Long-Term Care and the Private Insurance Market

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Issue Brief

- Increased life expectancy and the aging of the baby boom generation will bring rapid growth in the number of people at risk of needing long-term care (LTC). This *Issue Brief* provides an overview of the current LTC financing and delivery system in the United States, focusing on private-sector initiatives to meet the United States' LTC needs. It discusses private-sector plan design—particularly employment-based plan design—providing an indepth look at the dramatic changes taking place in the private-sector LTC market since its inception in the early and mid 1980s.

- Aside from informal care provided in the community, the current system of financing LTC depends largely on the Medicaid program and individual financing. Issues confronting this system include spiraling costs associated with LTC services that may threaten beneficiaries' access to care. Other issues include the potential depletion of personal assets and a bias toward institutionalization (which may not always provide the most cost-effective or desired type of care available).

- Many leaders regard private long-term care insurance (LTCI) as a way to increase access to financing and as a potential alternative to Medicaid and out-of-pocket financing.

- By the end of 1993, a total of 3.4 million private-sector LTCI policies had been sold, up from approximately 815,000 in 1987. While the majority of these plans were sold to individuals or through group associations, employment-based plans accounted for a significant proportion of this growth.

- Premiums for LTCI vary substantially based on age and plan design. Insurers generally attempt to set premiums such that they will remain level over the insured's lifetime. However, because little LTC claims insurance experience yet exists, the actuarial basis for developing premiums and statutory reserves is limited.

- Several bills over the last three Congresses have been introduced to address the issue of LTC. However, due to cost implications and lack of consensus regarding the optimum overall structure required to finance and deliver care, broad legislation to expand coverage—particularly public coverage—is not likely in the near term.

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Introduction

Increased life expectancy and the aging of the baby boom generation will bring rapid growth in the number of people at risk of needing long-term care (LTC). Relative to the number of individuals who can provide physical and financial assistance, the proportion of those in need will increase dramatically over the next several decades. Continuing trends of more two-worker families, more single workers, and the increased geographic spread of family members means that there will be fewer family members available to provide care on an informal basis.

This *Issue Brief* provides an overview of the current LTC financing and delivery system in the United States, focusing on private-sector initiatives to meet the United States' LTC needs. It discusses private-sector plan design—particularly employment-based plan design—and provides an indepth look at the dramatic changes taking place in the private-sector long-term care insurance (LTCI) market since its inception in the early and mid 1980s.

Long-Term Care

Long-term care—or long-term care services—refers to a broad range of health, social, and environmental support services and assistance provided by paid and unpaid caregivers in institutional, home, and community settings to persons who are limited in their ability to function independently on a daily basis. Functional dependency can result from physical or mental limitations and is generally defined in terms of the inability to independently perform essential activities of daily living (ADLs) such as dressing, bathing, eating, toileting, transferring (for example, from a bed to a chair), walking, and maintaining continence or to perform instrumental activities of daily living (IADLs) such as shopping, cooking, and housekeeping.[1]

The majority of LTC services are provided by the private sector but are financed through the public sector. LTC can include care in many different settings and for many different kinds of support services (see box). For example, care may be provided at home, in an adult day care center, or in a nursing facility. It may include both skilled medical care (care that can only be provided by a registered nurse on a doctor's orders) and custodial care (for example, assistance with bathing and dressing) or it may include only custodial care. However, skilled care for an acute temporary medical condition is different from LTC. This can be an important distinction because, while treatment for a temporary medical condition by a licensed provider is generally covered by private medical insurance plans and Medicare, custodial care generally is not.

