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Financing Long-term Care: Needs, Attitudes, Current Insurance Products, and Policy Innovations

In this issue

As the average age of the U.S. population continues to increase, the development and implementation of effective ways to provide for long-term care needs and expenses will become an increasingly important factor in the financial security of retirees and their families. This issue of **Research Dialogues** *presents a detailed review and analysis of issues related to the financing of long-term care expenses. The article includes a description of data and trends relevant to long-term care needs and costs, a review of survey results regarding the plans and attitudes of TIAA-CREF participants regarding long-term care, a description of currently available long-term care insurance products, and, finally, a discussion of some new ideas relating to how long-term care expenses could be financed in the future. The article was prepared for* **Research Dialogues** *by Mark Warshawsky, Ph.D., director of research, TIAA-CREF Institute; Lee Granza, product manager for long-term care insurance, TIAA-CREF; and Anna Madamba, Ph.D., senior research analyst, TIAA-CREF. The fourth section of this issue is a slightly modified version of a section that appeared in an earlier article by the same authors (Granza, Madamba, and Warshawsky, "Financing Long-term Care: Employee Needs and Attitudes, and the Employer's Role,"* Benefits Quarterly, *Fourth Quarter 1998, pp. 60–72). We use parts of that earlier article with the permission of the publisher.*

Introduction

Long-term care (LTC) is a broad range of services and assistance for people with chronic illnesses or injuries who are unable to care for themselves over a relatively long period of time. Such services are expensive, and their cost is increasing more rapidly than the cost of producing other goods and services in the economy, including other health care services. The need for long-term care services is particularly great among the elderly, especially the "old old" (those age 85 or above), a segment of the population that is projected to grow dramatically as the baby-boom generation ages.

It is becoming apparent that the federal and state governments will not provide adequate resources to support those households (particularly those with higher incomes and significant asset holdings) that have not made provisions to fund their long-term care needs. Hence, many individuals and families have a responsibility to finance their own future long-term care needs, possibly including coverage through an individual long-term care insurance policy. Employers and financial services companies can be of assistance by encouraging the use of current methods of financing long-term care needs and by developing new methods to finance these expenses.

This article reviews the evidence on how the need for long-term care insurance coverage has grown and is expected to grow even more. We begin by describing the typical and increasing expenses incurred in paying for nursing home and home health care. The article then summarizes evidence (based on a survey of TIAA-CREF participants) on the attitudes of both working and retired individuals and their seeming reluctance to act on their knowledge of long-term care needs. We then describe common features of individual long-term care insurance products currently sold in the marketplace and review current efforts and proposals to expand long-term care coverage, including employer-sponsored group plans and new government programs. The article concludes with a brief description of an innovative idea for the integration of life annuity benefits with long-term care insurance. (We note that this idea is presented here solely for the purposes of fostering research and a further discussion of issues.)

Long-term Care Needs

A number of factors have contributed to the increasing need for appropriate mechanisms to finance long-term care expenditures. These factors include longer life expectancies, changing socio-economic conditions, rising nursing home and home health care costs, and constrained government support.

Longer life expectancies and the need for care As is well known, the life expectancy of American adults has increased significantly over the last century, and is projected to increase further. Longer life expectancy has meant that increasing numbers of individuals will survive into what has been called "old old" age (i.e., age 85 or above). In fact, individuals in this age group will be the fastest-growing segment of the population by the year 2030. (The individuals who will be at the leading edge of this increase are roughly age 54 to 55 today—the oldest members of the baby-boom generation.)

It is epidemiologically difficult to ascertain whether longer life expectancies are the result of an increase in the age at which certain diseases present themselves or a reduction in age-specific death rates among the infirm.[1] Although some researchers now believe that the older population is healthier than ever, statistics nevertheless continue to show that those who survive to "old old" age are much more likely to need long-term care than those in their 60s. In other words, even those individuals fortunate enough to be healthy well into old age will eventually have to cope with the gradual lessening of their mental and physical faculties and the need for assistance to get through the everyday activities of life. The growth in the number of such individuals reaching "old old" age will continue to increase aggregate demand for long-term care services in the future.

Among those age 65 and over, it is estimated that 60 percent will need some long-term care in their remaining lifetime.[2] LTC needs can include a need for skilled medical care or a less formal need for simple assistance with daily activities. Current projections indicate that more than 40 percent of the 65+ population will spend some time in a nursing home. The likelihood of spending some time in a nursing home at some point during the remainder of life increases with age (from 39 percent at age 65 to 56 percent at age 85).[3] Similarly, the probability of needing help with the "Activities of Daily Living" (or ADLs, including bathing, dressing, feeding, toileting, transferring, and continence) increases with age. People tend to lose their ADL functions in the reverse order in which they acquired them when young. For example, while only 3.5 percent will need help bathing between ages 65 and 74, more than 20 percent will need such assistance at age 85 or older.

