How Much Might New Insurance Programs Improve Financing for Long-Term Services and Supports?

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For decades, policymakers have struggled to address the challenges of financing long-term services and supports (LTSS), with little success. To better understand new insurance-based alternatives and their effects on people age 65 and older, we analyze several proposals. We find that although none of the new plans is ideal, the options we review would generally improve access to LTSS and reduce Medicaid costs. We also find important differences among the proposals we study.

LTSS Financing

Older adults are at significant risk of developing chronic health problems and becoming unable to perform basic tasks on their own. In 2011, 7.7 million adults age 65 and older received help with everyday activities, including getting out of bed, bathing, dressing, eating, and using the toilet (Freedman and Spillman 2014). Urban Institute projections suggest that half of today's 65-year-olds will eventually need a high level of such LTSS for a prolonged period (Favreault and Dey 2015).

Most LTSS is provided at home by unpaid family caregivers (Spillman et al. 2014). Some people receive help from paid caregivers at home, but most paid LTSS are provided in nursing homes or other residential care settings. These paid services can be quite costly: lifetime LTSS costs will average about $138,000 (adjusted for inflation) for someone turning 65 today, and recipients could finance that cost by setting aside $69,500 at age 65—assuming their investment earns average returns (Favreault and Dey 2015).[1] But some people will incur much higher costs. For example, 15 percent of 65-year-olds will incur at least $250,000 in future LTSS costs.

The United States lacks a national policy for LTSS financing. Medicare does not provide extended coverage for LTSS needs, standard health insurance and Medigap policies do not cover LTSS, and relatively few people purchase private long-term care (LTC) insurance (Brown and Finkelstein 2007). Private coverage rates are low because premiums tend to be high; underwriting standards exclude some potential buyers; Medicaid potentially crowds out demand; relatively few people are aware of the high cost of LTSS; and insurance tends to attract people who are most likely to need services, in turn driving up premiums and limiting the size of the market. Between 2005 and 2012, sales of private LTC insurance fell from 528,000 to 395,000 policies (Cohen 2014). Consequently, many families needing LTSS rely first on unpaid family members, turn to paid services when more intensive care becomes necessary and pay out of pocket until their financial resources run out, and then enroll in Medicaid.

People who lack the resources for LTSS can receive poor or inappropriate care (Komisar, Feder, and Kasper 2005). This care gap can not only harm those who need assistance but also increase costs for Medicare, which pays for the hospitalizations and other medical treatments that often result from acute episodes caused by inadequate assistance (Komisar and Feder 2011).

What We Modeled

We examine three new insurance options; each could be operated by the government or the private sector. For each, we analyze both voluntary and mandatory insurance. Voluntary insurance would be financed by premiums paid by participants, and the mandatory programs would be funded through dedicated uncapped payroll taxes. Each of the voluntary programs would include both a subsidized option to help make insurance affordable for low-income consumers and an unsubsidized option. Because high earners would pay more taxes, our mandatory programs would provide indirect subsidies to low earners.

Each of the new insurance options would provide a daily cash benefit of $100 in 2015 that increases 3 percent a year. The cash benefit is an important change from private LTC insurance, which typically reimburses consumers only for approved expenses, such as time from a certified home health aide. Participants would become eligible for benefits once they develop a high need for personal assistance, much as they do with today's private LTC insurance.

Although the new options would offer identical daily benefits, they would differ in when benefits begin and how long they last. The alternatives we model include a front-end benefit, a back-end (catastrophic) benefit, and a fully comprehensive benefit that combines elements of both the front- and back-end programs.

A front-end plan would provide benefits for up to two years (after a 90-day waiting period). Under the back-end plan, consumers would be responsible for the first two years of expenses after developing a need for a high level of care. But after two years, they would receive the daily benefit for the rest of their lives.

The comprehensive plan combines the front- and back-end plans. Once triggering the benefit, a consumer would pay for the first 90 days of care. After that, however, the program would pay a daily benefit for life.

