLICY ISSUES More generally, based on the experience of the private market to date, several issues are important in developing public policy. These center on better integrating the long-term care insurance market with Medicaid and on related proposals such as the disability insurance model of the CLASS Act. These are as follows.

► **OVERALL RETIREMENT SECURITY STRATEGY:** Protecting against long-term care costs

Any voluntary public program will have to balance concerns about adverse selection against broad goals pertaining to covered populations.

through some kind of insurance mechanism should be considered part of an overall retirement security strategy, not merely as an extension of health reform. Similar to how Social Security payments, pensions, and personal savings combine to provide retirement income security for people, long-term care needs can be met through a combination of resources. Reframing the challenge in this manner might help us move forward in debates about the roles of public and private resources, including insurance, and devise more innovative approaches.

► **PUBLIC EDUCATION:** Public education is vital to ensuring that consumers and their families understand the long-term care risks they face, the importance of planning ahead for these needs, and the planning options they have. An important goal of educational efforts such as the current federal-state Own Your Future Long-Term Care Awareness Campaign is to ensure that consumers have a clear understanding of where public coverage begins and ends—something that would be particularly important if a limited public disability insurance benefit were established. In other words, in the context of partial public coverage (whether through Medicaid alone or in combination with some supplemental benefit), people need to understand the limits of that coverage and, in turn, the value of any supplemental private coverage.

► **LESSONS FROM THE PRIVATE MARKET:** To the extent that any public coverage expansion relies on an insurance model, policymakers should take note of lessons learned in the private

market. Any voluntary public program will have to balance concerns about adverse selection (that is, attracting only those at higher risk of needing services) against broad goals pertaining to covered populations. A related point is that such a program must be structured so that premiums are no more costly than those of similar plans that can be purchased privately, yet sufficient to ensure that the program is actuarially sound. If not, additional selection issues could threaten the solvency of the public program.

In addition, risk-management approaches at the time of benefit need (such as verifying initial and ongoing eligibility) will be required, to ensure premium stability. What's more, a cash benefit, although easier to administer, encourages moral hazard, a fact reflected in substantially higher private-market premiums for similar policies. Finally, even with a cash benefit, there is a need for assistance to help consumers navigate a fragmented long-term care system.

► **TARGETING SUBSIDIES:** Although tax incentives for the purchase of long-term care insurance would be likely to have a modestly positive impact on purchase rates, the cost of subsidizing premiums sufficiently to overcome the supply- and demand-side failures that challenge this market would be substantial. In addition, effectively targeting subsidies to people who would otherwise qualify for Medicaid poses an administrative challenge that is difficult to overcome. In the context of these challenges, policymakers should focus efforts on more innovative strategies that encourage people to purchase plans at younger ages and that make plans less costly by making them available through flexible spending accounts (for example, section 125 cafeteria plans). Efforts also should support growth in models that explicitly connect Medicaid and private insurance coverage such as the Long-Term Care Partnership plans.

Given the political and fiscal constraints on the expansion of publicly financed programs as well as the market factors that shape private insuring pricing, neither a public nor private financing approach on its own can meet the long-term care needs of all Americans. In all likelihood, public and private coverage will continue to work in tandem to mitigate the catastrophic risks of long-term care. Public policy that supports a coordinated public-private financing approach holds the greatest promise for achieving efficient and equitable outcomes for taxpayers and consumers. ■

NOTES

- 1 Kemper P, Komisar HL, Alecxih L. Long-term care over an uncertain future: what can current retirees expect? *Inquiry*. 2005;42(4):335–50.
- 2 Long-Term Care Financing Strategy Group. Index of the long-term care uninsured. Washington (DC): Long-Term Care Financing Strategy Group; 2005.
- 3 LIMRA International. Annual market reports. Windsor (CT): LIMRA; 2000–2005.
- 4 America's Health Insurance Plans. Who buys long-term care insurance: a fifteen-year study of buyers and non-buyers, 1990–2005. Washington (DC): AHIP; 2007.
- 5 Wiener JM, Tilly J, Goldenson SM. Federal and state initiatives to jump start the market for private long-term care insurance. *Elder Law Journal*. 2000;8(1):57–99.
- 6 Brown JR, Finkelstein A. Why is the market for long-term care insurance so small? *Journal of Public Economics*. 2007;91(10):1967–91.
- 7 Moses SA. Aging America's Achilles heel: Medicaid long-term care. Washington (DC): Cato Institute; 2005.
- 8 Brown J, Finkelstein A. The interaction of public and private insurance: Medicaid and the long-term insurance market. *Amer Econ Rev*. 2008;98(3):1083–102.
- 9 Brown J, Finkelstein A. The private market for long-term care insurance in the U.S.: a review of the evidence. *Journal of Risk and Insurance*. 2009;76(1):5–29.
- 10 National Long-Term Care Partnership Data Repository. 2009.
- 11 LifePlans Inc. (Watertown, Massachusetts). Service use and transitions: decisions, choices, and care management among an admissions cohort of privately-insured disabled elders. Washington (DC): Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; 2006.
- 12 Duhigg C. Aged, frail, and denied care by their insurers. *New York Times*. 2007 March 26.
- 13 Brown J, Coe N, Finkelstein A. Medicaid crowd-out of private long term care insurance demand: evidence from the Health and Retirement Survey. *Tax Policy and the Economy*. 2007;21:1–34.