Can Private Insurance Solve the Long-Term Care Problems of the Baby Boom Generation

Testimony before the Senate Special Committee on Aging

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The current American system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent either by Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston and Hanley, 1994).

As the American population ages, demand and expenditures for long-term care are certain to grow. It is projected that nursing home and home care expenditures for the elderly will increase by 123 percent in inflation-adjusted dollars between 1993 and 2018; public expenditures for Medicare, Medicaid and other public programs will increase by 109 percent over that same time period (Wiener, Illston, and Hanley, 1994). Although spending will grow substantially, the burden will not be as heavy as commonly assumed because the economy will be expanding as well. Assuming that the economy grows at a real rate of 2.5 percent a year, long-term care for the elderly will increase from about 1.21 percent of the gross domestic product in 1993 to about 2.14 percent in 2048 when the baby boom generation hits its stride in needing nursing home and home care services. While a nontrivial additional burden, this level of increase is not the end-of-the-world as some would maintain and by itself would be sustainable without much problem. What makes these expenditures more difficult to finance is that they are on top of additional resources that will inevitably be needed for Medicare and Social Security.

To address the problems of long-term care, a small, but growing private long-term care insurance market has developed over the last fifteen years. Although over 95 percent of the elderly have Medicare coverage and about 70 percent have supplemental private insurance policies, insurance against the potentially devastating costs of long-term care is relatively rare (Committee on Ways and Means, 1996). As of the end of 1995, only 4.3 million long-term care policies ever had been sold (although far fewer were in force), overwhelmingly to the elderly on an individual basis rather than to younger people on an employer-subsidized group basis (Coronel and Kitchman, 1997). [1]

By far the greatest impediment is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most elderly. The average annual premium for policies covering four years of nursing home and home care with inflation protection and nonforfeiture benefits in 1995 was $1,124 per year if purchased at age 50, $2,560 per year if purchased at age 65, and $8,146 a year if purchased at age 75 (Coronel and Kitchman, 1997). [2]

The policies are expensive for two reasons: 9 out of 10 are sold individually and, therefore, carry high administrative costs; and, most policies are bought by older people whose risk of needing long-term care is substantial. Consequently, most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston and Hanley, 1994; Crown, Capitman and Leutz, 1992; Rivlin and Wiener, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered interested in purchasing insurance (Cohen, Kumar, McGuire, and Wallack, 1992; and, Cohen, Tell, Greenberg, and Wallack, 1987). Affordability is not likely to dramatically improve in the future (Wiener, Illston and Hanley, 1994).

To estimate the potential impact of various private long-term care insurance options, Wiener, Illston, and Hanley simulated several different private long-term care insurance options using the Brookings-ICF Long-Term Care Financing Model (Wiener, Illston, and Hanley, 1994). Figure 1 describes the simulation assumptions, which represent an optimistic upper-bound estimate of potential market penetration and impact for some of the options. Under these assumptions, affordability and medical underwriting are the only barriers to the purchase of policies; actual market penetration and impact is likely to be far less than the simulation.

The simulations show that the market penetration and ability to finance long-term care of private insurance aimed at the elderly is likely to remain extremely limited (Table 1). Even under the assumption that the elderly with only minimal assets will spend a substantial portion of their income for policies, only one in five elderly people could have a policy in 2018. Because of limited market penetration, private insurance bought by the elderly is unlikely to substantially ease the burden of out-of-pocket long-term care costs. Moreover, because private insurance is bought mostly by upper-middle and upper-income elderly with substantial assets, it will have little impact on public spending through Medicaid. For policies sold to the elderly, the projected Medicaid savings are 2-4 percent, basically rounding error for estimates 20 years into the future.

Given the limitations of the current market for private long-term care insurance, public subsidies to promote its purchase are frequently proposed. One approach is to provide employers a tax subsidy for the purchase of long-term care insurance policies for their employees by allowing them to deduct insurance contributions as a business expense. A second strategy is to provide a tax deduction or credit to individuals for purchase of private long-term care insurance. Tax incentives for employers and individuals were part of the Health Insurance Portability and Accountability Act of 1996 (the Kassebaum-Kennedy law). A final strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long-term care insurance policies, an approach being tried in several states. The shared intent of these strategies is to induce more people to purchase policies by lowering premium costs through tax breaks or guaranteeing publicly-funded coverage once privately purchased coverage is exhausted. Proponents argue that a key consequence of any of these actions is public endorsement of the importance and desirability of private long-term care insurance.

