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Funding Long-term Care in the United States: The Role of Private Insurance

by Yung-Ping Chen*

1. Introduction

This article complements an earlier publication (Chen, 1994) in which I discussed financing long-term care as a significant public policy issue in the United States because of a confluence of factors, which juxtaposed the growing number of older people against the slower-growing public and private resources. The major demographic and economic factors summarized then included the continued graying of America; the relative shrinkage of informal (non-paid) caregivers; declines in the growth rate of productivity; and federal budget deficits. Since then, although productivity has reversed course and budget surpluses have replaced deficits of late, public resources are not becoming more available because of other policy priorities. Meanwhile, as the large cohort of baby-boomers will be entering older ages beginning in about ten years, the trend toward fewer available informal caregivers is showing no sign of abating. Therefore, financing long-term care is becoming more of a challenge, not less. Although I am discussing the condition in the United States, funding long-term care is an issue that pervades most societies. I believe some of the solutions I am suggesting for the U.S. may have applicability in other countries as well.

The way we fund long-term care in the U.S. now may be likened to sitting on a stool with only two legs because the bulk of costs is paid out of personal savings (out-of-pocket payment) and public welfare (Medicaid and other public sources), with social insurance and private insurance playing a minor role. This method of funding is unlikely to be sustainable because it tends to impoverish many people and severely strain Medicaid budgets nationwide.

It is my view that a better funding method could be found by (a) more widespread use of the insurance principle for both private- and public-sector programs, and (b) linking several sources of funds in each sector that already exist so as to increase the efficiency with which these resources may be used. I therefore propose a "three-legged stool" funding model, consisting of social insurance, private insurance, and personal savings. When these three sources fail to provide for some individuals, public welfare will serve as a safety net. These are the same sources of funds presently in use, but they will be deployed vastly differently in the proposed model.

Given the dim prospect for new public and private resources for meeting long-term care costs, I suggest use of a trade-off principle. Applying the trade-off principle in the public sector, we could create a social insurance program to provide basic long-term care coverage

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by diverting a small portion (say 5 per cent) of a retiree's social security cash benefits for long-term care (Chen, 1994). Using the trade-off principle in the private sector, we could increase purchase of private long-term care insurance by linking it to life insurance or annuity, pensions, personal savings, or home equity. Application of the concept of trade-off in the private sector is the focus of this article.

The article will proceed as follows. Section 2 reports the limited use of insurance in the present funding mix. Section 3 presents the rationale for the three-legged funding model. Section 4 explains the argument for the trade-off principle. Section 5 describes how to apply the trade-off principle to promote use of private insurance. Section 6 points out the role of federal and state governments, the role of insurance regulators, and the role of trust in the use of private insurance. Section 7 concludes.

2. The present funding mix: limited use of insurance

2.1. Risk-pooling in private and public sectors

The need for long-term care is a risk that may carry with it substantial, even catastrophic, financial consequences to an individual or his or her family, but it actually occurs only to a relatively small and predictable proportion of persons in a population at any one time. In theory, such a contingency is best covered by insurance; insurance may be used in both the private and public sectors.

2.2. Limited use of private and public insurance

In practice, however, insurance is used infrequently in funding long-term care by either the public or private sector in all countries, except Germany and Japan where social insurance for long-term care exists. In the United States, of the total formal (paid) long-term care for the elderly estimated at $98 billion in 2000 (Tilly *et al.*, 2000), personal savings (out-of-pocket payment) and public welfare (Medicaid[1] and other public sources) each paid 40 per cent, with social insurance (Medicare[2]) and private insurance playing a minor role (Figure 1).

Combined, out-of-pocket private payment and Medicaid (and other public sources) defrayed 79.8 per cent of the costs. The former, sometimes called self-insurance, fails to use the insurance principle of pooling risks for a group of persons. The latter similarly lacks risk-pooling, although some analysts regard Medicaid as a public insurance program. Only 20.2 per cent of the total long-term care costs was paid by Medicare and private insurance, using risk-pooling (Figure 2).

In the public sector, one-third of the expenditures (Medicare) represented risk-pooling, while two-thirds (Medicaid and other public sources) did not (Figure 3).

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[1] Medicaid is a joint federal and state program that provides medical assistance for the poor. The program is administered by the states and provides federal matching grants for a portion of the cost of medical benefits, solely from general revenues.