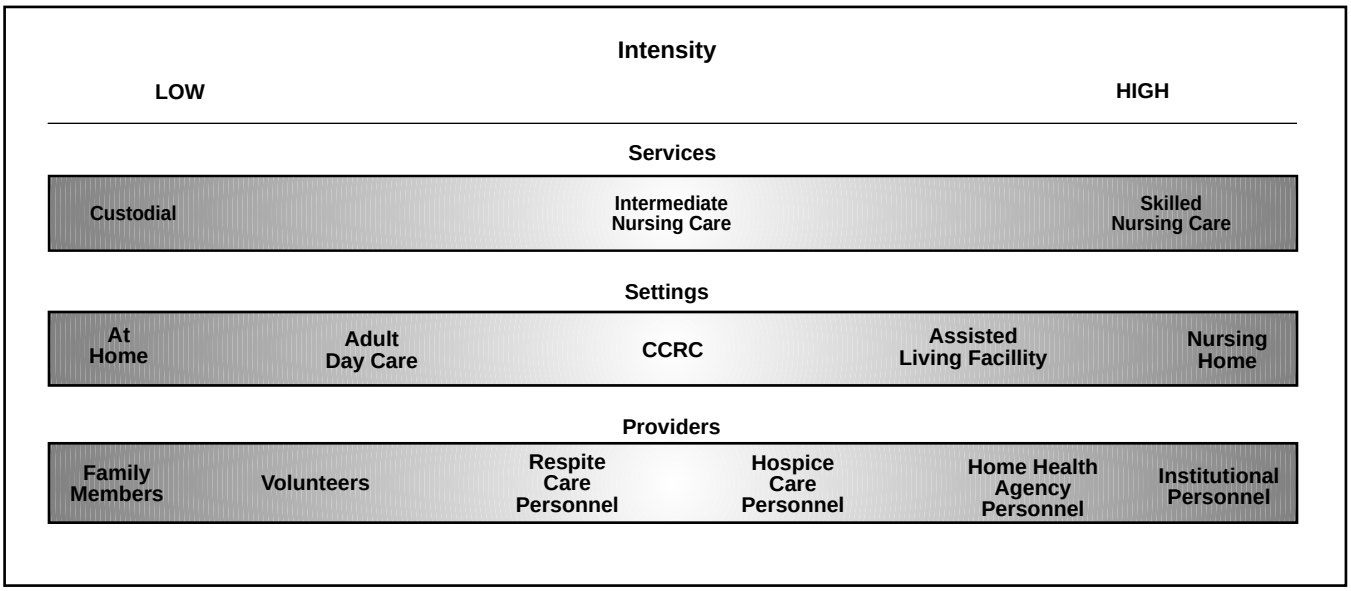
The Market

The population in need of LTC has become increasingly diverse. A growing proportion of those in need of services are under age 65. A recent study by the U.S. General Accounting Office indicates that, of the 12.8 million people needing assistance with everyday activities, 5.1 million (39.6 percent) are working-age adults, and approximately 420,000 (3.3 percent) are children under age 18 (table 1) (U.S. General Accounting Office, 1994). Chronic conditions

[1] *The index of independence in activities of daily living was developed by Sidney Katz and colleagues as a measure of function that could be used to objectively evaluate the chronically ill and aging. Results were first published in 1963. For a further discussion of the index, see Katz, et al., 1963 and Katz, et al., 1970.*

Long-Term Care Services, Settings, and Providers

Long-term care can generally be classified as skilled nursing care, intermediate nursing care, and custodial (or personal) care. These services have traditionally been provided either by family members at home or in formal settings such as in a nursing home. While care is still often provided at home by family members, a number of nontraditional settings and types of providers have developed that focus on providing care in the most home-like setting possible. While it is difficult to classify these settings and providers, the following continuum attempts to present a range of the services, settings, and providers—from the least intensive to the most intensive—now available.



This continuum is by no means all inclusive or standardized. It is meant to give a general idea of the range of LTC services, settings, and providers. For example, while assisted living facilities are presented as more intensive with regard to the type of setting in which care is provided, based on the given individual's needs, the type of care provided at an adult day care center may actually be more intensive. In addition to variation based on each individual's needs, definitions vary and may overlap. Following are general descriptions of the terms used in this illustration.

Adult Day Care
Adult day care offers a structured daytime program that typically includes assistance with personal care, lunches, and a variety of social, recreational, and rehabilitative activities in a protective environment (The Prudential, 1994). Long-term care insurance (LTCI) contracts may only pay for care in an adult day care center if the center is appropriately state licensed or is recognized as a home health agency by Medicare.

Assisted Living Facilities
These facilities offer shared and supervised housing for those who cannot function independently, including individuals needing only minimal support as well as those who are more severely impaired (Teachers Insurance and Annuity Association, 1993).

Continuing Care Retirement Community (CCRC)
A CCRC is a residential community for older people that offers lifetime housing and a range of social and health care services (Teachers Insurance and Annuity Association, 1993). These services are generally provided in exchange for an upfront fee and monthly payments.