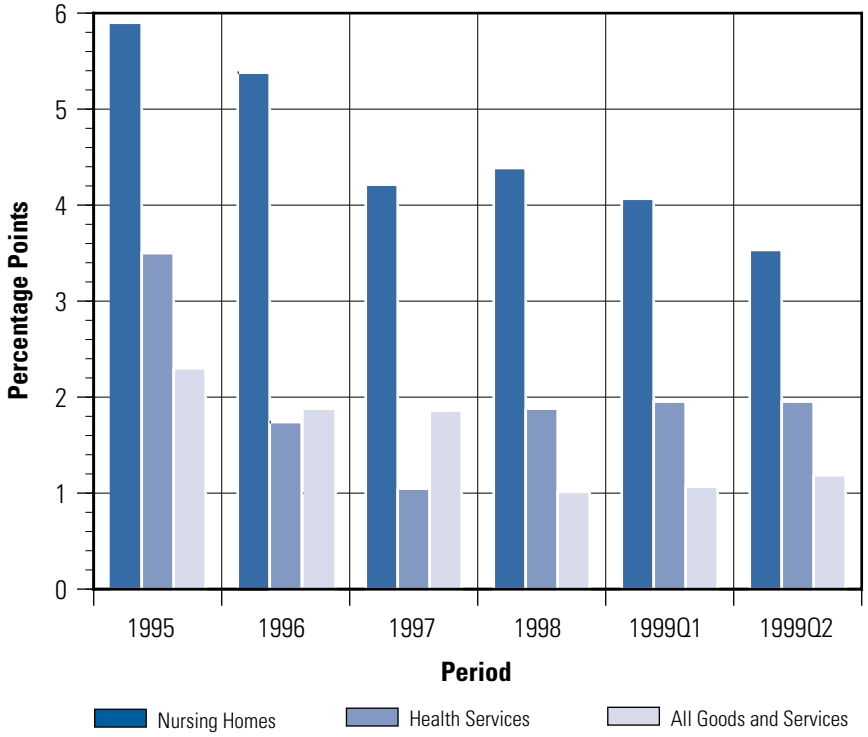
The provision and cost of care Traditionally, long-term care for the elderly was provided by family members, primarily women. With more women entering the workforce, more dispersion of families across the country, a rise in divorce rates, smaller family sizes, and a trend toward later childbirth, traditional forms of family-provided home health care are disappearing. As a result, the use of costly alternatives, such as nursing homes and skilled and unskilled home health care, is increasing. (Skilled care refers to care that must be rendered by a licensed medical professional, such as that provided by a registered nurse or a physical therapist. Unskilled care is personal or custodial care, such as provision of assistance in bathing or dressing, that does not require specific training.) In addition, new types of care providers and facilities are appearing. These include "assisted living facilities" that provide some nursing home-type services with the look and feel of in-home health care and that allow greater independence on the part of the patient.

The average expected stay in a nursing home among users of all ages is 2.4 years. The expected stay for most is less than a year; but for almost 20 percent of users, it is more than five years. Women, whites, those widowed or never married, and Midwesterners are more likely to experience a stay in a nursing home and have relatively longer expected stays. The mean number of years of nursing home use declines with age, from 2.8 years in the 65 to 74 age group to 1.9 years in the 85+ age groups.[4] The average lifetime home health care use is just over 200 visits. About half of those expected to use home health care will use fewer than 90 visits during their lifetime, while 12 percent can expect to use more than 730 visits.[5]

The escalating cost of typical long-term care services presents a substantial financial risk to individuals and their families. The average annual cost for a stay in a nursing home was $38,000 in 1995, and this increased to $44,500 by 1998.[6] Assisted living facilities currently charge, on average, $26,000 a year. Home health care expenses are somewhat harder to quantify because care is sometimes provided by informal and unskilled care givers "off the books." Focusing on skilled care, the average cost per home health care visit by a nurse increased from $62 in 1987 to $96 in 1997.[7]

Figure 1 compares cost inflation trends for nursing homes, health services, and all goods and services over the period 1995 through the second quarter of 1999. Inflation for nursing home services has consistently run at a faster pace than inflation for both health services and all goods and services, even as the overall inflation rate in the economy has declined. In particular, nursing home inflation has exceeded general inflation in the economy by three percentage points in the latter half of the 1990s. At that rate, the real cost of nursing home care will double over the next 23 years. The rate of cost inflation for nursing home services seems not to be influenced by the same factors that influence the broader category of health services; presumably, this reflects the importance of HMO penetration and other innovations in health care production and financing

Figure 1
Annual Rates of Cost Inflation for Nursing Homes, Health Services, and All Goods and Services, 1995–1999



Source: Authors' calculations based on data from the U.S. Bureau of Labor Statistics.

over this period that have not affected nursing homes.

The cost of a stay in a nursing home varies widely by the area of the country. As one might expect, urban areas are usually costlier than suburban or rural areas. In 1998, a nursing home in New York City, for example, could cost well more than $250 a day, for an annual cost of more than $91,000; whereas in other parts of the country (e.g., Oklahoma), the cost was closer to $70 a day.[8] The nature of the care received, whether at home or in a facility, will impact the ultimate cost. Individuals who are more dependent, or who need more skilled care that can normally only be rendered by a medical professional, will realize greater costs than someone who requires limited assistance in bathing or dressing. The cost of nursing facilities also depends on the level of sophistication and breadth of the amenities offered. Those with private insurance appear to purchase more costly long-term care services, as private-pay nursing home stays are about 25 percent more expensive than stays paid by Medicaid.

