

Recent trends in financing long-term care

by Stanley S. Wallack

There has been dramatic change in the financing of long-term care in the last few years. Major private insurance carriers have introduced long-term care insurance policies to meet some of the custodial care needs of a variety of consumer groups, including old and young retirees as well as current employees. Newer policies are tying coverages more closely to a measure of disability that reflect the ability of persons

to live independently. Insurers, consumer groups, and policymakers have come to understand the importance of developing innovative financing mechanisms that emphasize prefunding and cash accumulation to make policies more affordable and more desirable to a broader spectrum of the aged and nonaged population.

Introduction

In the last few years, dramatic changes have occurred in the private long-term care insurance market. The major commercial insurance companies, Blue Cross/Blue Shield plans, and numerous regional companies have introduced long-term care (LTC) insurance plans. In fact, there are twice as many policies today as there were just 2 years ago, and more than 70 companies currently offer products that meet the National Association of Insurance Commissioners' (NAIC) criteria for classification as a LTC insurance product (NAIC, 1986; Task Force on Long-Term Health Care Policies, 1987). These products are being marketed largely to individuals, but an increasing number of companies are either offering, or considering making available, group products to active employees as well as to retirees on an employee-pay-all basis. Group products for nonemployer clients such as continuing care retirement communities (CCRC's) and religious or professional associations, are also emerging. Still, there are only about 500,000 or so policies in force, meaning that less than 2 percent of all elderly have any long-term care insurance protection.

At the same time that the private market is developing, the public sector is displaying a renewed interest in the financing and delivery of long-term care services. Although approaches at the State level vary, a common objective is to encourage the growth in private long-term care policies. If designed appropriately, such an expansion will lower State expenditures on long-term care by reducing the number of individuals who use their assets and income and thereby "spend down" to become eligible for Medicaid. The success of private insurance programs in reducing Medicaid depends on who purchases policies and how much protection is provided. A recent Brookings Institution study estimated that the largest Medicaid savings in the year 2020 would occur from a policy with only 1 year of nursing home coverage because of its greater market protection (Rivlin and Weiner, 1988).

At the Federal level, a uniform policy has not

emerged. Some policymakers favor tax changes or other incentives to encourage the development of the private insurance market. Others favor social insurance, pointing out that the cost of purchasing private policies is prohibitive for those over age 75 as well as for those with low incomes. In any case, it is important to note that the rationale for increased Federal involvement in the long-term care finance arena has shifted in the last decade from market failure i.e., unknowledgeable consumers and no suppliers) to equity considerations. As a result, public sector involvement in long-term care financing is likely to depend on how well and not whether private insurance can protect the majority of the elderly from the devastating effects of disability (Rivlin and Weiner, 1988). The long-term care problem was recognized more than 10 years ago, but there were no private long-term care financing insurance plans at that time to point towards (U.S. Congressional Budget Office, 1977).

Now that the terms of the debate have shifted to a greater focus on equity, the balance between private and public long-term care insurance will need to be politically determined. One thing is certain: regardless of the sponsor, public or private, insurance protection for long-term care services will expand to cover the aged and nonaged population.

This article reviews the impetus behind these trends and the evolution of private long-term care insurance policies. Next a framework for evaluating the major components of private long-term care financing programs is presented. In the final section, the pivotal role of the public sector in determining the level of private financing is discussed.

Risk-pooling and prefunding

After the passage of Medicare and development of supplementary medical insurance, there evolved a recognition that the major cause of catastrophic expenditures among the elderly was chronic illness that led to the need for personal care services over a long period of time (U.S. Congressional Budget Office, 1977). Such services are provided either in nursing homes or in the community by family and friends or by paid caregivers.

Long-term care historically has been financed either by private out-of-pocket payments or by Medicaid

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Table 1

The risks and costs of nursing home care

Length of stay in nursing home	Percent probability of entering a nursing home	Average cost at \$80 per day
Will not enter a nursing home	57	0
1 day-1 month	13	\$1,200
1-3 months	9	4,080
3-12 months	9	18,000
1-2 years	4	43,000
2-5 years	5	102,200
More than 5 years	4	204,000

SOURCE: (Cohen, Tell, and Wallack, 1986).

programs. Medicaid currently pays more than 40 percent of nursing home expenditures, and more than 60 percent of all nursing home residents are on Medicaid (Rivlin and Weiner, 1988; U.S. General Accounting Office, 1979). Given the distribution of income and assets among the elderly, most (67 percent) could not afford to be private paying patients in a nursing home for even 1 year (Cohen et al., 1987). Nursing home costs are, thus, catastrophic on the basis of current income. They also are catastrophic in terms of dollar expenditures.