All of these options will, no doubt, promote the purchase of private long-term care insurance, but to what extent is unclear. Moreover, with the possible exception of easing access to Medicaid by persons who purchase private long-term care insurance, these strategies are not free to the government. All of these options could result in substantial loss of federal revenue, which is spending just as certainly as the direct expenditures of a public insurance program.

EMPLOYER CONTRIBUTIONS AND THE TAX STATUS OF PRIVATE INSURANCE

One approach to address the affordability problem is to encourage the purchase of private long-term care insurance at younger ages, especially through employers. Since 1987, a tiny but expanding market of employer-sponsored insurance for long-term care has developed. As of 1995, only about 500,000 policies had been sold through 1,260 employers (Coronel and Kitchman, 1997). In a key difference from acute care polices, where most employers pay a large proportion of the cost of insurance, most employer-sponsored long-term care policies are offered on an employee-pay-all basis.

The Advantages of the Employer-Sponsored Market

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, the premiums for a 42-year-old will be approximately one-quarter to one-third of the premium for a 67-year-old (Wiener, Harris and Hanley, 1990). Computer simulations suggest that purchase of long-term care insurance by the younger population could largely solve the affordability problem of private long-term care insurance, even without employer contributions (Table 1). Because of the improved affordability, significant Medicaid savings could be achieved if persons purchased long-term care insurance when they were younger.

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that the policy is employer-sponsored, the nonelderly are easiest to reach through their place of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, in group policies, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. However, informal discussions with insurance actuaries suggest that most assume only a ten percentage point difference in the anticipated loss ratio between individual and group plans.[3] Thus, although the administrative savings of group policies are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most younger persons with significant disabilities are

not in the work force and would not, therefore, be eligible for these policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase additional coverage from time-to-time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.[4]

Impediments to an Employer-Sponsored Strategy

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market may not expand enough to play a significant role in financing long-term care. Employers are reluctant to offer the policies, and employees are not rushing to purchase them. In particular, employers have been unwilling to contribute to the cost of policies.

Tax Treatment of Private Long-Term Care Insurance

Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out-of-pocket and might give employees confidence in the product. Until passage of the Kassebaum-Kennedy bill in 1996, private long-term care insurance was not specifically recognized in the federal tax code. Because of its unique characteristics, long-term care insurance did not fit neatly into the existing tax models of health and accident, life, or disability insurance, pensions or private annuities. As a result, the tax status of employer contributions and of insurance benefits were unclear and this lack of clarity no doubt slowed the growth of long-term care insurance, at least to some extent. The Kassebaum-Kennedy bill clarified that contributions towards the cost of group long-term care insurance policies was a tax-deductible expense for employers (like health insurance) and that benefits (within limits) were not considered income.

A persistent problem with tax incentives is the probability that most of the tax expenditures will be for people who would have purchased policies anyway. As a result, tax subsidies can be very costly ways of promoting private insurance. For example, Wiener, Illston, and Hanley (1994) estimate that the lost revenue to the federal government of allowing employers to deduct the cost of their contribution to private long-term care insurance would be $7,900 to $11,300 per year per additional policy sold.

These tax benefits are also not free to the federal government, producing potentially substantial tax losses. Some advocates argue that reductions in government expenditures for Medicaid nursing home and home care will offset the tax loss because some people who will buy private insurance would otherwise be eligible for Medicaid. At least for a long time period, these offsets are unlikely to occur because the tax loss will happen immediately, because the revenue loss is linked to premium payments, but the savings, if any will not occur until the benefits are used, typically many years into the future. This imbalance in timing guarantees short-term tax losses. Using a computer simulation model, Wiener, Illston, and Hanley (1994) estimate that it could take twenty-five years before the annual tax loss approximately equals the Medicaid savings.