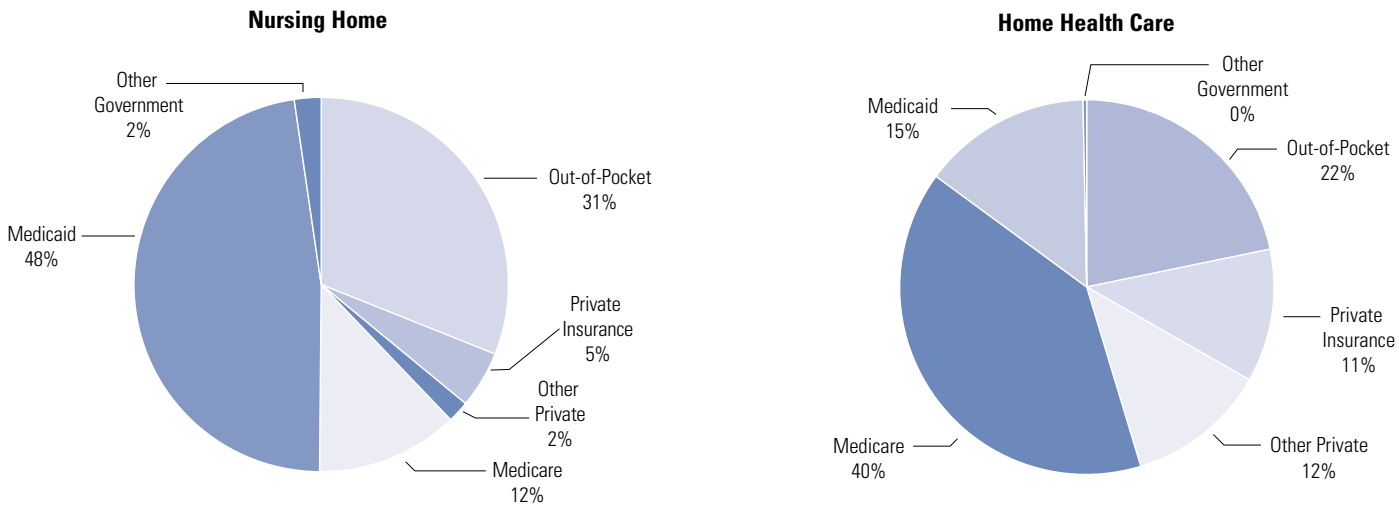
Constrained government support In 1997, the nation spent almost $83 billion on nursing home services and more than $32 billion on home health care.[9] Figure 2 shows the sources of funding for these expenditures. Clearly, government support is significant, but there are several constraints on that support, both under current policy and likely future conditions.

Medicare is designed to pay for acute care needs. The program covers care in a skilled nursing facility for up to 100 days (with a substantial copayment applied after the twentieth day) following a hospital stay of at least three days. In aggregate, Medicare pays for about 12 percent of nursing home expenses. Medicare also provides home health care benefits on a part-time or an intermittent basis; this entitlement is more significant and has grown rapidly in the early 1990s, and now pays for 40 percent of aggregate home health care expenses. Medicare benefits, however, must be medically oriented; once care is no longer rehabilitative and becomes custodial in nature, benefits may no longer be payable.[10] Moreover, in 1997, Medicare instituted strict limits on payments to home health care agencies and began to pursue more vigorously instances of fraud and abuse. Future funding for long-term care from Medicare is also likely to be limited, as the Hospital Insurance Trust Fund is projected to be depleted by 2015. Payroll taxes will cover only one-half of its costs 75 years from now.[11]

Medicaid, the joint federal/state health care program for those with low income and few assets (or those who deplete their assets paying for long-term care), pays for almost 50 percent of aggregate nursing home expenses and almost 15 percent of home health care expenses. But for most middle- and high-income households, Medicaid is either unavailable or undesirable. Few resources are exempt from the eligibility guidelines, asset transfers are strictly controlled, spousal protection is somewhat limited, and only approved care providers can be used, limiting freedom of choice. Neither Medicaid (in most states) nor Medicare pays for assisted living facilities. One study has shown that growth in Medicaid spending, assuming current law and reasonable demographic and economic projections, will outpace growth in tax revenues traditionally devoted to Medicaid over the next 30 years.[12]

The recent enactment in 1996 of the Health Insurance Portability and Accountability Act (HIPAA) clarified the tax treatment of long-term care benefits and premiums and sent a clear message to citizens: They should not rely on the government to fund their long-term care expenses. HIPAA essentially provided that LTC expenses and insur-

Figure 2
Sources of Funding for Long-term Care, 1997



Source: Health Care Financing Administration.

ance premiums could be treated like medical expenses with respect to the individual income tax. Accordingly, LTC expenses are deductible from federal income taxes, provided that the expenses exceed 7.5 percent of adjusted gross income. HIPAA also allows individuals to deduct long-term care insurance premiums up to certain limits based on age, again provided that medical expenses and premiums exceed 7.5 percent of income. HIPAA stipulates clearly that benefits payable under a tax-qualified LTC policy will not be treated as taxable income. In addition, it provides employers with a tax incentive if they elect to pay some or all of the LTC insurance premiums for employees. Employees also benefit from this provision, as their employer's contribution is not included in the taxable income of the employee. The implementation of these tax incentives is a strong signal from the federal government that individuals must be self-reliant when it comes to providing for their LTC needs.

Attitudes: Evidence from a Survey of TIAA-CREF Participants

In January 1998, TIAA-CREF conducted a survey among its pension plan participants to clarify their attitudes and knowledge with regard to long-term care issues. A total of 450 currently employed and 249 retired participants responded to the survey. Most respondents were married, had children, and worked in a university or four-year college. Most retirees had been teaching faculty; by contrast, employed participants were about evenly split among faculty, management and administration, and staff and support positions.