We simulate the cost and impact of these options using DYNASIM, Urban Institute's projection tool.[3] We model very basic plan designs that omit many specific details, but simplifying each alternative allows us to easily compare the options. Note that we study just three of many possible policy alternatives, and changes in their designs could lead to very different results. We also look only at how these options would affect people age 65 and older. Although about half of those with LTSS needs are under age 65, data limitations prevent us from studying that population. For more details on the plans we model and how the model works, see Favreault, Gleckman, and Johnson (2015) and Favreault and Johnson (2015).

What We Learned

The affordability of potential new LTSS insurance programs; how much they favor low-income people; and their impact on coverage, out-of-pocket savings, and Medicaid savings vary across the options we model (table 1). We find substantial differences between mandatory and voluntary programs; we also find important distinctions between plans that provide front-end and back-end benefits and between plans that do and do not provide subsidies to low-income people.

- **Coverage:** The mandatory programs would enroll nearly all adults, a dramatic improvement over the current system, which excludes nearly all low-income adults and most middle-income adults while covering no more than 20 percent of high-income adults. Voluntary programs without subsidies would not expand coverage much beyond current private LTC insurance. Voluntary programs with subsidies would enroll many low-income adults but would not expand coverage much for moderate- or high-income adults, who would be ineligible for premium assistance.
- **Affordability:** Most moderate- and high-income workers could pay the mandatory insurance tax with little difficulty. Those payroll taxes, however, would be more burdensome for low-income workers, especially for the more costly comprehensive plan. (We estimate that the payroll tax rate would be 1.35 percent for the comprehensive plan, 0.75 percent for the back-end plan, and 0.60 percent for the front-end plan.)
    - People would generally pay more for voluntary coverage than for mandatory plans. Voluntary plan participants would not enroll until they were middle-aged or older; the mandatory plan would require workers to pay taxes for their entire careers. Because most voluntary enrollees would contribute for fewer years, their annual premiums would be higher. And although nearly all workers would enroll in the mandatory programs, the voluntary programs would disproportionately attract people most likely to use LTSS, who would benefit most from coverage. This "adverse selection" would raise costs and hence premiums.
    - We estimate that annual premiums for someone enrolling at age 55 in the voluntary unsubsidized programs would be about $3,600 for the comprehensive plan, $2,900 for

the back-end plan, and $1,900 for the front-end plan. These premiums would be especially burdensome for low- and middle-income people. Under the subsidized versions of these plans, insurance would be free or nearly free for many low-income people, but other taxpayers would have to pay for those subsidies.

TABLE 1

Performance of the Baseline LTC Financing System and New LTSS Options

		Mandatory			Voluntary, No Subsidies			Voluntary, with Subsidies		
	Baseline	Front end	Back end	Comp.	Front end	Back end	Comp.	Front end	Back end	Comp.
Coverage										
Low income	Very low	Very high	Very high	Very high	Very low	Very low	Very low	High	High	High
Moderate income	Low	Very high	Very high	Very high	Low	Low	Very low to low	Low	Low	Very low to low
High income	Medium	Very high	Very high	Very high	Medium	Medium	Low to medium	Medium	Medium	Low to medium
Affordability										
Low income	Very low	Medium	Low	Low	Very low	Very low	Very low	Very high	Very high	Very high
Moderate income	Low to medium	Medium to high	Medium	Medium	Low to medium	Low to medium	Low	Low to medium	Low to medium	Low
High income	Medium to high	Very high	Very high	Very high	High	Medium	Medium	High	Medium	Medium
Out-of-pocket savings	NA	High	Medium	High	Very high	High	Very high	High	Medium	High
Medicaid savings	NA	Medium	High	High	Low	Low	Low	Low	Medium	Medium
Progressivity	Medium	High	High	High	Low	Low	Low	High	High	High

Source: Authors' analysis of data from DYNASIM.

Notes: Comp. = comprehensive; LTC = long-term care; LTSS = long-term services and supports; NA = not applicable. The table compares outcomes under each of the potential new LTSS options to the baseline system of private LTC insurance. The coverage measure is based on the share of the population projected to enroll in each program relative to the share covered by private LTC insurance in the current baseline system. The affordability measure compares required annual contributions to annual income. The progressivity measure indicates how much each program favors low-income participants.

