



Can Catastrophic Insurance Improve Financing for Long-Term Services and Supports?

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June 2016

The Bipartisan Policy Center (2016), LeadingAge (2016), and the Long-Term Care Financing Collaborative (2016) recently advocated changing how we finance long-term services and supports (LTSS). Currently, most people with LTSS needs rely mostly on unpaid family caregivers for assistance. If they need more help, they generally pay out of pocket until they exhaust their financial resources and then turn to Medicaid. New financing approaches could combine public insurance for catastrophic LTSS costs with initiatives to promote private long-term care coverage for other expenses. Our projections suggest that these options could significantly reduce Medicaid spending and provide better financial protection for older people who develop LTSS needs.

Who Pays for LTSS Today?

The prospect of becoming disabled and needing LTSS is perhaps the most significant risk facing older Americans. Favreault and Dey (2015) estimate that about one half of today's 65-year-olds will eventually need substantial amounts of LTSS. Most will receive informal help from family and friends, but increasing numbers of older Americans will receive home care from paid helpers, and many will end up in nursing homes (Johnson, Toohey, and Weiner 2007).

Many older adults who develop LTSS needs experience financial hardship. Older adults with health problems tend to have less wealth than healthier older adults, and wealth tends to fall when people develop health problems (Johnson 2016; Poterba, Venti, and Wise 2010). One study, for example, found that over a nine-year period median household wealth grew 20 percent for married people age 70 and

older who did not receive nursing home care, but fell 21 percent for their counterparts who received nursing home care; for single people who received nursing home care, median household wealth fell 74 percent (Johnson, Mermin, and Uccello 2006). Home equity does not decline much at older ages, except when homeowners become widowed or enter a nursing home (Venti and Wise 2004).

Older people receiving LTSS generally suffer financially because these services and supports are expensive and there are few public or private insurance options. Estimates from a 2015 national survey of nursing homes show that the median cost of nursing home care in a semi-private room is now about \$80,000 per year, and as much as 80 percent more in certain parts of the continental United States (Genworth 2015). Standard health insurance plans do not cover LTSS, and Medicare covers LTSS only in special circumstances.

Only about 11 percent of adults ages 65 and older now have private long-term care insurance (Johnson forthcoming), and this market is shrinking (Cohen 2014). Consumer surveys indicate that people are often reluctant to purchase long-term care insurance because many underestimate future LTSS costs; mistakenly believe that Medicare or standard health insurance will cover much of their expenses; do not trust insurance companies; or believe that premiums are too high (Associated Press-NORC Center for Affairs Research 2015; Brown, Goda, and McGarry 2012; Wiener et al. 2015).

Because paid services are costly and insurance is limited, many LTSS recipients rely on unpaid caregivers, typically spouses and adult children (Wolff et al. 2016). Those who need additional care generally pay out of pocket until they exhaust their resources and then end up on Medicaid, which is restricted to people with very little wealth.¹ According to a recent study, Medicaid covers about two-thirds of nursing home residents ages 65 and older (Spillman and Waidmann 2015).

As the population ages and LTSS costs rise, there is growing concern that Medicaid will increasingly strain federal and state budgets (Commission on Long-Term Care 2013). Although exact estimates vary, Medicaid pays more than \$100 billion a year for LTSS, covering between 40 and 60 percent of the nation's LTSS costs (Congressional Budget Office 2013; Kaiser Family Foundation 2013; O'Shaughnessy 2014). The Congressional Budget Office (2015) projects that between 2015 and 2040, total Medicaid spending as a share of gross domestic product will rise from 2.2 to 2.9 percent.

People who lack 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 become necessary when people receive inadequate assistance (Komisar and Feder 2011).

Could Catastrophic LTSS Insurance Help?

New LTSS insurance programs could provide better financial protection to people with disabilities; improve the care they receive; and reduce Medicaid costs, which are creating financial problems for many state governments. By setting aside funds today to cover future LTSS spending, new insurance programs could raise national saving. And they could provide families with stronger incentives to save

by reducing reliance on Medicaid, which discourages saving because it only pays benefits to people with virtually no wealth outside of their home. The effectiveness of any new insurance program, of course, depends on its particular features, such as eligibility requirements, the size of the daily benefit, and the financing mechanism.