The distribution of lifetime nursing home costs for those over 65 years of age is presented in Table 1. Approximately 40 percent of the general population over age 65 are likely to enter a nursing home during their lifetime, and, of these, most stay less than 1 year (Meiners and Trapnell, 1984). As a result of this distribution, about 15 percent of the population account for 90 percent of expenditures, and the 4 percent that stay for more than 5 years account for approximately 50 percent of the expenditures (Cohen, Tell, and Wallack, 1986).

When a small percentage of people face a high probability of incurring a large expenditure, risk-spreading or insurance is an attractive option. With all individuals paying an equal amount, the catastrophic costs for a few could be avoided. The likelihood of needing nursing home care rises significantly above age 65. Thus, the affordability of risk-spreading or risk-pooling and the market penetration potential of a private insurance program both fall with age.

For the over-65 population, less than 5 percent are in a nursing home at any time. The rate, however, varies dramatically by age. About 1 percent of those 65 years of age, 5 percent of those 75 years of age, and more than 20 percent of those 85 years of age or over are in nursing homes. If the total annual cost of a year in a nursing home—say \$25,000—were shared by all persons 65 years of age on a pay-as-you-go basis, then each would have to contribute \$250 a year or about \$20 a month. If the same approach was used for persons 85 years of age or over, the average cost would be more than \$6,000 a year or \$500 a month. Clearly, broad affordability requires that policies be

Table 2

Percent of retirees who have the resources to pay for insurance programs that could protect them against the costs of long-term care

Premium payments	Percent who could afford
\$25-49	60-80
\$50-99	50-70
\$100-125	30-60
\$125-150	25-50
\$150 or more	20-35

SOURCE: (Cohen et al., 1987).

risk-pooled across age groups and/or prefunded at younger ages.

Private insurance companies are following the principles of life insurance by establishing the premium based on the age at the time of initial purchase. One result of this approach is that the premiums more than double every 10 years, for example, from age 50 to age 60.¹ In addition to being priced relative to one's age, private long-term care policies include some underwriting criteria, which makes some individuals ineligible because of illness or disability. Public sector intervention, through subsidies, mandates, or social insurance could provide coverage for the disabled and those unable to afford premiums.

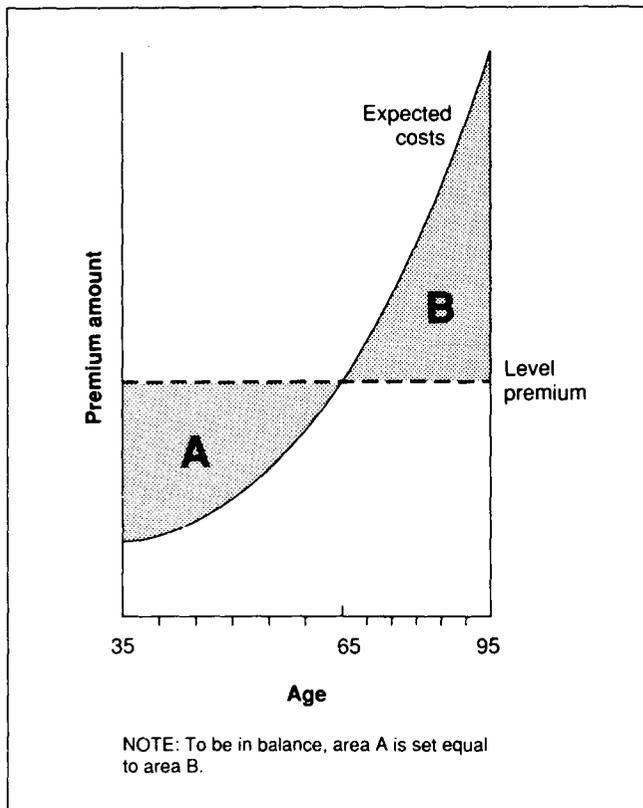
The potential affordability of long-term insurance for all those over 65 years of age is shown in Table 2. The lower bound assumes 10 percent of the elderly's discretionary income is used for the purchase of long-term care insurance and the upper bound assumes 25 percent is used.