Custodial (or Personal) Care
Custodial care may be given by people without medical skills to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, and other routine activities. It is less intensive or complicated than skilled or intermediate care and can be provided in many settings, including nursing homes, adult day care centers, or at home (National Association of Insurance Commissioners, 1993a).

Family Members
Although a large proportion of LTC services are provided informally by family members,[1] most policies, with rare exceptions, specifically exclude coverage for such care.

Home Health Care
This care includes a wide variety of services delivered at home or in a residential setting that can range from skilled nursing care and physical therapy to personal care and help with household chores (Teachers Insurance and Annuity Association, 1993).

Hospice Care
Hospice care includes services provided to assist a person with a terminal illness that may be provided in various settings, including, for example, at home or in a nursing home care setting (Travelers Group, 1995).

Intermediate Nursing Care[2]
This type of care is ordered by a physician and supervised by a registered nurse for stable conditions that require daily, but not 24-hour, nursing supervision. Intermediate care is generally needed for a long period of time (National Association of Insurance Commissioners, 1993a), is less specialized than skilled nursing care, and often involves more personal care.

Respite Care
Respite care offers temporary relief, or time off, for family members or other unpaid caregivers who are responsible for the care of a dependent person (The Prudential, 1994). This service is provided by volunteers, an institution, or an adult day care center (Teachers Insurance and Annuity Association, 1993). LTCI plans generally limit the number of days for which respite care is reimbursable (The Prudential, 1994).

Skilled Nursing Care[3]
This care is available 24 hours a day, is ordered by a physician, and involves a treatment plan for medical conditions that require care by skilled medical personnel such as registered nurses or professional therapists. Some people need skilled care for a short time after an acute illness. Others require skilled care for longer periods of time. Sometimes skilled care is provided in a person's home with help from visiting nurses (National Association of Insurance Commissioners, 1993a).

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[1] In 1989, one study estimates that 70 percent of the severely disabled elderly relied solely on family members or other unpaid help to provide long-term care services. See U.S. Bipartisan Commission on Comprehensive Health Care, 1990. (Data are based on Lewin/ICF and Brookings Institution estimates of the 1982 National Long-Term Care Survey.)

[2] Medicare and Medicaid have their own definitions of nursing care that do not necessarily match definitions found in LTC policies.

[3] Ibid.

such as mental retardation and AIDS affect individuals of all ages. In addition, due to advances in medical technology and treatments, individuals are increasingly likely to survive—although not necessarily free from disability—what may in the past have been a fatal accident or childhood ailment.[2]

The needs of this growing and diverse population vary considerably. For example, some individuals may need around-the-clock assistance. Others may simply need assistance with shopping or traveling to and from school or work.

Individuals, employers, and public policymakers have all begun to focus on the impact of these trends. Among the general population, recognition that neither Medicare nor most private health insurance plans cover LTC has come slowly. Nevertheless, **many retirees and workers have now begun to understand their exposure to the risk of needing costly community or institutional LTC as an increasing number have faced the necessity of caring for a parent, spouse, or child needing chronic (and often increasing) assistance for personal care.** Employers have also begun to realize that not only must many of their employees now care for young children, but many are being called on to care for elderly parents. Recognizing and meeting the needs of these individuals by assisting them in providing for their children, parents, and grandparents may have the potential to reduce absenteeism and improve morale, company loyalty, and ultimately productivity.

Policymakers have also become increasingly active in the debate over the future of LTC services and policy in the United States. Proposals focusing on increasing access and improving the quality of care through incentives to encourage the growth of the LTCI market are now being discussed. Public program proposals are focused on effectively managing and minimizing costs.

The debate can be expected to continue about whether government or private-sector initiatives hold greater promise for meeting the needs of a growing and increasingly diverse LTC population. Currently, initiatives are being taken in both sectors. The federal/state

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[2] However, the likelihood of requiring long-term care does increase with age. In 1991, 29.2 percent of those aged 45–64 had a disability, 44.6 percent of those aged 65–74 had a disability, and 63.7 percent of those aged 75–84 had a disability (15.3 percent, 25.3 percent, and 41.5 percent, respectively, had a severe disability) (McNeil, 1993).