Knowledge and awareness An overwhelming majority (87 percent) of survey respondents recognize that long-term care is "a problem" in the United States today. About two-thirds claim to be familiar with LTC services, with familiarity higher among retirees than employed participants (79 percent versus 59 percent). For over half of the respondents, this familiarity comes from having actually provided hands-on care (60 percent) or having provided financial assistance for long-term care services for someone else (19 percent). Retirees are more likely to have provided hands-on care and financial assistance than are the currently employed.

All respondents agree that long-term care costs would significantly reduce their income and assets should they need long-term care. The top three concerns about long-term care among employed participants are: "not having enough money to pay for LTC," "not being able to pay for health care," and "Social Security not being able to pay benefits in the future." By contrast, the concerns of retirees are: "having to live in a nursing home," "not being able to live in your own home for the rest of your life," and "not having enough money to pay for LTC." Therefore, while employed participants are concerned about financial considerations, retiree concerns focus more on how and where LTC will be provided. Among the retirees, a nursing home is the most frequently associated place for LTC assistance (81 percent unaided association), with home health care as second (46 percent unaided association), and assisted living even farther behind. When asked which LTC arrangements participants would consider for themselves (assuming they

Table 1
Planning for Long-term Care and Ownership of Long-term Care Insurance
Among TIAA-CREF Participants, by Active/Retired Status and Age, 1998

Respondent Group	Sample Size	Has Done at Least Some LTC Planning	Owns LTC Insurance
Active Employees		(%)	(%)
Age <45 years	(n=222)	31	1
Age 45–54 years	(n=136)	42	7
Age 55–64 years	(n=74)	55	16
Total	(n=450)	39	6
Retired			
Age 55–64 years	(n=45)	56	13
Age 65–69 years	(n=100)	61	15
Age 70+ years	(n=100)	56	17
Total	(n=249)	58	15

Source: TIAA-CREF Survey Research.
Note: Totals include individuals who did not specify age.

could make a choice), home health care was the overwhelmingly preferred choice (92 percent and 88 percent for the currently employed and retirees, respectively), with nursing homes as the least preferred (54 percent and 56 percent, respectively).

The survey responses also reveal that respondents underestimate the percentage of adults age 18 to 64 who are receiving long-term care, underestimate the percentage of adults receiving LTC who get that care at home, overestimate the likelihood of ever being admitted to a nursing home at age 65 or over, and overestimate the length of the average nursing home stay. At the same time, they correctly assess their inability to rely on Medicare to cover extended nursing home costs. They can also provide accurate estimates of the average cost of a one-year stay in a nursing home. The respondents' perceptions of the risk of requiring care, as well as their estimates of the typical duration of that care, are in fact greater than the reality of the risk.

Indeed, given the general awareness of the issues and costs involved in long-term care, one would expect very high interest in long-term care insurance. However, other perceptions may also play an important role in determining the level of interest in LTC insurance. For example, the survey results indicate that respondents associate the notion of long-term care assistance with being in a nursing home, and that nursing homes are the respondents' least preferred option for receiving long-term care. Moreover, while respondents would most prefer to receive any necessary long-term care at home, they underestimate the actual fraction of long-term care recipients who, in fact, get their care at home. Therefore, there appears to be a belief that "receiving long-term care" is synonymous with "being in a nursing home." To the extent that individuals believe LTC insurance is solely intended to provide funding for an undesirable nursing home stay, one might expect them to see little need for LTC insurance—perhaps to even try to avoid the subject of buying such insurance. This type of "avoidance" is, in fact, consistent with what the data reveal with regard to planning and coverage.

Planning and insurance coverage

Despite their awareness of the issues, the surveyed individuals have taken little or no action to deal with their anticipated LTC needs. Slightly less than half of the respondents have done "at least some planning" for their LTC needs. Only 23 percent of retirees and 8 percent of currently employed participants claim to have done "a great deal of planning." Table 1 shows that the likelihood of doing "at least some planning" for anticipated LTC needs increases with age. However, the table also shows that even among those aged 55 and over, only roughly 55 percent of respondents report having done any planning. Only 6 percent of currently employed TIAA-CREF participants, and 15 percent of the retired participants, own an LTC insurance policy. Most of the currently employed do not have LTC insurance because they "have not thought about it," while cost is the major consideration among retirees. In addition, close to 3 in 4 of the currently employed, and 4 in 10 retirees, agree that long-term care is not a priority because they have "so many concerns to deal with right now."

Among the one-third of respondents who considered purchasing LTC insurance for themselves, the cost of the insurance was the most important reason that kept them from buying it. While retirees are twice as likely as currently employed participants to have considered buying LTC insurance (42 percent versus 20 percent, respectively), more currently employed participants (21 percent) say they plan to purchase LTC insurance in the future compared to retirees (13 percent). Although only a minority, currently employed participants who have considered and applied for LTC insurance name "protection of current assets" as the primary reason for wanting LTC insurance. Retirees tend to want LTC insurance because they "may need it someday/prepare for future." Survey results show that LTC insurance features which are attractive to participants include: having LTC available through their employer (71 percent of currently employed participants and 44 percent of retirees) and having home health care coverage. Two other options, shared care coverage and pension-integrated LTC insurance, were also considered attractive.

While there is a high awareness of possible LTC needs and costs, three factors seem to inhibit the purchase of LTC insurance:

1. The need is abstract or far into the future (especially among currently employed participants); therefore, they "have not thought about it";
2. there is a strong aversion to the notion of living in a nursing home, especially among retirees; therefore, they have avoided the entire issue; and
3. the cost of the insurance coverage itself is thought to be too high.