While the uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees, these factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health insurance benefits for retired employees which supplement the Medicare program. Unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated $187 billion to $400 billion in mostly unfunded liabilities (U.S. General Accounting Office, 1993; Warshawksy, 1992; U.S. General Accounting Office, 1989).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits, making retirees pay a greater part of the cost or dropping that coverage altogether. For example, data from Foster Higgins' annual survey of mostly large employers found a drop in retiree health benefits between 1988 and 1992 (Foster Higgins, 1993). In 1988, 55 percent of responding firms offered retiree health benefits to Medicare eligible retirees; by 1992, only 46 percent of responding firms did so. The percentage of full-time workers in state and local governments with retiree health benefits declined between 1990 and 1992 from 58 percent to 50 percent (U.S. Department of Labor, 1994, 1991). A recent study of 50 of the largest companies showed that 31 companies reported increases in retiree cost sharing for medical benefits in 1994 (Watson Wyatt Worldwide, 1995). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty to thirty years after they have left the company. Indeed, employers are trying to distance themselves as much as possible from such benefits.

Limited Employee Demand

To date, employee demand has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits or a personal sensitivity to the problem by a senior officer or employee benefit manager have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them. Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that, depending on how the

universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (Coronel, 1991).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are lower at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age 50 can cost more than $1,000 a year (Coronel and Kitchman, 1997). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc., reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90 percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc. (1992), survey, 80 percent of nonpurchasers stated that "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages could be locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

TAX INCENTIVES FOR INDIVIDUAL PURCHASE OF PRIVATE INSURANCE

Another set of options would improve the affordability of private long-term care insurance by offering direct tax incentives to individuals who purchase policies. For example, the Kassebaum-Kennedy legislation allow individuals to count private long-term care insurance premiums as a health expense.[5] Health care expenses in excess of 7.5 percent of adjusted gross income are tax deductible. As a result of the ability to deduct part of the cost of private long-term care insurance, the net price of insurance policies will be reduced. Some insurance advocates argue that providing a tax benefit will have a "sentinel" effect, promoting insurance beyond merely reducing the price. A tax incentive, they contend, will signal potential purchasers that the government thinks private long-term care insurance is a worthwhile product.

The type of tax chosen to provide the tax subsidy defines the scope of who can benefit. Allowing taxpayers to deduct all or part of the cost of a private long-term care insurance policy would provide a premium subsidy valued at the marginal tax rate of the household. Since upper-income taxpayers have higher marginal tax rates than lower-income taxpayers, deductions are regressive in nature. That is, they are worth more to upper-income people than to lower-income people. However, for the 72 percent of taxpayers in the 15 percent tax bracket in 1993, this type of tax subsidy would reduce the cost of obtaining long-term care insurance by only about one-seventh, probably not enough to motivate very many additional people to purchase polices (Cruciano and Strudler, 1996). The other major drawback is that relatively few taxpayers itemize their deductions. In 1993, only 29 percent of all tax returns included itemized deductions; only 4 percent claimed a deduction for medical expenses (Internal Revenue Service, 1996).

The other broad approach is to provide a tax credit, which is a direct reduction in the amount of tax owed, for purchase of policies. In theory, tax credits need not be as regressive as deductions. However, as a practical matter, moderate and low-income taxpayers may not have the cash on hand to pay premiums during the year so as to be able to claim a tax credit in the following year. The other problem is that, unless the credit is refundable, it is an ineffective policy for people who do not have a tax liability. This is especially a problem for the elderly; only about half of whom have any federal income tax liability (Committee on Ways and Means, 1996).

As with tax subsidies for employer contributions to private long-term care insurance, the key issue is whether tax incentives are an effective and efficient way to promote the purchase of private long-term care insurance, and thereby, the reform of nursing home and home care financing. For example, estimating the effect of an income-related tax credit for the purchase of private long-term care insurance, Wiener, Illston and Hanley (1994) estimated the cost per additional policy induced by the tax benefit at between $1,700 and $1,900 per year. Similarly, they estimate that the tax loss through 2018 will be at least four times the Medicaid savings.

EASIER ACCESS TO MEDICAID: A PUBLIC-PRIVATE PARTNERSHIP

While changing the tax code is the most commonly proposed way of publicly subsidizing private long-term care insurance, the initiatives by Connecticut, Indiana, California, Iowa and New York take a substantially different approach. Commonly referred to as the "Robert Wood Johnson Public-Private Partnerships" (named for the foundation that promoted this strategy), these states provide easier access to Medicaid for persons who purchase a state-approved private long-term care insurance policy. In essence, these states allow nursing home patients with private long-term care insurance to be Medicaid eligible with substantially higher levels of assets than is normally allowed.[6] At present, Medicaid only allows unmarried nursing home patients to retain $2,000 in assets (excluding the home). While employer-paid plans and tax incentives seek to reduce

the net cost of insurance, this public-private partnership does the reverse by trying to increase the amount of benefits received per dollar spent.