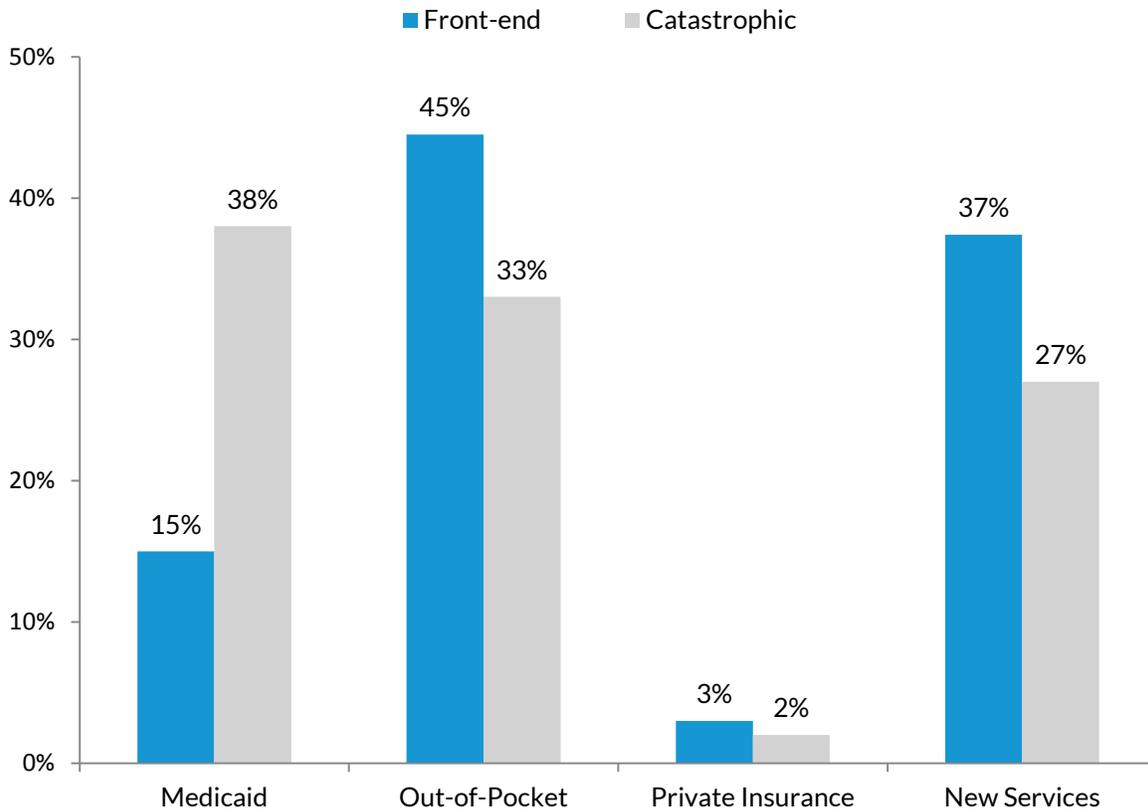
The length of time enrollees must wait to begin receiving benefits as well as length of coverage are two key design issues for any LTSS insurance program. Plans could provide front-end benefits, covering enrollees relatively soon after their LTSS needs become severe enough to qualify but providing benefits for only a limited time. Alternatively, plans could provide catastrophic (or back-end) benefits, requiring enrollees to wait longer after they develop LTSS needs to collect benefits but then allowing beneficiaries to remain covered for as long as their LTSS needs last.² Among 65-year-olds today who eventually develop LTSS needs, nearly half will require help for at least two years, and slightly more than a quarter will need help for at least five years, according to projections from DYNASIM, the Urban Institute's dynamic microsimulation model (Favreault and Dey 2015).³ However, most of the nation's LTSS costs are incurred by people with long-lasting needs. DYNASIM projections suggest that average LTSS spending is about five times higher for older people whose LTSS needs last for at least two years than for older people whose LTSS needs do not last as long.

