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THE FEASIBILITY OF EMPLOYER-PROVIDED LONG-TERM CARE INSURANCE

Statement of

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Introduction*

The development of a market for private long-term care insurance offers the potential to pool risk and reduce public expenditures for long-term care. To realize this potential, the number of covered persons must represent a broad portion of the population. One way to ensure that a broad spectrum of people have long-term care insurance is to encourage employers to provide the insurance as an employee benefit.

Employer-provided benefits such as pensions and health insurance have proven effective at providing active workers health insurance and retirees retirement income security in the form of pensions and post-retirement medical benefits. Without these benefits the rate of health insurance coverage would probably be far less and the economic security of many retired persons would be substantially more uncertain.

The development of a private insurance market for long-term care has been hindered by conceptual problems and a lack of information that affects both supply and demand. Actuarial data to estimate risk, costs and predict consumer behavior are not readily available. Public (and public-sector) reluctance to acknowledge the cost of long-term care, as well as widespread misinformation about existing Medicare coverage for long-term care, have also contributed to the absence of private or public financing.

Over the past five years, however, private insurer interest in marketing coverage for long-term care has grown. Most major health insurers are now either marketing or testing a long-term care product. One recent survey of insurance trade association members indicates that at least 13 insurers are currently selling long-term care policies of some type, and another 15 expect to do so this year (HIAA, 1986). Estimates of the market place the number of insurers at 60, with about 200,000 policies written (Lane, 1986).

The long-term care insurance market is currently dominated by individual products marketed primarily to the elderly. Long-term care insurance products are almost without exception indemnity plans that pay a fixed dollar amount per day for each day spent in a nursing home or for each day of home health care. Policies commonly require a waiting period to qualify for benefits and a hospitalization to trigger benefits. Indemnity amounts are generally not indexed for inflation, and benefits may be limited to three or four years.

These types of insurance products reflect insurers' considerable concern about moral hazard. The potential insurer cost resulting from informal caregivers substituting formal, covered services is substantial, although experience from other countries suggest that relatively little substitution might in fact occur. Countries that have added long-term care coverage to their national health insurance, have seen minimal substitution of formal for informal care (Kane and Kane, 1985; Kane, 1986). Nevertheless, U.S. insurers have focused on limiting their exposure by offering unindexed indemnity plans that pay benefits only after hospitalization, and then for a limited (although generally sufficient) period of time.

The pricing of these first-generation insurance products reflects the fact that they are marketed primarily to retirees or people who are close to retirement age, and marketed as individual (rather than group) products. Premiums are high, reflecting the greater imminent risk of long-term care need among an older population. Coverage sold to a younger population would offer the opportunity to average individual risk over a longer period of years, reducing the present value of expected long-term care cost and, therefore, the annual premium. This is the premise of whole or universal life insurance, compared to term insurance for that risk.

The sale of long-term care insurance to individuals rather than groups also contributes to its cost. A group product reduces the likelihood of adverse selection and lowers marketing costs; it may also broaden the risk

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pool to include younger, healthier populations' subsidizing the current cost of older participants. Economies of scale in the administration of group insurance may also reduce cost. The advantages of marketing to groups, and insurers' experience with employer group products, make employers an obvious target for a group long-term care insurance product. Nevertheless, very few employer group products have been developed.

Employers and Income Security in Retirement

The role of employers in assuring retirement income security is substantial. In 1984, 34 percent of people over age 65 reported income from a pension. Among higher-income elderly (those with family income at twice the poverty level or more), 43 percent reported pension income. For a significant number of elderly, private and public pension plans provide a substantial portion of their total retirement income. Among elderly couples and individuals reporting private pension income in 1984, 47 percent received 20 percent or more of their total income from one or more private pensions; 12 percent received half or more of their total income from private pensions. Public pensions (which commonly are automatically indexed after retirement) are an even more important source of income among elderly recipients. In 1984, 75 percent of elderly couples and individuals reporting public pension income derived 20 percent or more of their total income from public pensions, and 35 percent reported half or more of their total income from public pensions (Grad, 1985).

More than half of workers age 25 to 64 participate in an employer-based pension plan. Although the rate of pension plan participation among workers is several points lower than before the economic recession of the early 1980s (52 percent in 1985, compared to nearly 56 percent in 1979), employer-based pension plans are expected to remain important as an employee benefit and source of retirement income among future retirees (Chollet, forthcoming).

Employer-sponsored health insurance benefits for retirees have also become an important and fairly common employee benefit. In 1985, 84 percent of private sector workers in medium and large establishments in the United States (generally establishments that employ 250 workers or more) had health insurance plans that continued benefits after retirement at age 65.[1] Although many employers may have initiated retiree health benefits rather casually, as a presumed low-cost alternative to enhanced pension benefits, retiree health plans now provide a valuable real retirement income supplement. For low-income retirees, the value of their retiree health benefits (automatically indexed to the rising cost of health care) can exceed the amount of their pension benefit over time.