LTC insurance is not beyond the financial means of most elderly. At least one-third of all elderly could afford policies costing \$100 per month, and more than one-quarter could afford higher premiums for fairly comprehensive products. These estimates are somewhat conservative, since they assume that only a small portion of discretionary resources would be used to purchase long-term care insurance. However, about 75 percent of the elderly own their own homes, most of them with no mortgages, so their financial capacity far exceeds their current income. There are several mechanisms emerging through which equity in homes or life insurance could be converted into revenue streams for purposes of purchasing LTC insurance.

Risk-pooling across an elderly cohort makes sense. Prefunding and the participation of younger age groups in insurance risk-pools are also important if we are to greatly expand the affordability of private long-term care insurance. Prefunding of long-term care is critical for each individual age cohort and for society as a whole if done on a social insurance basis.

¹The level of the monthly rates of major companies, such as AETNA, Travelers, and American Association of Retired Persons (AARP)/Prudential vary, but a similar pattern is reflected in the rates that have been published to date. For example, the AARP/Prudential policy has rates of \$20.00 per month at age 55 and \$135.00 per month at age 75.

Figure 1
Prefunding long-term care liabilities
with a level premium



Today, one out of nine individuals are over 65 years of age. In 40 years, the ratio will increase to one out of five. The advantage of beginning the prefunding at an early age is shown in Figure 1. The flat line depicts the level premium for someone who purchases an insurance plan at age 35. By paying more than the expected costs at younger ages, a fund builds up to pay the higher costs as one ages. The impact on rates is quite dramatic. For example, if an individual purchased a policy at age 35, the required premium would be less than \$15 per month to cover 3 years in a nursing home at \$50 per day and 2 years of home health care. By waiting until age 65, the premium rises to about \$60 per month.

Prefunding during employment or at the time of retirement is critical if private financing is to be maximized. The willingness of some individuals to set aside small amounts of money on a monthly basis has been shown by the willingness of employees, about 10 to 15 percent, to participate in the initial employer-based group programs. Tax law changes that would allow the use of pretax dollars for premium payments could make this accumulation more attractive.

Evolution of private insurance

A major advantage of having the private market develop long-term care policies is that purchasers help determine the general form of the products available

on the market. Although choosing between competing insurance plans is often difficult because of the nuances and special "twists," purchasers must view the basic product (e.g., long-term care insurance) as having value. Certainly, to sell a policy that costs \$100 or more a month to a person 75 years of age, the perceived value must be significant. Recent trends in insurance offerings suggest that insurers are responding to consumer interest.

The typical LTC insurance product offered in 1986 had serious limitations. Most of these policies offered inadequate protection against catastrophic nursing home costs and provided little or no provision for either in-home health care or custodial level care. The vast majority of offerings were indemnity policies sold on an individual basis, and emphasizing skilled nursing home care (Meiners, 1984). All the plans had limits on the cost or length of coverage, or both. For example, most plans limited the nursing home benefit to between 3 and 4 years. Other coverage requirements, such as waiting periods, preexisting condition clauses, prior skilled care requirements, and prior hospitalization requirements, further reduced the extent of nursing home care covered by these policies. In effect, their emphasis on medical underwriting, medical necessity as a condition to receive benefits, and skilled level care made these policies really "super-medigap" policies, not long-term care insurance that covered custodial care needs.

As a result of the limitations and provisions of these earliest products, advertised benefit levels were usually quite deceptive. It was difficult, if not impossible, for the consumer to evaluate how much LTC benefit they might actually receive from a specific policy once all the restrictions and conditions were met. One such feature that required a 30-60 day prior nursing home stay to be eligible to receive home care benefits rendered the home health benefit virtually useless. However, some policies with this provision advertised that they provided up to 3-6 years of home health benefits.

In 1987, a second generation of LTC insurance products emerged which included several improvements over the earlier offerings. More plans offered custodial-level coverage, included home care benefits, and eliminated prior institutional care requirements. Also, more of the insurance plans incorporated consumer protection features such as guaranteed renewability and inflation protection option (Consumer's Union, 1988).

In 1988, the LTC products are offering case management and information and referral services to assist policyholders in finding providers of needed care. For some of the more innovative products, the underwriting and benefit determination criteria are moving away from medical criteria and medical necessity toward a focus on functional and cognitive disability. Although carriers are moving at different speeds, the current generation of products focus more on providing custodial and personal care services to the chronically ill. This is in sharp contrast to the industry's initial focus on skilled, medically oriented care.