Table 1
The U.S. Long-Term Care Population by Age and Care Setting

Age Group	In Institutions	At Home or in Community Settings	Total Population
		(thousands)	
Total	2,440	10,400	12,840
Children (Under Age 18)	90	330	420
Working-Age Adults (Aged 18–64)	710	4,380	5,090
Elderly (Aged 65 and Over)	1,640	5,690	7,330
		(percentage)	
Total	100.0%	100.0%	100.0%
Children (Under Age 18)	3.7	3.2	3.3
Working-Age Adults (Aged 18–64)	29.1	42.1	39.6
Elderly (Aged 65 and Over)	67.2	54.7	57.1

Source: U.S. General Accounting Office, *Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages,* GAO/HEHS-95-26 (Washington, DC: U.S. General Accounting Office,1994). These data are based on information from the U.S. Department of Health and Human Services, the Institute for Health Policy Studies at the University of California, San Francisco, and other sources.

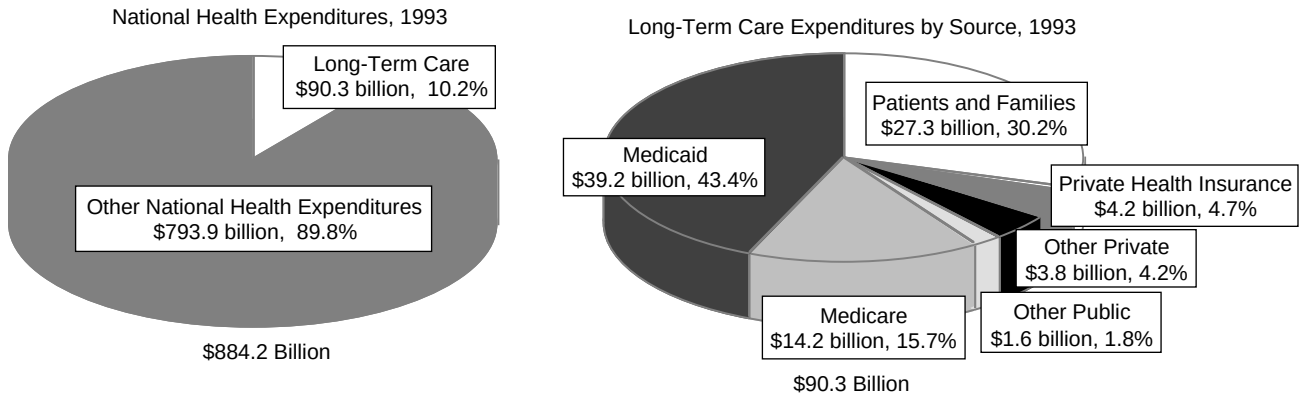
Medicaid program has increased coverage for home- and community-based care, while several public/private sector partnerships have developed that allow people to become eligible for Medicaid while maintaining some of their assets.

The private-sector LTCI market has also evolved significantly in recent years, growing from approximately 815,000 policies sold by 1987 to a total of 3.4 million by 1993 (Coronel and Fulton, 1993).[3] Improvements in plan design have helped to fuel this growth. For example, many plans now include protection against inflation and loss of benefits due to policy lapses. However, perhaps the most significant change has been in the increased flexibility that is now built into many policies, in some cases even allowing individuals to customize the use of their benefits package to meet their needs at the time care becomes necessary. This flexibility enables plans to keep pace with the continually evolving LTC market.

While private insurance now finances only a small portion of LTC needs (chart 1), it is expected to grow as plan design improves and as an increasing

[3] *These data represent the total number of policies sold as of the date indicated. Due to policy lapses, the number of policies actually in force is lower.*

Chart 1
Long-Term Care Expenditures as a Proportion of Total National Health Expenditures and by Source of Funds, 1993



Source: Katharine R. Levit, et al., "National Health Expenditures, 1993," *Health Care Financing Review* (Fall 1994): 247–294.
Note: These data represent nursing home and home health care expenditures from the National Health Accounts. They include expenditures for acute care—generally not considered long-term care—as well as expenditures for custodial care. The data do not include an additional $4.1 billion furnished by facility-based (generally in hospitals) home health agencies, long-term care costs incurred outside of home health agencies or nursing homes, or costs for informal—"unpaid"— long-term care.

number of individuals recognize the possibility of needing LTC and the associated costs. Both individually purchased policies and employment-based plans will expand further if tax laws are changed. However, barriers remain that may inhibit this growth. For example, some studies indicate that growth potential is limited because only a small portion (10 percent to 20 percent) of those most likely to need services—the elderly—can afford a good quality LTCI policy (Wiener, 1994; Friedland, 1990). In particular, though, there is currently no clear public policy with regard to LTC in the United States.