The survey results described here reflect the attitudes and behavior of TIAA-CREF participants only; however, the results largely parallel those of a similar survey of the general population conducted in 1997.[13]

Only 6 percent of all currently employed TIAA-CREF participants, and 15 percent of the retired participants, own an LTC insurance policy.

Individual Insurance Products

Typical coverage Most long-term care insurance policies are indemnity policies and cover expenses for care incurred in a nursing facility, at home, in an adult day care center, or in an assisted-living facility. While there are "nursing home-only" policies and some that solely cover home health care, the majority of policies offer coverage for both. Some policies, however, will make a distinction as to the level at which benefits will be reimbursed, with skilled care payable at the highest levels.

Benefit amounts Virtually all individual policies offer applicants the opportunity to design a plan suited to their individual preferences and budget. Typical individual policies allow individuals to select from a range of maximum daily benefits that may be available to pay for nursing home care, with a corresponding amount payable for community-based care (often 50 percent to 100 percent of the nursing home benefit maximum).[14] Some policies may offer monthly or weekly dollar maximums instead of daily values, but daily maximums are currently the most prevalent.

Individuals also choose a benefit "duration" that will determine how long the benefits payable under the policy will last. Most often, this duration is translated to a total dollar amount of benefits that is available and is tied to the daily benefit. For example, an individual choosing a $100 daily benefit intended to last at least five years will actually have a total benefit maximum, or "duration," equaling $182,500 ($100 × 365 days/year × 5 years). If benefits are payable at the maximum amount each day, it would last the full five years. If benefits are paid out at a lower rate (e.g., if care is not being provided every day, or if the cost for the care is less than the maximum daily amount the individual chose), then the total benefits under the policy may last longer than the expected duration. While policies in the past typically specified separate durations for nursing home care and for home- or community-based care, most policies today use an integrated approach, where the total benefit amount is available for any type of benefit the policy covers. This makes practical sense because, despite personal preferences, it is difficult to predict where one will end up needing care or how much one might use, especially when making the selection well in advance of the need.

Inflation protection Individuals purchasing long-term care insurance today must consider that while the benefit amounts they choose may reflect today's costs, the costs of care are likely to increase substantially by the time they actually need care. While it is possible to purchase a higher daily benefit amount at the time of purchase in anticipation of increasing costs, insurance companies offer as options at least two different mechanisms intended to help policyholders keep pace with inflation.

Many insurers offer some sort of automatic annual inflation benefit that increases the policy's daily benefit maximum and total benefit maximum by a set percentage each year, usually 5 percent, with no action required by the policyholder. The increases may stop after a predetermined period of time (e.g., after the policy's daily benefit amount doubles) or may continue for the life of the policy, and can be on a simple or compounded basis.

Another means of funding inflation

protection in a long-term care policy is what has been called a "periodic" inflation option. Under this arrangement, policyholders are routinely given an opportunity, which they accept or decline, to purchase additional amounts of coverage without proof of good health. The actual frequency at which these offers may be given can vary by insurance company. To avoid adverse selection, policyholders are usually limited by the insurance provider to a certain number of declinations after which the inflation protection offers are no longer extended without additional underwriting. Premiums for inflation increases offered in this manner are usually based on the policyholder's new attained age. This means that, over time, the cost for the policy may increase and, depending on the frequency at which the purchases were made, could eventually exceed that of a policy with the automatic inflation feature. Experts disagree on the better method for funding inflation, but do agree on the fact that some mechanism to account for inflation in the cost of long-term care services should be included in every policy.

Waiting periods Most policies apply a waiting period (also known as an elimination or deductible period) before benefits become payable, and insurers offer a number of different waiting period options. Naturally, the shorter the waiting period, the higher the insurance premium. Choices range from zero-day waiting periods to as long as 365 days. Shorter waiting periods are more common and seem to be most preferred, with those in the 30- to 90-day range being fairly typical. Individuals selecting 180- or 365-day waiting periods generally have significant assets and are willing and able to pay their own way for the first year, being more interested in having insurance to cover any ongoing, catastrophic needs on the back end. For a typical LTC policy, a 90-day waiting period implies periodic premiums that are about 14 to 15 percent lower than for a 30-day waiting period.[15]

Benefit triggers Most policies stipulate that benefits become payable once an individual has exhibited a functional or cognitive impairment. Functional status is measured using the Activities of Daily Living (ADLs); the standard list of six ADLs includes: bathing, dressing, eating, transferring, toileting, and continence. The most popular policies generally use a list of five or six ADLs and require that an individual experience impairment in at least two of these to qualify for benefits. This is also in keeping with the requirements for a policy to be considered a tax-qualified policy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Experts disagree on the better method for funding inflation, but do agree on the fact that some mechanism to account for inflation in the cost of long-term care services should be included in every policy.

Nonforfeiture Another option that may be found in a long-term care policy, for an additional cost, is a nonforfeiture benefit. In general, individual LTC policies are guaranteed renewable and will remain in force unless premiums are not paid when due; insurers cannot cancel a policy due to the policyholder's increased age or changes in health status. However, an LTC insurance policy can "lapse" if the insured fails to remit premiums on the policy when they are due (assuming that the insured is not collecting benefits under the policy; a "waiver of premium provision" in most policies typically dictates that premiums are waived when a policyholder starts to receive benefits). The nonforfeiture benefit ensures that at least some continued, limited benefit is paid in the event that the policy "lapses" while the insured is not collecting benefits.