There are two models of how to link Medicaid and private insurance.[7] In both cases, Medicaid acts as a kind of reinsurance for persons with limited private long-term care insurance. In one model used by Connecticut, California, Indiana, and Iowa, the level of Medicaid-protected assets is tied to the amount that the private insurance policy pays out. For example, if a person buys a policy that pays $100,000 in long-term care benefits, then that individual can keep $100,000 in assets and still be eligible for Medicaid. Consumers are able to purchase insurance equivalent to the amount of assets they wish to preserve, potentially reducing the amount of insurance individuals need to buy.

The other model, used by New York, provides protection of an unlimited amount of assets if an individual purchases a policy that meets state standards, including coverage of at least three years of a combination of nursing home and home care, with a minimum $100 per day indemnity payment. The rationale for not requiring an asset test for Medicaid coverage is that nursing home costs are so high in New York that few individuals can avoid Medicaid over an extended period of time.[8] Thus, New York is targeting a higher income population, with potentially more assets, than are the other states.

The key observation supporting the public-private approaches is that long-term care insurance that covers shorter periods of nursing home and home care are cheaper and more affordable than policies that cover longer periods of care.[9] The problem with the current system is that if an individual buys a policy that covers, for example, two years of nursing home care and ends up staying in a nursing home for five years, then the insured's assets can still be lost. Thus, under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. Proponents of this approach contend that the goal is not asset protection, per se., but rather to preserve financial autonomy toward the end of life.

Supporters assert that by encouraging purchase of insurance, Medicaid long-term care expenditures will possibly be reduced or, at least, will not increase. This argument is probably stronger for the approach used by Connecticut, Indiana, Iowa, and California, where there is a "dollar-for-dollar" correspondence between the amount the insurance pays and the level of Medicaid protected assets. In New York, the ability to protect potentially very large amounts of assets makes this argument weaker, although still possible. To the extent that these systems are budget-neutral, these strategies will be a move toward what economists call "Pareto Optimality," that is, making some people better off without making anybody worse off. Insurance dollars are simply substituted for private asset dollars.

There are two other potential advantages to this approach. First, since only "approved" policies are eligible for the enhanced asset protection, state regulators can use the initiative as a "carrot" to induce insurance companies to upgrade the quality of their policies.[10] Second, by giving the elderly the alternative of protecting their assets by purchasing insurance, legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility may be reduced.

Despite these arguments, there are several concerns about the equity and efficiency of this option. The first concern is whether it is appropriate to use a means-tested welfare program--Medicaid-- as a mechanism to protect the assets of upper-middle and upper-income elderly. Indeed, under this approach, it remains an open question how far down the income distribution insurance purchase will go. Computer simulations by Wiener, Illston and Hanley (1994) suggest that the vast bulk of private insurance expenditures will be for the relatively well-to-do elderly.

The second concern is whether providing improved asset protection will actually induce substantial numbers of people to purchase long-term care insurance who would not otherwise have bought it. As of December 1996, participation in partnership plans has been disappointing, with only 22,000 policies in force, over half of which are in New York State (University of Maryland Center on Aging, 1997). While it is difficult to sift through people's motivations for buying insurance, one recent study of purchasers found that only 23 percent of respondents listed protection of assets as the "most important" reason for buying insurance (LifePlans, 1995). Asset protection may have a narrow appeal because most elderly have relatively modest levels of financial wealth (Radner, 1993).

Even more fundamentally, many elderly do not want easier access to Medicaid. Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy (LifePlans, 1995). Medicaid's relatively low reimbursement rates have led to inadequate access and quality of care problems in nursing homes heavily dependent on Medicaid (Nyman, 1988; Institute of Medicine, 1986; and, Scanlon, 1980). In addition, upper-middle and upper-income elderly will probably find the $30 a month personal needs allowance of the Medicaid program to be inadequate. Therefore, they would use up at least some of their newly-protected assets for daily living expenses. Avoiding Medicaid is also the principal argument that insurance agents use to market policies; the partnership plans require a radical revision in the agent's "sales pitch." In sum, it is not clear that easier access to Medicaid will be enough of an inducement to get large numbers of additional elderly to purchase private long-term care insurance.