Public policy issues that will need to be clarified involve the tax treatment of LTCI, the relationship of public and private LTC programs, regulatory concerns, and ways to increase understanding of the potential need for LTC among individuals and employers who have previously not considered it.

Public Programs

Medicaid

Medicaid, the federal/state health insurance program for certain categories of poor individuals, is the single largest source of public financing for formal LTC, accounting for 71.3 percent of nursing home and home health care financed through public programs in 1993 (calculated from chart 1). In addition to an array of medical services, Medicaid covers all levels of institutional care[4] and provides limited coverage for home care and formal community-based LTC. No other public program provides comprehensive coverage for LTC.

Two general categories of individuals are eligible for Medicaid: categorically eligible and medically needy. Categorically eligible individuals receive Medicaid because they belong to one of several categories, including those receiving cash welfare assistance, those receiving Supplemental Security Income (SSI),[5] the blind, and pregnant women and children in poor families.[6]

Individuals with incomes too high for categorical Medicaid eligibility may qualify for Medicaid as medically needy if their medical and/or LTC expenses exceed their incomes and if they have less than a state-specified amount of assets. In states that have these programs, individuals must first "spend down" their resources to a specified level (amounts vary by state and exclude such assets as housing and personal effects)[7] and are then eligible for Medicaid as long as their current monthly income minus allowances for a spouse and family is insufficient to cover medical expenses, including the cost of care in nursing homes.[8] All remaining income (pensions, Social Security, etc.) in excess of a minimal amount disregarded for personal needs must be applied to the cost of care.

Some individuals have also been able to become eligible for Medicaid by transferring assets to a spouse or

[4] Institutional care is generally categorized as skilled, intermediate, or custodial, depending on the need for medically trained attending staff. Intermediate care and custodial care are generally provided by Medicaid in nursing homes and are the types of care most often needed by individuals with chronic disabilities. In a limited number of states, Medicaid may cover care in an assisted living facility.

[5] Supplemental Security Income (SSI) is a means-tested, federally administered income assistance program that provides monthly cash assistance to needy aged, blind, and disabled individuals.

[6] Women and children aged six and younger are eligible for Medicaid if they are in families with incomes up to 133 percent of the federal poverty level. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) expanded Medicaid eligibility to include children aged 7 through 18 in families with incomes up to 100 percent of the poverty level, for children born after September 30, 1983.

[7] In January 1993, legislation to allow the spouse of a Medicaid recipient to retain approximately $1,149 a month in income and at least $14,148 in countable assets other than the couple's home, went into effect. However, allowances vary by state. These allowances are indexed to increase with the Consumer Price Index (Teachers Insurance and Annuity Association, 1993).

[8] The Tax Equity and Fiscal Responsibility Act of 1982 authorized states to place liens on the real property of Medicaid recipients to insure the property's availability for later recovery. It also authorized states to receive the cost of care financed by Medicaid from the estates of deceased recipients if not needed for support of the spouse or dependent children (U.S. Department of Health and Human Services, 1988).

By the end of 1993, a total of 3.4 million private-sector insurance policies had been sold, up from about 815,000 in 1987.

children or by "sheltering" assets. This practice enables individuals to become eligible for Medicaid quickly without spending down. However, provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) restrict asset transfers, making this practice more difficult.

Medicare

Although Medicare, the publicly financed health insurance program for the elderly and certain disabled individuals, does not cover LTC, it accounted for 15.7 percent of national nursing home and home health care expenditures, or just over one-quarter (25.8 percent) of public expenditures, in 1993 (chart 1). This figure represents Medicare's coverage for recuperative medical care in Medicare-certified skilled nursing facilities (SNFs) for individuals who require skilled nursing after a hospital stay. Medicare may also provide limited coverage for home health or hospice care, but only in certain situations. Medicare does not cover custodial care, intermediate nursing care, or long-term home health care costs.

Other Public Sources

Aside from Medicaid, individuals may be able to receive LTC from miscellaneous community-based programs financed through federal grants to state governments, including the Older Americans Act programs and Social Services Block Grant programs.