[2] Medicare is a federal health insurance program for people who are 65 and older and for some younger people with disabilities. Medicare has two parts: Medicare Part A helps pay for hospital stays, skilled-nursing facility stays, home health care, and hospice care. Medicare Part B helps pay for doctor bills, home healthcare, medical equipment, and preventive services. Medicare does not pay for all healthcare costs. For example, it does not pay for most prescription drugs, nor long-term care in a nursing home or in one's own home, nor routine medical check-ups. Part A of Medicare is financed principally by payroll taxes paid by employees, employers, and the self-employed. Part B of Medicare is paid for by premium payments from enrollees with subsidies from general revenues.

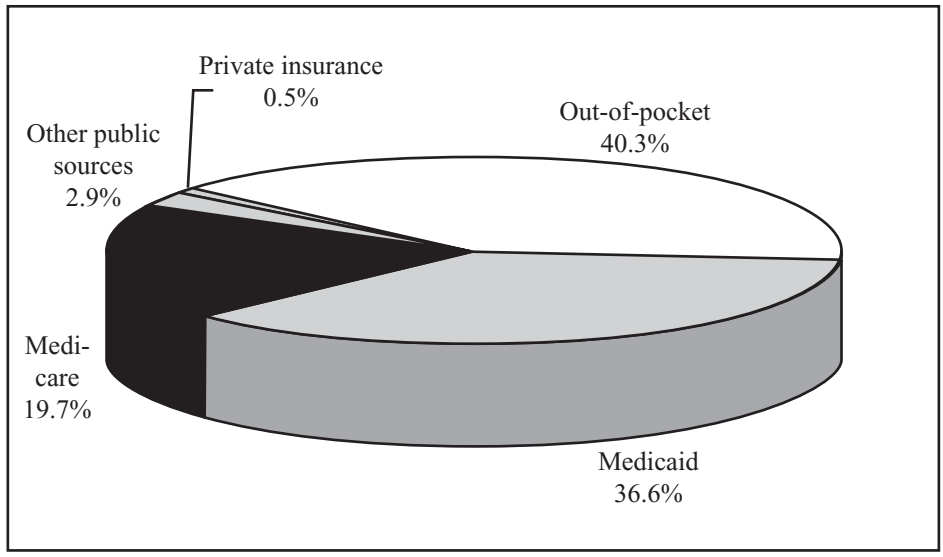

Figure 1: Formal long-term care expenditures for the elderly, 2000

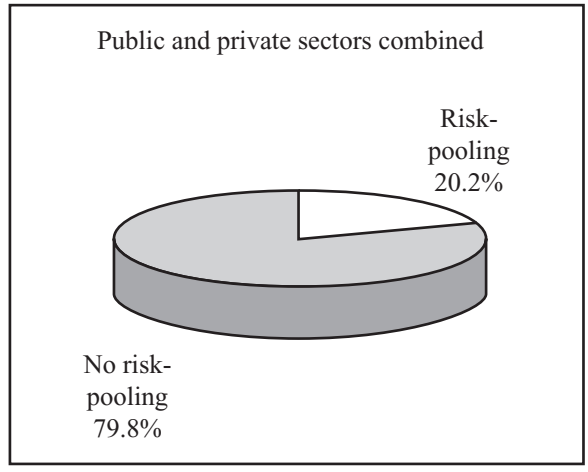

Figure 2: Formal long-term care expenditures for the elderly, 2000

In the private sector, only 1.2 per cent of the outlays (private insurance) represented risk-pooling, whereas 98.8 per cent (out-of-pocket payment) did not (Figure 4).

3. Sharing public and private responsibilities: a three-legged stool funding model

Many have come to realize that neither the public nor the private sector has the financial resources to meet the high and growing long-term care costs because competition for funding