Among current retirees age 65 or over, at least 24 percent have health insurance benefits from a past employer to supplement Medicare (See Table 1). Although retiree health insurance benefits are more common among pension recipients, a significant number of elderly without pension income also report health insurance benefits from a past employer.

The success of employer pension plans in facilitating retirement saving, as well as employers' established position in financing health care among workers and retirees, suggest that employer plans might also offer an excellent opportunity for workers to finance the expense of long-term care during their higher-income working years. The specification of such a plan, however, is likely to be critical to its acceptability to employers. Most employers who would consider adopting a plan to assist in financing long-term care may strongly resist any expansion of unfunded liability for retiree health benefits.

Structuring Long-Term Care Insurance as an Employee Benefit

Several employers (including the federal government) have expressed interest in providing a long-term care benefit for retirees, few (perhaps only one: the state of Alaska) offer a plan to current retirees. These first long-term care plans are likely to serve as models for future plans and may affect employer and employee opinions about what constitutes appropriate

[1]EBRI tabulation of the 1985 Employee Benefit Survey (U.S. Department of Labor, Bureau of Labor Statistics).

Table 1

RETIREE HEALTH INSURANCE BENEFITS[a]
AMONG CURRENT ELDERLY BY FAMILY INCOME, 1984

	All Elderly		Elderly With Retiree Health Benefits		
Family Income	Number (millions)	Cumulative Percent	Number (millions)	Percent Within Income Group	Cumulative Percent of All Recipients
Total	26.1	(100.0)	6.3	24.1	(100.0)
$0 - $9,999	9.2	35.4	1.3	13.8	20.3
$10,000-$19,999	8.8	68.9	2.5	28.7	60.3
$20,000-$29,999	4.3	85.2	1.3	31.7	81.7
$30,000-$39,999	1.9	93.5	0.6	29.7	90.7
$40,000-$49,999	0.8	95.7	0.3	34.2	95.2
$50,00 +	1.1	100.0	0.3	26.6	100.0

Source: Preliminary EBRI tabulations of the Survey of Income and Program Participation (SIPP), Waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

[a] Includes persons age 65 or older with no earnings who reported health insurance coverage from a current or past employer at any time during the year.

long-term care coverage. To facilitate discussion about employer-provided long-term care insurance as an employee benefit, this section offers two general approaches to structuring LTC insurance on employee benefit.[2]

The primary distinction is whether the plan is "outside-funded" (capital accumulation to purchase the benefit in retirement is separate from the insurance plan) or "inside-funded" (capital accumulation occurs within the insurance plan). The definition of plan beneficiaries, the benefits covered, how benefits are triggered, and limits on coverage are factors that affect the cost of the plan and, potentially, the magnitude of potential employer liability. These details, however, are beyond the scope of this paper.

An "outside-funded" long-term care insurance plan might be an employer-sponsored capital accumulation plan (for example, a supplemental defined-contribution pension) with access to a group long-term care insurance policy at retirement. Assets to purchase long-term care in retirement would accumulate separately from the insurance plan, and the rate of asset accumulation could be independent of increases in the group plan cost. Employer and employee contributions to the cash accumulation plan, however, could be targeted to allow retirees to fully or substantially pay the projected premium. At retirement, the group insurance could be priced in at least two ways: on a "term" basis (increasing with retiree age and risk), or on an entry-age basis (reflecting the present value of the expected cost over the retiree's expected life). Purchasing a plan that is priced according toentry age is equivalent to the employee initiating an inside-funded plan at retirement.

An outside-funded plan would offer employers one primary advantage: they could avoid liability for increases in the cost of the long-term care benefit. The full indexation of retiree health liability associated with conventional retiree health plans that define benefits in terms of covered services poses a critical problem for employers that they would presumably want to avoid in devising a long-term care insurance plan. Employers may, in fact, look to an "outside-funding" approach like that described here to finance post-retirement health insurance for future retirees, if they are required to disclose and/or fund the liability accruing for their plans. Outside funding might also facilitate employers offering to retirees coordinated or alternative plans to finance acute and long-term care. Even if the employer were liable for guaranteeing access to a group long-term care plan when participating workers retired, that obligation might be met in an expanding private insurance market for long term care by negotiating an agreement with one or more insurance carriers.

An outside-funded type of plan would also offer employees some advantages. First, if such a plan were more acceptable to employers, access to long-term care coverage would be a more widespread benefit. Second, capital accumulation plans offer portability that is more difficult in other types of plans. However, such plans would place employees at risk for any short-fall between accumulated assets and the price of long-term care coverage at retirement.