Another type of nonforfeiture benefit offered by some insurers takes the form of a reduced "paid-up" benefit, which essentially provides a lower daily benefit payout than the policy would have provided if the premium payments had been current. The benefit is calculated based on the policyholder's age at issue and the number of years the policy has been in force. Another common form of nonforfeiture benefit is a shortened benefit period, which allows for the original maximum daily benefit to be paid, but for a shorter period of time than the original policy duration. The shortened benefit period, which was included in the National Association of Insurance Commissioners (NAIC) Model Act and Regulation, is becoming more popular, as an increasing number of states adopt this provision as a mandated benefit offer.

LTC policies may also include any number of additional features designed to give them more appeal and value. For example, some insurers offer policies that include a rider that permits spouses to access each other's benefits in the event one exhausts the benefits under their own policy. Another new feature geared to couples is a survivor waiver of the premium, which calls for the premium of a surviving spouse to be waived in the event of the other spouse's death.

Underwriting Individual policies are medically underwritten. Applicants are usually required to complete a form that requests information about their health history. In many instances, the insurer will request medical records from the applicant's physicians and, in some cases, will interview the applicant either over the telephone or in a face-to-face assessment. The age of the applicant may drive

the level of scrutiny. An increasing number of insurers are introducing distinct underwriting classes into their premium determinations. Those applicants in the best health may sometimes qualify for a preferred rate. There are also situations where those in poorer health, who normally might not have been able to obtain a policy, can now qualify for coverage at a higher premium rate.

Premiums Periodic premiums for long-term care insurance policies are determined based on the age at which coverage is initiated and, once determined, are designed to be fixed for the life of the policy. (Premium rates are not, however, guaranteed to be fixed; insurers typically reserve the right to increase premiums for identifiable classes of policies if claims experience so dictates.) Premium rates will, of course, be higher or lower depending on the plan options that an individual may select. As an example of typical premium levels, Table 2 shows annual premiums as of October 1999, by age, for a basic TIAA long-term care insurance policy, without and with automatic inflation protection. Of course, there is some variation in premium levels charged by different insurers; however, the rates in the table are fairly typical rates for policies offered by reputable long-term care insurers. As is evident, premiums increase rapidly with age. Automatic inflation protection nearly doubles the cost of a policy sold at typical issue ages, that is, around age 65.

Many insurers now offer a variety of discounts that can lower premiums. Spousal discounts are becoming common and can lower the cost anywhere from 10 to 20 percent for each spouse's policy. Insurers recognize that couples can often provide some long-term care services for one another, slightly reducing overall LTC needs and expenses. Some companies will provide a discount to applicants based solely on marital status, regardless of whether both spouses apply for a policy with that company. Employers who sponsor a program of making individual policies available to employees can help to secure an employer discount in some instances.

Current Efforts and Proposals to Expand Coverage

There are different approaches to expanding insurance coverage for long-term care needs. Some have suggested that the employer is best able to provide its workers with coverage, and there has been some activity along those lines. Others have advocated an expansion of the role of the government, and yet others maintain that more widespread ownership of individual policies is possible.

Current efforts by employers As employers become aware of the general aging of the workforce and the implications for those employees who have found themselves caring for aged parents, some employers have added, or are at least considering adding, long-term care programs to their benefit packages. By the end of 1996, more than 1,500 employers were offering some type of long-term care insurance to their employees; some 440,000 individuals were insured through these programs.[16] While the majority of plans installed have been voluntary employee-pay-all

Table 2
Annual Premiums, As of October 1999, by Age, for a Basic TIAA Long-term Care Policy, Without and with Automatic Inflation Protection

Age	Base Policy	With 5% Inflation Protection
40	$ 430	$1,670
50	540	1,760
60	940	2,290
65	1,310	2,730
70	1,950	3,460
74	2,800	4,420

Notes: The LTC policies quoted here, "Teachers SelectCare," have a $100/$100 daily benefit for nursing home/home health care coverage, an unlimited benefit period, and a 90-day waiting period; the base policy also includes a rider that offers an option to purchase periodic CPI inflation additions. The policy will reimburse 100 percent of covered expenses up to the insured's elected daily benefit maximum. Benefits are payable when the insured is functionally impaired in at least two activities of living or suffering from a cognitive impairment. Homemaker services are also reimbursable, and home health care providers can be an independent/licensed individual who is not affiliated with a home health care agency. The inflation protection option above is a 5 percent automatic inflation adjustment (a "periodic" inflation-protection option, as described in the text of this report, is also available). Many other options are available at added cost; a detailed description can be found on TIAA-CREF's Corporate WebCenter, at http://www.tiaa-cref.org/ltc/index.html.

Source: TIAA-CREF Corporate WebCenter, viewed October 1999 (http://www.tiaa-cref.org/ltc/index.html).

arrangements, some employers (typically those employing fewer than 100 people) have contributed at least part, and in a few cases all, of the premium.