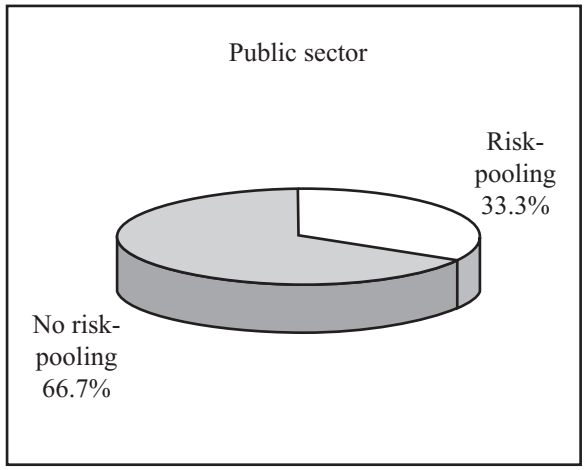

Figure 3: Formal long-term care expenditures for the elderly, 2000

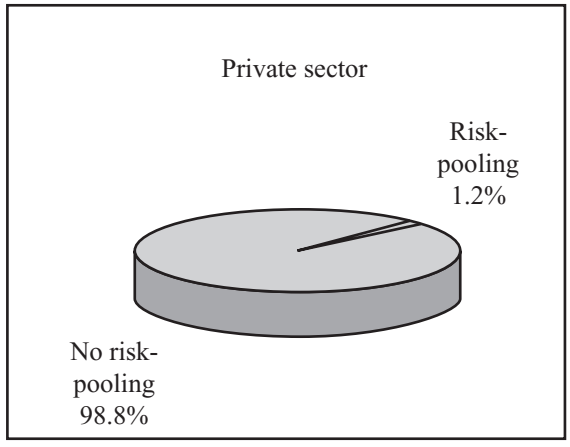

Figure 4: Formal long-term care expenditures for the elderly, 2000

always exists in both sectors. Government expenditures on long-term care will compete with social security and Medicare, as well as with other public programs for general healthcare, education, welfare, defense, the environment, and others. Private spending for long-term care will compete against all other consumer needs and wants, including the bequest motive.

In order to provide long-term care services, it appears necessary, therefore, to draw on both public and private resources. In order to incorporate insurance as a key component, a three-legged-stool funding model, consisting of social insurance, private insurance, and personal savings may be appropriate.

The idea of a three-legged stool is patterned after the way, as a model or an ideal,

retirement income and acute healthcare for the older population are provided in the United States. Reflecting shared private and public responsibilities, retirement income is provided using social security for a floor of protection, with employment-based (occupational) pensions and personal savings supplying supplemental income. When these three sources fail to provide for some individuals, public welfare (supplemental security income) serves as a safety net. Similarly, acute healthcare for the elderly is provided by Medicare, supplemented by employer-provided health benefits for retirees and by personal payments for non-covered expenses, in some cases through Medicare Supplemental (Medigap) policies which individuals purchase for themselves. When a person's healthcare needs cannot be met by these sources, public welfare (Medicaid and other public sources) acts as a safety net. The message for policy from the three-legged-stool approach is that it would simultaneously foster self-reliance and community spirit.

4. Enhancing insurance and linking resources: a trade-off principle

In the same vein, building a three-legged stool for financing long-term care would begin with creating a compulsory social insurance program for a basic amount of long-term care coverage. This social insurance program would then be supplemented, on a voluntary basis, by more private long-term care insurance coverage and by personal savings.

4.1. Compartmentalizing resources ill advised

Assuming acceptance of this model, where do we find the funds for a new social insurance program and for the purchase of private insurance? Many people seem unable or unwilling to devote new resources for meeting long-term care costs. At least part of the inability or unwillingness may stem from the fact that people in general tend to compartmentalize their total resources (financial and non-financial assets as well as income) into different expenditure items such as for various living expenses, housing, healthcare, and the like. Once compartmentalized, one's resources are segmented or dedicated only for specific purposes or accounts. Since exact allocations of funds for specific purposes are difficult to achieve, there will be either excess or shortage in one account or another. The starkest example of this outcome is a "house-rich and income-poor" homeowner who has a disproportionate share of his or her total resources in housing. Such an individual would suffer from less consumption for items other than housing than if the resources that are locked in home equity could be unlocked. Put differently, "a house-rich and income-poor" person would be able to afford paying for more purchases than at present if the purchasing power embodied in home equity could be used.

4.2. Linking resources for greater utility

Some people behave as if money were not fungible, but it is. We should be able to accommodate more expenditure if we can commingle our funds instead of consigning them to specific accounts. In order to increase the total utility of existing resources for meeting various costs through commingling, we should link resources together and we could create linkages in both public and private sectors. I therefore suggest a new paradigm, the trade-off principle, in order to implement the three-legged-stool model.