The changing nature of the long-term care insurance product reflects an improved understanding among insurance companies of what long-term care really encompasses and what types of services and benefits the elderly are willing to purchase. Market surveys indicate that older individuals are, above all, seeking to maintain their independence and their current lifestyle (Cohen et al., to be published). They want support in recovering at home, and they want the financial means (i.e., insurance) that enables them to pay for needed care. Older individuals are not looking for just a nursing home benefit. Specifically, surveys suggest that there are at least three features which the elderly want (U.S. Department of Health and Human Services, 1988; Tell et al., 1987). First, the elderly want products which can provide estate protection so that there is something to pass on to their families, and they want to assure adequate income for their spouse in the event that one member needs costly care. Only products with catastrophic (deep) coverage can meet these needs. Second, the elderly also want products which will help them avoid ever having to go into a nursing home by providing meaningful home care coverage and a variety of other alternatives to nursing home care. Third, the elderly want to be assured of access to high quality care, including nursing home care and community services, should they need it. Many elderly worry more about where and how they will obtain care than about how they will pay for care.

Attributes of financing

In developing a long-term care insurance program, planners should not be thinking of creating a variant of acute health care insurance. The importance of prefunding as contrasted with the "pay-as-you-go" financing that characterizes acute care insurance has already been discussed. Conceptually, long-term care has the accumulation aspects of life insurance and pensions. Also, in terms of insurance, it would appear that a disability perspective (the loss of independence as opposed to the capacity to perform a job) is as beneficial an approach as indemnity or service benefit programs. Under a disability program, payments are keyed to the loss in function. A health insurance program ties the indemnity or service benefit payment to the use of services. Finally, because the demand for long-term care services emanates, in part, from a desire to maintain one's independence and lifestyle, the link between insurance (the paying for services) and the service itself appears closer in long-term care than in acute care. Thus, the combining of insurance and delivery suggests the development of various managed-care approaches and systems.

A well-established model of this latter linkage is the continuing care retirement community. As of 1986, there were more than 700 of these communities, which combined housing and long-term care services. They offered various amounts of risk-pooling. About one-third of these communities provided unlimited

coverage for long-term nursing home care on a risk-pooled basis (Tell, Wallack, and Cohen, 1987). The age of entrants to these communities is usually in the high 70's. Other linkages between housing, services, and insurance need to be developed for these older age groups as well as younger retirees. The concept of "life care at home" developed by researchers at the Bigel Institute at Brandeis University is now in the early developmental stages in at least four sites (Tell, Cohen, and Wallack, 1987; American Association of Homes for the Aging, 1987). In this program, individuals can purchase lifetime long-term care benefits that are provided to them in their own homes by a specified network of providers. Thus, these individuals are assured of having access to the long-term care providers of their choice.

Interrelated concepts

Long-term care financing must incorporate three distinct, but interrelated, concepts. First, as discussed previously, the financing for long-term care, whether done on an individual or societal basis, must include adequate accumulation mechanisms or prefunding. Second, risk-pooling or risk-spreading is desirable because of the skewed distribution of expenditures. Third, the program must include the services that will allow individuals to maintain their lifestyles.

Funds accumulation

The accumulation of funds can occur through a dedicated individual retirement account or other form of savings that could be directed to help pay for long-term care insurance premiums. Another option is to begin the prefunding through the purchase of a long-term care insurance plan at an early age. To date, a small number of companies have been willing to allow the group marketing of plans for which employees pay the entire premium. To appeal to the active workforce, however, these programs will need to have a cash value or return of premium and/or be portable.

Other financing approaches tied to employee benefits are also possible. Group disability can be broadened to include nursing home services, and the face value of life insurance policies can be reduced by the amount of long-term care services paid for up to a specified percent of the policy. The adaptations of existing policies is a recognition of the growing market interest in finding ways to finance long-term care.

The introduction of products that allow for the accrual and transfer of accumulated funds to long-term care will depend, in part, on tax implications. For example, the tax law could be changed so as to allow an individual to withdraw funds from a pension plan and use the funds for long-term insurance without paying taxes on the income which has been earned to date, but not taxed.

Risk-pooling

We are likely to see a continuation of indemnity and service benefit programs as well as a growing interest in disability systems that have a "cash value" assigned to the insurable event. Currently, most long-term care insurance policies have as the insurable event the use of service, usually nursing home, upon the recommendation of a physician. The determination of need by a physician reflects the philosophy that was behind the development of medigap policies, that is, that the elderly needed protection from acute care costs rather than from the costs associated with chronic illness.