The third concern is whether the public-private partnership will truly be budget-neutral. After all, Medicaid benefits are being offered to people who would otherwise not be eligible. Because most policies probably will be sold to healthy young elderly who are at least 10 to 20 years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for a decade

or two. If additional public expenditures should prove to be required, then one may well ask whether providing asset protection to relatively well-to-do elderly is the best place to put our next long-term care dollar.

It is also important to realize that an indispensable component for assessing the effect on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care insurance at all, it is likely, although not certain, that the partnership would be budget-neutral. However, there is likely to be continuing modest growth in the number of private long-term care insurance policies sold. Compared to this scenario, if the partnership does not induce substantial numbers of additional insurance purchasers, then the partnership will require larger Medicaid expenditures than would otherwise be needed. This is because under current Medicaid rules purchasers of insurance who would have bought policies without the public-private partnership would have to spend-down their assets after their insurance benefits have been exhausted before qualifying for Medicaid, something that they are not required to do under the partnership.

In addition, while supporters argue that the partnership offers persons a more appealing alternative to transferring assets as a way to avoid Medicaid's claim on these resources, it is conceivable that it will actually increase the level of premature asset transfer. Current rules prohibit the transfer of assets to other persons at less than fair market value for 36 months prior to application for Medicaid eligibility (Burwell and Crown, 1996). Once the partnership has encouraged the elderly to look to Medicaid as a way to protect their assets, some insurance purchasers may only buy the 36 months worth of coverage required to comply with Medicaid rules and then legally transfer the remainder of their financial wealth upon entry to a nursing home. Others may calculate that they can transfer or shelter their assets and obtain Medicaid benefits without purchase of any long-term care insurance policy.

CONCLUSIONS AND RECOMMENDATIONS

The United States faces major challenges in the way it organizes and finances long-term care for the elderly. The aging of the baby boom generation absolutely guarantees that expenditures for nursing home and home care will grow substantially in the future. Based on the available evidence, the following observations should form the framework for reform:

- Although the role of private long-term care insurance will inevitably grow over time, it is doubtful that it will ever play a major role in the financing of long-term care. Especially for the elderly population, good-quality policies are simply too expensive. Medicaid savings are particularly unlikely because the people who can afford policies are not the people who spend down to Medicaid.
- Selling private long-term care insurance to younger people through employers can make policies significantly more affordable. However, policies are still costly and employees have so far been unwilling to buy policies in large numbers. Substantial employer subsidies could make private long-term care insurance more attractive, but even with tax subsidies employers are unlikely to make contributions because of their large unfunded liability for retiree acute care benefits. Employee demand among people in their 40s is low because of competing demands for their spending. As a result, market penetration is likely to be far below the levels projected by simulations (including my own) based solely on upper-bound determined affordability.
- While some of the tax clarifications for private long-term care insurance enacted in the Health Insurance Portability and Accountability Act of 1996 were desirable, the tax deduction for individual purchase of private long-term care insurance is regressive, primarily benefits the well-to-do, and is a highly inefficient way to encourage the purchase of private long-term care insurance. Most of the subsidy will go to people who would have bought insurance without the tax benefit. Even clarifying the tax treatment of employer contributions will result in federal tax losses that are "spending" are surely as any direct appropriation. Congress should refrain from providing any more tax incentives for the purchase of private long-term care insurance.
- While the quality of policies has improved dramatically over the last ten years, the lack of inflation protection and nonforfeiture benefits in most policies are significant deficiencies. Congress lost a major opportunity to upgrade policies when they provided tax breaks to insurance companies without requiring any substantial upgrading in consumer protection.
- While a favorite of some policy analysts, the public-private partnerships for long-term care have failed the market test--very few policies have been sold, even in states that have promoted them for several years. Although the reasons are unclear, probably the primary reason is that insurance agents prefer to sell policies by emphasizing the negative aspects of the Medicaid program, a strategy that is inconsistent with a product whose primary benefit is easier access to the program.
- Given the limitations of private long-term care insurance, serious long-term care reform that seeks to make life better for the great majority of elderly will require expansions of public programs--Medicare, Medicaid, and others--that currently are the major source of third-party funding. To ignore the public programs in the hope that private insurance will replace them someday is a luxury that the disabled elderly and their families can ill afford.