5. Private insurance for long-term care: trading benefits

Private long-term care insurance policies have been in use since the early 1970s. Some expansion in the purchase of such insurance has occurred recently. Approximately 315,000 new insurance policies were sold in 1988. In 1999, the number of new policies sold increased to 660,000. The total number of policies sold by 30 June 1998 was in excess of 5.8 million, increasing from 815,000 policies sold in 1987. However, only an estimated 3.5 million policies were still in force (Health Insurance Association of America (HIAA), 1998; Tilly *et al.*, 2000).

5.1. Limited use of insurance: demand factors

Despite the fact that private insurance policies today are much improved over those in the past, covering almost all forms of long-term assistance including homecare and assisted living, this market has not flourished. Various reasons may explain the lack of market penetration (Fibiger, 1997; Bernheim, Shleifer and Summers, 1985; Bernheim, 1991; Hurd, 1987, 1989; Norton, 2000; Pauly, 1996; Cutler, 1996). On the demand side, high costs of private long-term care insurance policies tend to discourage purchase. Long-term care policies are much less expensive when purchased at younger ages, but people buy them at older ages because few people become concerned while younger. Some people resist buying long-term care insurance because it provides no benefit if they do not need services (the fallacious "money-down-the-drain" or "use-it-or-lose-it" syndrome). Until recently, private long-term care insurance, unlike other health insurance or some pension programs, was not subsidized under income tax; this may be another reason why some people do not purchase such policies. Some people think they can finance long-term care out of savings or rely on Medicaid. Some may still believe that Medicare will pay for long-term care. Some procrastinate. Some may become uninsurable. Then there are those who believe that they will never need long-term care.

5.2. Limited use of insurance: supply factors

On the supply side, insurance companies are concerned about moral hazard (greater use of services induced by insurance) and adverse selection (buyers are those who suspect they will need long-term care services). Long-term care insurance policies also pose problems for insurance agents, who may be unable or find it time-consuming to convince customers to purchase. In addition, there is likely to be a long lapse of time between initial purchase of an insurance policy and its eventual use, making projections difficult for the insurer and policyholder alike.

5.3. Linking resources for insurance purchase

Using the trade-off principle we may be able to enhance the ability and willingness of individuals to purchase long-term care insurance by:

- Linking it to life insurance or annuity products;
- Linking it to individual retirement accounts (IRAs), or other employment-based saving vehicles; to occupational pensions from employers, including Teachers Insurance and Annuity Association-College Retirement Equities Fund; and government employee retirement programs at federal, state, and local levels;

- Linking it to home-equity conversion plans (e.g., reverse mortgages[3]).

5.4. Life insurance or annuity policies with a rider

Linking life insurance or annuity products to long-term care benefits already exists in the market. About a dozen life insurance companies are marketing this type of combination product. Of all the long-term care policies sold in 1996, about 6–7 per cent were of the type of life insurance policy with a rider for long-term care (HIAA, 2000b).

Companies vary in their products to suit their respective markets. There are many varieties such as a fixed annuity with long-term care benefits or a variable annuity with long-term care benefits, or a universal variable life insurance policy with a long-term care rider. But the underlying concept is the same, that of combining long-term care protection with income protection through life insurance or annuity.

An example may suffice. For a single premium of $100,000, a 65-year-old woman could buy a life insurance policy which provides an initial death benefit of $190,000. The death benefit, by definition, is payable on the death of the insured. The death benefit can also be used by the insured prior to death to pay for long-term care expenses, such as nursing home or home healthcare for at least 50 months, at less than actual cost or 2 per cent of death benefit or $3,800 monthly. This arrangement is akin to the accelerated death benefit for critical illness that may be available under some life insurance policies. In short, this is a life insurance policy that pre-pays the death benefit for long-term care expenses. If the insured does not need long-term care, then the funds in the insurance policy continue to grow. Viewed differently, unused long-term care benefits will pass to the beneficiaries of the policy. Under this arrangement, in essence, then, the policyholder is trading off some or all of the death benefit for long-term care.

Tying long-term care insurance benefits to life insurance products could possibly resolve many of the issues troubling both the demand and supply sides of the market. Not willing or able to recognize the value of insurance protection, some people inaccurately consider paying the premium wasteful. Providing a long-term care rider to a life insurance policy would overcome this concern. The cash value of the life insurance policy will continue to accrue if the policyholder does not use long-term care services. Closest to the idea of a combination product suggested here is a proposal of long-life insurance which combines nursing home,

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[3] Currently, some 79 per cent of the elderly (age 65 and older) in the United States are homeowners, and some 77 per cent of them own their homes without mortgage debt. Home equity, which is the current market value of the house minus an existing mortgage, if any, represents, on average, nearly half the elderly's net worth. A house is an illiquid or a frozen asset, however, because it does not yield cash income to the owner. Furthermore, property taxes and maintenance costs represent demand on cash that the elderly homeowner may not have. Hence, this creates a "house-rich, cash-poor" predicament for some.