The easiest way for an employer to provide its workers access to long-term care insurance is by sponsoring a program wherein individual long-term care insurance policies are made available. An alternative is to offer employees a "group" LTC plan. Although the benefits, triggers, and options in a group plan are virtually the same as those found in an individual policy, there are a few distinctions. The most significant is the availability of guaranteed issue enrollment for employees, which is generally not available through an individual policy. Employees who meet an "actively at work" definition can get guaranteed coverage without having to submit medical information. While the plans may offer a rolling enrollment, typically the privilege of guaranteed issue is available for a limited window of time. This helps to limit the insurer's exposure to adverse selection, particularly because, even with guaranteed issue, participation rates in group LTC plans are generally only around 6 percent.[17]

Relative to the variety of benefit levels and optional features that may be available under an individual program, group plans typically offer a more limited selection of options. Employers will most often provide some choice in daily benefit maximums to allow for potential differences in costs in the different parts of the country to which their employees may ultimately retire. In addition, eligibility under group LTC plans is usually extended to employees and their spouses (and domestic partners in some cases, depending on the employer). Parents and parents-in-law of the employee are often included in the eligible group in recognition of the financial burden that may result if the employee is solely responsible for care giving to parents. Retirees of an employer may also be included.

Despite the advantages of group LTC plans, including lower administrative costs for large employers and convenience to employees, there are business risks that may prevent most employers from establishing such plans. In the first instance, many employees, especially young employees, will not appreciate such a program in the absence of a strong educational effort by the employer. Given that one of the main business reasons for sponsoring employee benefit programs is their attractiveness to workers, especially prospective ones, most employers will devote their attention to benefits areas better appreciated, such as health insurance and child care benefits. Second, employers want to avoid creating any new employee entitlement program; even an employee-pay-all program can turn into an entitlement, which may add costs and liabilities in the future. (A good example of a program that some employers regret ever having offered is retiree health benefits.) Finally, employers want to avoid sponsoring programs that in the future may be burdened by government regulations which may increase costs or limit flexibility.

A proposal for a new social insurance/government entitlement program In *Sharing the Burden: Strategies for Public and Private Long-term Care Insurance*, written at the time of the Clinton administration's health reform proposals, Joshua Weiner, then a senior fellow at the Brookings Institution, proposed a major expansion of the involvement of the federal government in financing long-term care needs.[18] Specifically, he suggested that financial eligibility for the means-tested Medicaid program be significantly liberalized. In addition, Weiner recommended that a social insurance program be created, which would provide home health care benefits to all disabled elderly persons, regardless of income and asset holdings, as well as coverage for the first six months of nursing home stays. Funding for the Medicaid liberalization and social insurance programs would come from increases in payroll taxes and premiums paid by the elderly. Private insurance would be left to provide asset protection for well-to-do families.

In order to protect against the risk of runaway costs to the federal government and, ultimately, taxpayers, Weiner recommended that expenditures be limited and no legal entitlements created. In order to accomplish this, as well as to allow coverage for a wide range of services to be determined by the states, services would only be provided on a funds-available basis.

Given the necessary legislative and regulatory changes and clarifications, an immediate life annuity and a long-term care insurance policy could possibly be integrated into one product or program and made available to participants in pension plans.

Whether Americans would be satisfied with this approach or would ultimately demand an entitlement program is uncertain. The last major entitlement program to be created, Medicare, resulted in a major unexpected increase in government spending, some fairly rigid and unchanging program structure and rules, and an enormous increase in demand for services. Moreover, the expansion of a means-tested program (Medicaid) as proposed by Weiner, may cause increased resentment and invite fraud.

Can individual long-term care insurance provide widespread coverage? A study by the American Council of Life Insurers (ACLI) has measured the extent to which the increased ownership of individual long-term care insurance by the general population can help to finance future long-term care expenditures.[19] Using a

large-scale simulation model, the study found that increased ownership can reduce future Medicaid nursing home expenditures by 21 percent and reduce out-of-pocket expenditures for nursing home care by 40 percent. The key assumptions of this model are that everyone age 35 and older in the year 2000 who can afford to purchase a long-term care policy will do so, and that three-fourths of the purchasers will retain their policy until old age.

Clearly, realization of these assumptions would necessitate a major change in behavior among consumers. Ownership of private long-term care insurance among the elderly is low (around 8 percent, according to the authors' rough estimate), and even fewer younger individuals have coverage. There would also need to be great public trust in the long-term financial capability of insurers and a strong belief that government and social insurance programs will not be forthcoming in the future to cover long-term care needs. The main advantages to the purchase of long-term care insurance at younger ages are lower annual premiums and fewer underwriting problems; about three-quarters of the individuals age 35 to 44 could afford a policy if they spent 2 percent or less of their income on private insurance. It is unclear whether younger individuals would be willing to incur such a significant expenditure to insure against a risk that is so abstract and distant at that age.

Integrating the Life Annuity and Long-term Care Insurance

Another innovation may have a particularly large potential in terms of expanding long-term care coverage. Given the necessary legislative and regulatory changes and clarifications, an immediate life annuity and a long-term care insurance policy could possibly be integrated into one product or program and made available to participants in pension plans. There are some strong reasons to encourage the necessary public policy steps that would make development of this type of benefit feasible. (We mention this idea in this publication for the purposes of fostering discussion only; there are a number of issues, some of which are discussed below, that must be resolved before such a product could be made available.)