We modeled several LTSS insurance program options, including one that provided front-end benefits and one that provided catastrophic benefits, to evaluate potential costs and the protection they might provide to enrollees (Favreault, Gleckman, and Johnson 2015).⁴ The front-end plan would begin paying a benefit after the first 90 days of need and continue coverage for up to two years. Under the catastrophic plan, insurance would be available only after two years but would then continue indefinitely; consumers would be responsible for the first two years of expenses once they develop substantial LTSS needs. The program would provide a modest benefit equal to \$100 per day with 3 percent annual increases. For simplicity, we focus here on options that require all workers to enroll in the programs and pay taxes to finance them, but we also modeled voluntary variants of the program for which people could decline coverage.

Once fully phased in, the front-end and catastrophic programs would cost about the same (Favreault and Johnson 2016). However, the front-end option would reduce family out-of-pocket spending more than the catastrophic option, whereas the catastrophic option would reduce Medicaid spending more. Our projections show that 45 percent of spending by the front-end benefit program would displace out-of-pocket costs, compared with 33 percent of spending by the catastrophic benefit program (figure 1). The front-end option would significantly reduce out-of-pocket spending because families self-finance much of the LTSS provided in the first two years of a care recipient's disability spell. Similarly, a larger portion of spending by the front-end option than the catastrophic option would fund new services, covering unmet needs and offering relief to family caregivers, who provide much of the care received early in a disability spell. By the time catastrophic benefits would kick in, many care recipients would have already depleted their financial resources and enrolled in Medicaid. As a result, 38 percent of spending by the catastrophic option would displace Medicaid spending, compared with only 15 percent for the front-end option.

FIGURE 1

Percentage of Program Spending that Offsets Other Financing Sources or Funds New Services, 2070



Source: Favreault and Johnson (2015).

Notes: The front-end plan would begin paying a benefit after the first 90 days of need and continue coverage for up to two years. The catastrophic plan would begin paying a benefit after two years of need and continue paying benefits as long as LTSS needs last. The options shown here would require all workers to enroll in the programs and pay taxes to finance them.

Conclusions

An LTSS catastrophic insurance program that requires enrollees with LTSS needs to wait a few years before collecting benefits but then extends those benefits as long as necessary could substantially improve the way LTSS needs are financed in the United States. Such a program could reduce Medicaid spending, providing financial relief to hard-pressed states. It would also reduce out-of-pocket spending for families facing catastrophic costs and fund new services for older adults with LTSS needs, although these impacts would be somewhat smaller than those from a similar-sized program that provided front-end, but time-limited, benefits. By setting aside funds today to cover future LTSS spending, a new catastrophic insurance program could raise national saving. And it could provide families with stronger incentives to save by reducing reliance on Medicaid, which discourages saving because it only pays benefits to people with virtually no wealth outside of their home.

Program details need further analysis. We modeled only a few options, and alternative designs could have different effects. For example, a new insurance program could provide larger daily benefits, which would reduce Medicaid and out-of-pocket spending more than the plan we modeled but would also require more funding. Or new programs could require enrollees to wait even longer to receive benefits than the program we modeled, which would offset less Medicaid and out-of-pocket spending but cost less. Our research is only the first step in the analysis required to design new LTSS financing programs, but it illustrates the potential power of our simulation tool in demonstrating how new options can interact with existing programs.

Notes

1. Medicaid does not, however, count certain assets when determining eligibility, such as a home, car, or personal effects, and allows spouses living in the community to retain additional assets (US Department of Health and Human Services 2005).
2. Plans could instead provide comprehensive benefits, providing lifelong benefits after a relatively short initial waiting period.
3. We classify people as having significant LTSS needs if they require help with two or more activities of daily living for at least 90 days or have severe cognitive impairment. This is the level of need that triggers benefits from private long-term care insurance under the Health Insurance Portability and Privacy Act.
4. Because of data limitations, our projections only cover adults ages 65 and older, although we recognize that LTSS financing for younger people with disabilities is a pressing policy issue.

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Acknowledgments

This brief was funded by The SCAN Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at www.urban.org/support.



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