One way to convert home equity into cash is to advance cash to the homeowner based on his or her net equity in the house. It is the *reverse mortgage*, under which the lender pays cash periodically to the borrower (homeowner), while the borrower makes no repayment to the lender until the end of the loan, when a lump-sum repayment is due. With this feature, older homeowners (usually the minimum age to qualify is 62) can borrow without fear of involuntary displacement or foreclosure. Upon the borrower's death or a voluntary move-out (e.g., to an assisted-living facility or a retirement community), the property is sold to pay off the debt. If the sales proceeds are sufficient to pay the debt, including interest, the remaining cash usually belongs to the borrower or his or her estate. If the sales proceeds are insufficient, the lender absorbs the loss. Some reverse mortgages come with a government guaranty of full repayment, in which case, the lender will be reimbursed for any deficiency. For more discussion, see Chen (2001).

home health, and deferred annuity benefits (Getzen, 1988). The idea of trade-off has also been incorporated in other studies (Murtaugh *et al.*, 1999; Warshawsky, 2000).

5.5. Overcoming moral hazard and adverse selection

Providing a long-term care rider to a life insurance policy would reduce if not eliminate the moral-hazard problem: there would be a built-in resistance to over-using long-term care benefits because that would reduce the eventual insurance proceeds. The adverse selection problem would be limited because such a combination product would appeal to both healthy and not-so-healthy people. The high-cost issue could also be moderated because people could buy long-term care insurance coverage at younger ages. Moreover, if a long-term care rider could be provided under group life insurance policies, then the ability and willingness of workers to participate would be even more enhanced.

The method to combine long-term care benefits with life insurance or annuity products could be adapted to organizations that market both retirement income products and long-term care policies, such as TIAA–CREF (Teachers Insurance and Annuity Association–College Retirement Equities Fund).

6. Environment for the private insurance market

6.1. Role of federal and state governments

In addition to new product designs, the governmental role in encouraging the sale of private long-term care insurance is paramount. Federal and state governments influence the insurance market using the tax code and regulations. Tax deduction or tax credit for the premiums of these policies is one method.[4]

State laws also offer a variety of tax concessions to encourage purchase of private long-term care insurance.[5]

Governments may also encourage the use of private long-term care insurance by example. Recent legislation aimed at a group setting for long-term care insurance may have exemplary effects nationally. On 19 September 2000, President Clinton signed into law the Long-Term Care Security Act, authorizing the federal Office of Personnel Management to negotiate with private insurers to offer long-term care insurance to as many as 13 million government employees, retirees, and their families.

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[4] The Health Insurance Portability and Accountability Act (HIPAA), effective since 1997, provides favorable tax treatment for qualified long-term care policies. The Act provides that (a) benefits from long-term care policies are not subject to tax; (b) employers may deduct the costs of establishing a long-term care plan and the premium payments for their employees; (c) employer contributions to premiums are not counted as taxable income to the employee. In addition, premiums paid for these policies and out-of-pocket payments for long-term care services qualify as medical expense deductions if they exceed 7.5 per cent of AGI (adjusted gross income).

[5] As of 1 January 2000, 20 states (Alabama, California, Colorado, Hawaii, Indiana, Iowa, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, and Wisconsin) offer tax incentives of one kind or another. During 2000, there were 11 states (Connecticut, Georgia, Illinois, Kansas, Michigan, Nevada, New Jersey, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and Vermont) in which different Bills were introduced in their legislatures to provide tax incentives. In addition, nine states with existing tax incentives (California, Hawaii, Iowa, Maine, Maryland, Montana, Minnesota, New York, Ohio) were considering additional or different tax concessions (HIAA, 2000a, 2000b).

6.2. *Role of the National Association of Insurance Commissioners*

Insurance is one of the most heavily regulated industries, so regulation figures importantly in the development and maintenance of all insurance markets. The central purpose of regulation is to protect the customer (policyholder) by ensuring that the insurance companies are solvent and that the products they sell meet certain standards.