An integrated product or program could potentially be offered at a lower total cost (for both purchasers and providers) than a life annuity and long-term care insurance policy provided separately. This advantage results from a reduction of the "adverse selection" and underwriting expenses that are present in both products when they are sold separately. In particular, when individuals have a choice whether or not to purchase a life annuity for themselves, their choices will exhibit "adverse selection," meaning that unhealthy or frail individuals, who expect a relatively short life, will bypass the purchase of an annuity if given the choice, while healthier individuals will be more eager to purchase an annuity.[20] Stand-alone long-term care insurance is also exposed to adverse selection, but in "reverse": In the case of LTC insurance, those in poor health would be the most eager to buy the insurance, while those in the best health would be the least likely to buy the insurance. Underwriting for long-term care insurance "solves" the adverse selection problem for LTC insurance at the cost, however, of the underwriting expenses themselves. Moreover, underwriting denies a large portion of the elderly population access to insurance.[21] By integrating the provision of the LTC insurance and the annuity, these self-selection effects may to some extent offset each other, lowering the total cost of providing the combined product and making it more broadly available.

Initial research has shown that, among individuals of annuity purchasing ages, there is a significant positive relationship between the likelihood of living a short period of time and of needing long-term care in the near term.[22] Hence, it is possible that an integrated long-term care immediate life annuity could be offered with little or no medical underwriting, perhaps at a reduced premium as compared to the products sold separately.[23] Implicitly, a nonforfeiture benefit for the long-term care component would be included in the integrated program, because the product/program can best be understood as the simultaneous purchase of a single-premium long-term care policy and an immediate life annuity using a lump-sum of assets from a retirement account.

An integrated product or program might be attractive to retirement plan sponsors who otherwise would need to consider establishing group long-term care plans separately from their pension plans. It might also be attractive to plan participants, who would no longer need to conduct extensive searches for an individual long-term care policy (or, for that matter, if not already provided, an immediate annuity provider).

Significant changes and clarifications in tax laws would probably have to be made before an integrated program or product could be implemented as a distribution option for a qualified retirement plan. There may also be regulatory constraints imposed by some state insurance departments that would also need to be overcome. Furthermore, clear income-tax rules regarding the treatment of pension distributions used to purchase long-term care insurance would need to be developed. One possible approach here would be to develop tax rules similar to those that currently exist under section 401(h) of the Internal Revenue Code, which covers pension plans that provide health benefits to retired employees. Employer contributions to fund such benefits are not treated as taxable income to the employee, and the benefits, when paid, are not included in the taxable income of the retiree. Long-term care benefits could potentially be considered health benefits for the purpose of 401(h). Currently, however, there are strict con-

ditions imposed on benefits provided through 401(h), including the necessity to establish a separate account where the employer's contributions are collected. It is unlikely that an integrated long-term care and annuity program or product could meet the conditions of the law as it currently exists (particularly if offered through 401(k) and 403(b) plans). Nevertheless, the precedent of the 401(h) law could enable legislators to craft new provisions that would fit the long-term care annuity option. Such legal and regulatory change would help to encourage the utilization of annuities and to spread long-term care coverage among middle-class American retirees covered by pensions.

Conclusion

Because of increasing life expectancies, high costs for nursing home and home health care, declining levels of informal family care, and the stated policy of the federal and state governments to foster self-reliance, individuals are increasingly exposed to the risk of financial ruin from long-term care expenses. Yet, because of psychological barriers and aversions, particularly to thinking about residing in a nursing home, most individuals have not purchased long-term care insurance. Currently available individual long-term care policies are comprehensive instruments that can provide customized financial protection. Recent efforts by some employers and policy proposals attempt to encourage and ensure that more individuals have coverage for long-term care needs.

Endnotes

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[5] Lewin-VHI, Brookings-ICF Long-Term Care Financing Model, as quoted in Health Insurance Association of America, *Long-Term Care: Knowing the Risk, Paying the Price*, 1997, Table 1.3.

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[7] Data from U.S. Bureau of Labor Statistics.

[8] HealthCare Synergies, Inc., September 1998.

[9] Bradley Baden et al., "National Health Expenditures, 1997," *Health Care Financing Review*, Fall 1998, Vol. 20, No. 1, pp. 83–126. The statistics quoted here exclude long-term care provided by hospital-affiliated facilities and agencies, which in 1996 amounted to over $17 billion.

[10] Medicare also pays for long-term care for the terminally ill through hospice care.

[11] 1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medical Insurance Trust Funds.

[12] Janemarie Mulvey and Barbara Stucki, "Who Will Pay for the Baby Boomers' Long-Term Care Needs? Expanding the Role of Private Long-Term Care Insurance," American Council of Life Insurance, April 1998, pp. 7–8.

[13] National Council on Aging/John Hancock Long-term Care Survey, 1997.

[14] Community-based care is any care that is noninstitutional (i.e., it includes care rendered in a person's residence as well as care received in such facilities as adult day-care centers).

[15] Based on TIAA-CREF's experience.

[16] HIAA (Health Insurance Association of America) Research Findings, Long-Term Care Insurance in 1996, September 1998.

[17] *Ibid*.

[18] Joshua M. Weiner, Laurel Hixon Illston, and Raymond J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, 1994, Brookings Institution, Washington, D.C.

[19] Janemarie Mulvey and Barbara Stucki, *op. cit*.

[20] For information on the empirical extent and consequences of this problem, see Mark Warshawsky, "Annuity Prices in the United States: 1919–1984," *Journal of Risk and Insurance*, September 1988, pp. 518–28.

[21] Between 12 percent and 23 percent of the population would be rejected for private long-term care insurance because of their health if everyone applied at age 65 under common underwriting criteria; these figures rise to between 20 percent and 31 percent at age 75. See Christopher Murtaugh, Peter Kemper, and Brenda Spillman, "Risky Business: Long-Term Care Insurance Underwriting," *Inquiry* 32 (Fall 1995), pp. 271–284.

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