Outside funding of a retiree insurance plan has little or no precedent in employee benefits, although it borrows heavily from the concept of a defined contribution pension plan or cash-deferred savings plan. However, employers who would develop a plan restricting use of distributions to payment of long-term care insurance premiums or other expenses related to long-term care may face difficulty with tax qualification, since the tax code does not now explicitly provide for restricted-use capital accumulation.

An outside-funded plan as described here would be a significant departure from employers using a 501(c)(9) trust (a voluntary employee benefit association, or VEBA) to finance a promised long-term care benefit in retirement. Despite tax code restrictions that strongly discourage employers from using VEBAs to fund retiree health insurance liability of any type, these trusts may be poorly suited to the kind of long-term care insurance benefit employers may wish to provide. VEBAs are not structured as employee-owned capital accumulation accounts: employer contributions to a VEBA are not associated with particular employees, and workers who terminate employment before retirement cannot withdraw funds from the VEBA. Although employer contributions to either a 401(h) trust (designed as subsidiary to the pension

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[2]This section is from Chollet and Friedland, forthcoming.

benefit) or a Section 105(h) trust (a medical expenditure account) are associated with particular workers, these trusts are not intended for employee capital accumulation either. Use of any of these trusts by employers may be best-suited to funding a defined service benefit, something that employers might wish to avoid in designing a long-term care plan for retirees.[3]

An alternative to outside-funding an employee long-term care benefit is inside-funding: offering employees a long-term care plan that offers current coverage and is entry-age priced (that is, priced at the discounted present value of expected lifetime risk). Because entry-age pricing would result in plan premiums that exceeded younger participants' immediate risk of needing long-term care services, capital would accumulate inside the plan (called inside buildup) throughout all or most of workers' pre-retirement years. At retirement, participants who had bought coverage earlier in their worklives would continue to pay the same lower premium--less than the discounted expected value of benefits after retirement. An inside-funded plan could be offered to workers at the point of retirement (as is Alaska's public employee plan); premiums, however, would be higher than if the plan were marketed to workers before retirement.

In principle, employers could offer this type of benefit either as an insured or self-funded plan, analogous to their options in financing health benefits. In practice, however, employers might find self-funding very unattractive, if it impeded their ability to alter or terminate their involvement in the plan. Employers with an insured plan might be better able to define their contributions to the premium (containing their liability for the benefit) and to negotiate continuation of coverage for workers and retirees should they wish to terminate the plan.

An inside-funded long-term care benefit would offer employees several advantages over an outside-funded plan. First, the plan would provide current coverage; although the probability of needing such coverage is low for young employees, it does have some value. Second, employees' ability to continue purchasing the plan after retirement is a surer prospect, since the price would be substantially lower for long-time participants than it would be if the coverage were initially purchased at retirement.

For workers who terminate employment before retiring, however, portability may be more difficult in an inside-funded plan, since not all employers would offer a long-term care insurance plan or offer the same plan. However, portability might be facilitated by allowing terminated employees the option to buy into the plan or to buy conversion coverage from the same or another insurance carrier.

Similar to an outside-funded plan, inside-funded plans might face some difficulties in obtaining tax qualification, simply because there is no precedent for employer-sponsored long-term care insurance benefits. Although current law would allow employers to deduct premium payments, employer contributions and/or plan distributions could be taxable as personal income if coverage included substantial nonmedical, personal care services.

Employees' rights to the plan's inside buildup in the event of bankruptcy reorganization or merger might also be difficult to resolve; this is not now an issue for retiree health plans, since benefits are almost universally financed pay-as-you-go. In the event of insurer bankruptcy, employers might still be liable for providing long-term care insurance coverage, or for paying claims incurred but not paid by the insurance plan.

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[3]At least one employer has used Section 105(h) based on an IRS letter ruling to establish a tax-exempt "medical expenditure account" to finance health insurance benefits for current workers and retirees. While 105(h) plans have not been used widely or at all to fund accrued liability for future benefits, employee benefit consultants have suggested that these plans may be useful for that purpose since unused balances can be rolled over to subsequent years--a feature that is obviously critical to capital accumulation. However, 105(h) accounts may be poorly suited for funding benefits which may not be paid for a substantial number of years, since employer contributions cannot be deducted as a business expense until distributions are made from the account in payment of participants' health care bills.

The Potential for Long-Term Care Insurance as an Employee Benefit

The potential for achieving widespread long-term care insurance coverage among future elderly is a strong argument for fostering long-term care as an employee benefit. Long-term care coverage among retirees that would be as common as pension benefits or employer-sponsored health insurance would represent a substantial improvement on the current holding of such coverage among the elderly and might substantially exceed the coverage that could be achieved by individual purchases.