Because insurance is mostly regulated on the state level, the role of the National Association of Insurance Commissioners (NAIC) is significant. NAIC is a non-profit, unincorporated association composed of the chief regulatory insurance officer of each state, the District of Columbia, and the four U.S. territories. A primary function of the NAIC is to develop uniform model laws for insurance products that states can adopt.[6]

6.3. *Role of trust by the general public*

The sole objective of all the regulation by federal and state governmental bodies and oversight by industry groups is to ensure protection for the consumer. The individual insurance companies themselves must do all in their power to instill trust in the integrity of the industry by the general public. For trust offers the single most important guiding light for the consumer.

7. Conclusion

There appears a growing need for long-term care services by the aging baby-boomers in the next few decades. The costs could be immense. It is unlikely that the U.S. can meet that demand, given the present mix of funding, which relies primarily on personal savings and public welfare. Because insurance is the best method to protect against this type of risk and because neither the public nor the private sector alone has sufficient resources to pay for long-term care, I propose a three-legged funding model in which insurance, both public and private, will play a key role. Given constrained government resources and the unwillingness or inability of individuals to pay for long-term care, I further suggest a trade-off principle to be applied in both the public and private sectors in order to implement the three-legged-stool model.

To provide a context for my suggestions as well as a summary, Figure 5 may be useful. At present, for formal long-term care, there are four sources of funding: out-of-pocket and private insurance in the private sector; Medicaid (and other public welfare programs) and Medicare in the public sector. The proposed three-legged-stool funding approach employs the same four sources of funds but deploys them rather differently. In terms of the relative weights of these four sources, insurance (both social insurance and private insurance) will play a much more significant role in the proposed model than at present. Further, the methods by which public and private insurance will be offered in the proposed model are qualitatively different from those currently in use. Currently, Medicare is an inter-generational model of social insurance. In the proposed approach, social insurance for long-term care would be an intra-

[6] In order to promote standardization of long-term care insurance regulation and to define an acceptable minimum level of regulation, the NAIC published its first version of the Long-Term Care Insurance Model Act in 1986. A year later, NAIC issued a model regulation, providing greater specificity for implementation of the act. Both the Act and the regulation have been amended several times since, and the most recent amendments were published in 2000 (NAIC, 2000).

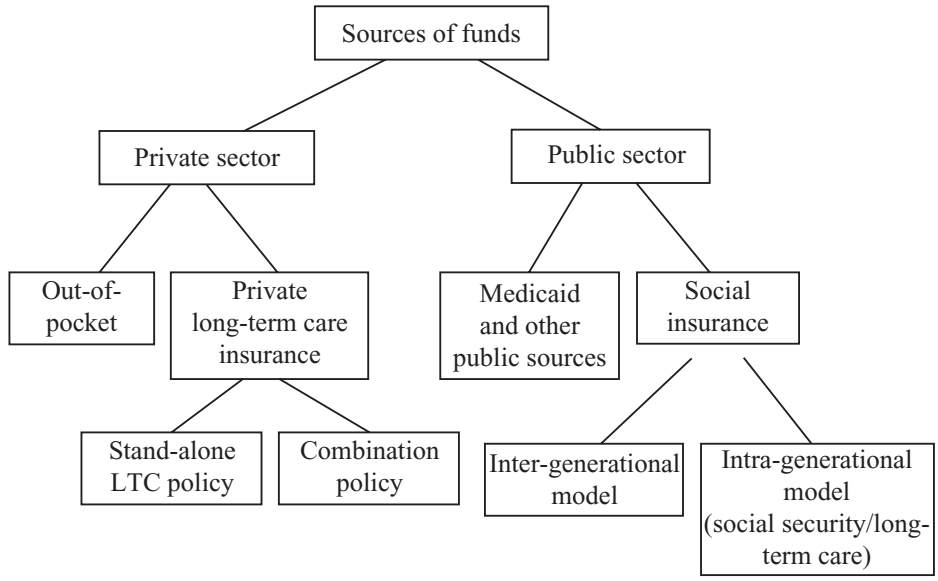

Figure 5: Funding long-term care: a schematic view

generational model of social insurance. Now, the stand-alone long-term care insurance policy is the predominant type of private insurance. Use of a combination policy is proposed in the new approach – an insurance or annuity policy that offers a rider for long-term care.

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