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Figure 1
Private Long-Term Care Insurance Options: Simulation Assumptions

All persons purchase insurance policies that cover two or four years of nursing home and home care and pay

an initial indemnity value of $60 per day for nursing home care and $30 per visit for home care in 1986. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled person who meet affordability criteria buy as much as insurance as they can afford.

- ***5% Income:*** All elderly purchase policies if they can afford them for 5% of the income or less and if they have $10,000 or more in nonhousing assets.
- ***Medicaid Insurance:*** Elderly who purchase private long-term care insurance may receive Medicaid nursing home benefits while retaining liquid assets beyond what is normally allowed. The additional assets that they keep equal the amount that the private insurance policy pays out in benefits. All elderly persons purchase policies when they can afford them for 7% of their income or less and if they have $10,000 or more in nonhousing assets.
- ***Tax-Favored Insurance:*** Provides an income-related tax credit of up to 20% of the premium cost for elderly purchasing insurance. All elderly purchase policies when they can afford them for 5% of their income or less and if they have $10,000 or more in nonhousing assets.
- ***Employer-Sponsored Insurance:*** Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have $10,000 or more in nonhousing assets.

Source: Wiener et al., 1994.

Table 1
How Much Can Private Insurance Do?
Simulation Results for Four Major Options, 2018

Option	Elderly with Private Insurance[a]	Total Long-Term Care Spending Paid by Private Insurance[b]	Private Insurance Spending on Nursing Home Patients with Incomes >$40,000[c]	Reductions in Medicaid Nursing Home Spending[d]	Reductions in Catastrophic Out-of-Pocket Spending for Nursing Home Patients[e]
5% Income	20%	9%	70%	-2%	-6%
Medicaid Insurance	32%	14%	61%	-4%	-11%
Tax-Favored Insurance	28%	12%	64%	-3%	-8%
Employer- Sponsored	80%	35%	26%	-32%	-28%

Source: Wiener et al. 1994.

Notes:
a. Age at initial participation is 67 for all options. Consequently, all are expressed as the percent of elderly aged 67 and older.
b. Total long-term care expenditures vary by option.
c. Income is presented in 1993 dollars.
d. Medicaid nursing home expenditures for the base case are $49 billion.
e. Defined as >40% of income and nonhousing assets.

Notes

1. "The number of policies ever sold" is a highly misleading figure because it does not take into account that many people have let their policies lapse or that some policyholders have died. The Health Insurance Association of America does not collect information on the number of policies in force.

2. While policies without inflation protection (i.e., at least 5 percent annual compound increase in the indemnity level) and nonforfeiture benefits are cheaper, they are essential elements of good policies.

3. The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.

4. For example, if a person buys a policy at age 42 that pays $60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of $20 a day to compensate for the inflation but at the price charged 47-year-olds, not 42-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age 82 would be approximately ten times what they were at age 42. This is because nursing home use is exponential by age.

5. The level of private long-term care insurance that can be included varies by age. For 1997, it is limited to $200 for persons age 40 and younger; for persons aged 70 and older, it is limited to $2,500.

6. Medicaid law allows states great flexibility in determining countable income and assets of medically-needy patients--patients with high medical bills in relation to their income. In essence, states using this strategy exclude insurance-related assets from their definition of resources that must be counted in determining Medicaid eligibility. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) severely restricts the ability of additional states to pursue this option by including the insurance-related protected assets in an individual's estate. OBRA 1993 requires states to attempt to recover the cost of institutional care from the estates of Medicaid patients. Thus, patients may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

7. In both models, nursing home patients must still contribute all of their income towards the cost of care except for a small (usually $30 per month) personal needs allowance.

8. In 1993, the average Medicaid rate was $185 per day, compared with $88 for the United States as a whole (American Health Care Association, 1996).

9. At age 67, prototype individual private insurance policy costs $2,337 a year for a policy that covers four years of nursing home and home care, but $1,617 a year for a policy that covers only two years of nursing home and home care (Wiener, Harris and Hanley, 1990).

10. For example, Connecticut mandates compound inflation adjustment of indemnity benefits. In addition, the State is requiring a type of nonforfeiture benefit that requires companies to offer a policy with less extensive coverage to individuals who discontinue their premiums payments and let their policy lapse. Connecticut has also mandated training for insurance agents selling certified policies and is requiring the distribution of a consumer booklet that compares insurance policies.

Other Publications by the Authors

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