There are a number of competing factors that make the likelihood of achieving this potential uncertain. A potential barrier is employer concern over the unfunded and accruing liability of post-retirement medical benefits. Another is the feasibility for employers and employees to consider restructuring employee compensation packages to include long-term care insurance. It is assumed that unless there are changes in productivity, employers are not likely to add additional benefits; nor are they likely to consider programs that might increase financial liability.

The cost of paying for promises of health care can be staggering. Many firms offering post-retirement medical benefits to current retirees, have not prefunded and may have an unfunded liability in excess of the value of the firm's assets. The Department of Labor estimated that based on the workforce age 40 or older in 1983, the unfunded liability was $98.1 billion. Firms are likely to seek ways to either avoid increasing their unfunded liability or reduce the continuation of accruing liabilities for retiree benefits.

Microsimulation projections of pension recipiency among future retirees indicates that both the proportion of elderly receiving pension benefits and the average real income provided by pensions may grow, even if pension coverage rates among current workers remain the same. (Chollet, 1987; Andrews and Chollet, 1987). This suggests that employers and workers may have some latitude in restructuring retirement benefits toward insurance benefits without jeopardizing current levels of retirement income.

Even assuming that within-industry pension plan coverage rates among workers show no growth over a forty-year simulation period, future retirees are more likely to have income from a pension plan than current retirees, and to have higher average real pension income than today's recipients (see Table 2). In part, this trend can be explained by the longer tenure of young workers in a post-ERISA workforce, compared to workers now retiring. Most of this growth, however, results from the greater opportunity of young workers to vest in several defined contribution pension plans and from increase in the labor force participation of women. (The microsimulation results presented here assume continuation of the longer defined-benefit vesting standards allowed before tax reform and, as a result, may understate eventual defined-contribution pension income among future retirees.)

In 1985 dollars, average pension income among married-couple retirees in the youngest cohort simulated with pensions is expected to rise more than 83 percent, to $13,000 compared with $7,100 among couples retiring today. Among single retirees, average pension income is projected to rise at a somewhat slower rate, from $5,300 among single workers now retiring to $9,000 among the youngest cohort of single retirees.

The prevalence and income distribution of retirees with employer-sponsored pension and health insurance benefits is a favorable indication of the potential for employer-sponsored long-term care insurance. If employer-sponsored long-term care insurance had emerged parallel with retiree health benefits supplemental to an employer pension, perhaps 19 percent to 24 percent of today's elderly may have had access to long-term care coverage in retirement--including many low-income retirees.[4]

Projections of future pension recipiency suggest the potential for the development of long-term care insurance as an employer sponsored benefit. However, the current political climate may not be well suited for these changes. Recent tax reform has broadened the tax base and lowered the

[4]Estimate is based on preliminary tabulations of retirees with employee-provided health benefits in the Survey of Income and Program Participation (waves 2 through 5). For more discussion on this observation please see Chollet and Friedland, Forthcoming.

marginal tax rate. Tax base broadening has already limited retirement income savings, suggesting that the legislative process might not be inclined to either extend or necessarily maintain tax preferences for current or retiree benefits. Lower marginal tax rates may lower employee incentives for more deferred nonwage compensation, especially if real income of the nonelderly continues to decline.

Preferences among employees for more deferred nonwage compensation could develop, however, as the baby-boom ages and the average age of the labor force rises. Changing demographics could bring about a new focus on retirement benefits that would not have occurred otherwise. This may be exacerbated as more individuals experience providing chronic care to their parents and grandparents.

Table 2

PERCENT OF FUTURE RETIREE FAMILIES
WITH PENSION INCOME AT AGE 67
AND AVERAGE PENSION INCOME IN CONSTANT 1985 DOLLARS:
MICROSIMULATION PROJECTIONS BY 1979 AGE COHORT[a]

	1979 Age Cohort			
	25-34	35-44	45-54	55-64
Percent with pension income	63	61	57	48
Average income among recipients (dollars in thousands):				
Married couples				
Total	$ 13.0	$ 10.4	$ 8.8	$ 7.1
Defined benefit pension	9.0	7.9	7.1	6.5
Defined contribution pension	9.9	7.9	6.1	4.4
Single individuals				
Total	9.0	6.8	6.9	5.3
Defined benefit pension	7.2	6.0	5.6	5.1
Defined contribution pension	6.9	5.1	4.8	3.3

Source: Employee Benefit Research Institute. Preliminary results from the Pension and Retirement Income Simulation Model (PRISM) (See Chollet, 1987).

[a] A description of the base-case PRISM assumptions underlying these microsimulation results appears in: Kennel and Shiels, 1986.

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