Underwriting and benefit determination are shifting towards an emphasis on the ability of an individual, as measured by physical and mental impairment, to take care of their personal needs. The benefit is either triggered by the assessment, like a disability payment, or is further conditioned upon the use of service.

Link to service

Because of the availability of an informal support system and the personal nature of the service provided in one's home, the risk-pooling program, whether an indemnity or disability benefit, should incorporate some aspects of service management. Although managed care programs that link the financing and delivery of care and assure access to high-quality care meet the needs of many older individuals, they entail higher start-up costs. An example of a successful managed system is continuing care retirement communities. The high start-up costs entailed in this delivery system that combines housing and long-term care are incorporated into the overall marketing and development budget. Because housing costs are so large (often \$100,000 or more), the substantiated marketing costs do not overwhelm the price of the product. However, in the life care at home demonstration, the marketing and delivery system costs are major hurdles to overcome (Tell, Cohen, and Wallack, 1987).

In addition to meeting the desires of the chronically ill for providing access to services, systems that merge financing and delivery, have been shown to yield efficiencies in the use of services. Health maintenance organizations (HMO's) and, perhaps just as importantly, social/HMO's, have been shown to decrease the use of expensive hospital care and increase the use of less expensive ambulatory care (Manning et al., 1984; Greenberg et al., 1988). If more efficient care patterns result for the acutely ill, than one can reasonably expect even greater efficiencies from the coordinated care for populations with chronic care needs.

The financing issues for a population already chronically ill, whether frail elderly or the mentally retarded/disabled, is quite different. Risk-spreading is not an important feature and, therefore, public financing is more appropriate. Nevertheless, the payment to providers, whether private or public,

should provide incentives to manage the care for an extended period of time. Capitation payments is one viable option. The On Lok program, which links acute and long-term care for frail elderly, effectively merges the financing for services and their delivery.

Conclusion

Although insurance or risk-pooling is the critical link in a long-term care financing program, cash accumulation and/or prefunding mechanisms, as well as service delivery provisions, must be present as well. A single organization (either public or private) could be responsible for all three elements—accumulation, risk-pooling, and services—or responsibility could be divided between organizations because these three elements are distinct and each element has a different risk associated with it. Enrollment risk, i.e., the need for an adequate number of enrollees, relates to accumulation. Incidence risk, i.e., the probability of needing long-term care services, relates to risk-pooling. Utilization risk, i.e., the intensity of care provided, relates to service provision.

Insurance companies are becoming more comfortable providing long-term care policies. However, trepidation still exists regarding the risk embodied in current plans. Nevertheless, the trend to date has been toward greater depth in benefits, and a greater breadth of benefits is occurring as well. Delivery systems are beginning to develop partnerships with insurance companies. Insurance companies that assume the incidence risk will do the underwriting and the providers of services that assume the utilization risk will have the responsibility for the management of care. The concepts of risk-sharing and risk-management is being considered by a number of long-term providers currently and should become more commonplace in the future.

Private long-term care financing and delivery policies will become better values in terms of prices and benefits as competition among companies grows. The improved products are more likely to appear first as group plans since decisionmakers, such as employers, have more knowledge and experience in this area than would elderly individuals. The number of private long-term care insurance plans certainly will grow.

The major obstacle to the widespread growth in financial protection against long-term care costs for the elderly will be enrollment in the programs that are developed. The price of the product will loom more and more important. It is with regard to accumulation or financing that the public role is pivotal.

Private programs require voluntary enrollments. Private demand appears to be quite price sensitive. When the reason for such purchase is asset protection, governmental policies, particularly Medicaid, are important. Individuals will compare the cost of spending down (2 years in a nursing home as a private patient) and the willingness to become a Medicaid recipient with the cost of purchasing a private policy. Governmental policies and activities regarding

financing, such as tax policy, mandates, and subsidies, will determine both the content of private long-term care insurance and the balance between public and private long-term care financing.

The major debate in the future over public financing is not likely to be whether the government should do more, but rather the form of the support. The challenge for the public sector is to establish a financing program that permits and encourages the development of innovative benefits and delivery models as well as flexibility in the caring for individuals with chronic disabilities. The financing vehicle could be public or private. For example, a social insurance program using disability as opposed to service payments could provide the flexibility in benefits and care patterns. Alternatively, the government could provide subsidies for the purchase of private long-term care insurance based on the income and age of the individual. The latter approach could provide the necessary financing and allow the private sector to introduce necessary innovations in both insurance and service delivery.

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