- **Out-of-pocket savings:** All of the new insurance programs we model would reduce out-of-pocket LTSS spending for enrollees, provide additional resources to families to satisfy unmet needs, or provide relief to unpaid caregivers. However, programs that cover front-end costs would benefit families most because such programs now pay most of those expenses. People who purchase voluntary unsubsidized insurance would also reduce out-of-pocket spending because their high incomes make them less likely to receive Medicaid-financed LTSS.
- **Medicaid savings:** The mandatory programs would offset much more Medicaid LTSS spending than the voluntary versions because mandatory insurance would cover many more people. In

addition, the programs that cover back-end costs would generate more Medicaid savings than those that cover only front-end costs because many people qualify for Medicaid LTSS coverage only late in a disability spell, after they have incurred substantial out-of-pocket costs that deplete much of their wealth.

- **Progressivity:** This measure indicates how much each program favors low-income people. The voluntary subsidized programs are most progressive because very low income people could enroll without paying any premiums. The mandatory programs are also progressive because they tie enrollee contributions to taxable earnings. Voluntary unsubsidized programs are least progressive because all enrollees pay the same premium regardless of income.

Conclusions

No solution we model is the "magic bullet" that could fully address the challenge of long-term care financing in the United States. However, each would be an improvement over today's ineffective financing system, which imposes large out-of-pocket costs on families and shifts costs to the underfunded Medicaid system once those families have exhausted their financial resources. We find substantial trade-offs between voluntary and mandatory insurance and smaller but important differences among the voluntary programs.

Mandatory programs would provide the most people with insurance. At age 65, nearly everyone would participate, and the risks and costs of LTSS would be spread broadly across almost the entire population. However, mandatory insurance would require a significant tax increase and force nearly everyone to obtain coverage, even those who preferred to self-insure.

Voluntary insurance would cover far fewer people, and many buyers would be relatively high-income consumers who would replace their private LTC insurance with this new coverage. Most low-income seniors would participate in subsidized versions of voluntary insurance, but enrollment would drop sharply as the subsidy declines. In addition, other taxpayers would have to fund the subsidies. Only about 1 in 10 middle-income people would enroll in voluntary programs or purchase private insurance.

Because few middle-income people would buy voluntary insurance, none of these programs would reduce Medicaid LTSS spending for older adults more than 10 percent. But high participation in back-end and comprehensive mandatory insurance would significantly reduce Medicaid spending.

The alternatives would also differ in their ability to provide families with new resources to purchase assistance. Although the largest share of benefits paid by back-end insurance would reduce Medicaid spending, the front-end options we study would primarily provide families with new resources to pay for personal assistance or other supports. Overall, we find that between 25 and nearly 40 percent of new insurance benefits would finance care that participants would otherwise not get or that is now provided by family members or other unpaid caregivers.

We model only a few options, and alternative plan designs could have different effects. For example, mandatory LTSS insurance could be financed with a capped payroll tax instead of an uncapped payroll

tax, or it could be financed with income or consumption taxes. New programs could provide larger daily benefits or require enrollees to wait longer before the program pays benefits. Policymakers could create stronger incentives for people to purchase private LTC insurance or combined medical and LTC insurance. Our research is still in its early stages, but it demonstrates that evidence-based models can highlight the important trade-offs policymakers must confront when designing new LTSS insurance programs.

Notes

1. These estimates cover only those costs associated with severe LTSS needs and exclude the often substantial sums spent coping with less severe disabilities.
2. When individuals have both medical (for example, for postacute care) and LTSS needs, Medicare may provide services in skilled nursing facilities or at home to beneficiaries who otherwise would have received LTSS alone.
3. Milliman provided us with premium and participation estimates for the voluntary programs (Giese and Schmitz 2015). For more information on DYNASIM, see "DYNASIM: Projecting Older Americans' Future Well-Being," Urban Institute, accessed January 26, 2016, http://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/dynasim-projecting-older-americans-future-well-being.

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