Private Programs

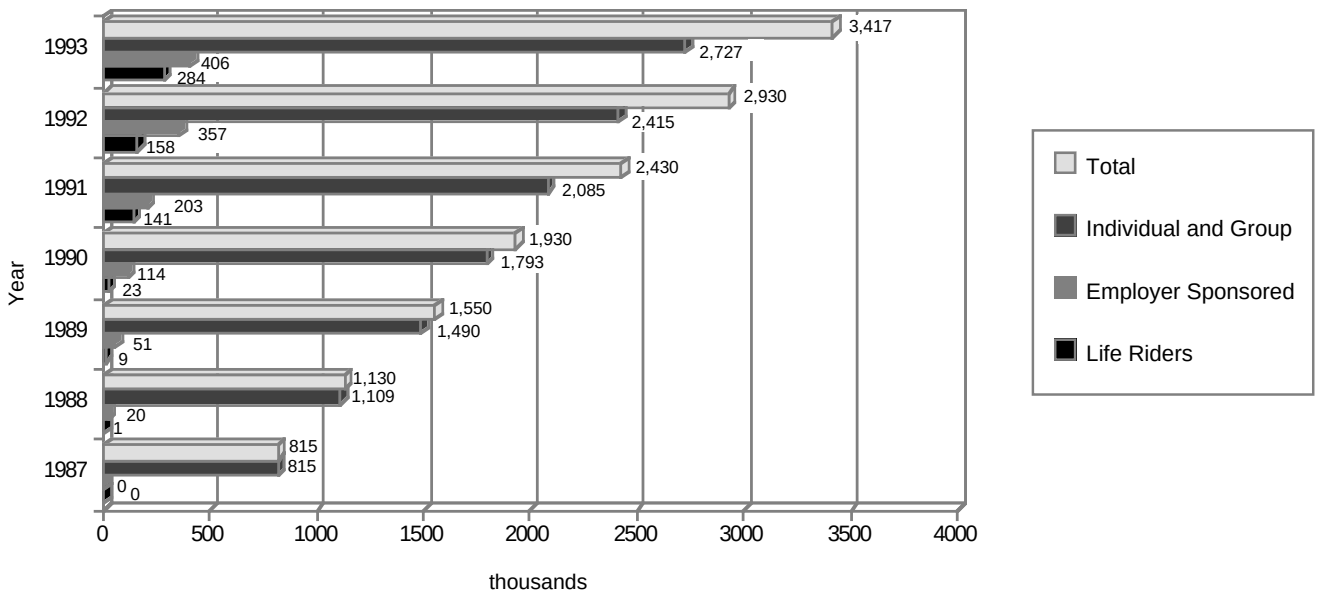
Private Insurance

Private insurance now finances only a small portion of LTC needs (chart 1). Theoretically, individuals with assets to protect should be willing to pay for LTCI. Furthermore, since people of any age may potentially need LTC services, their assets could be at risk at any time. While the chances of having extended LTC needs are small, the costs of such needs are extremely high. However, for a variety of reasons, only a small portion of those who can afford LTCI have actually purchased it. For individuals who have no assets they wish to protect or who believe they will never require formal care (perhaps because they have a large family), LTCI may never be worth the price. However, others may lack information on the probability of needing such care; may mistakenly believe that they are already covered by Medicare, health insurance, or disability insurance;[9] or may be dissatisfied or mistrustful of policies that are currently available. Still others may not purchase insurance because of the knowledge that Medicaid covers LTC, albeit while restricting choice and requiring that the individual be at or near the poverty level to qualify for coverage.

However, as an increasing number of individuals recognize the possibility of needing LTC and the costs associated with such care, private initiatives to provide for this need have grown, both through individually purchased and employment-based plans. By the end of 1993, a total of 3.4 million private-sector insurance policies had been sold, up from about 815,000 in 1987 (chart 2). Private policies include individual, group association, CCRC, employment-based, and accelerated death benefits specifically for LTC. While the majority of these plans were sold to individuals or through group associations, employment-based plans accounted for a significant proportion of this growth (increasing from 20,000 policies sold and 7 employers offering LTCI in 1988 to over 400,000 policies sold and 968 employers offering LTCI in 1993) (chart 2 and table 2). A separate study indicated that 12 percent of all employers with 10 or more employees offered LTCI in 1993, 10 percent to

[9] *Disability insurance replaces lost wages; it does not cover any health or long-term care costs.*

Chart 2
Long-Term Care Policies Sold in Individual and Group, Employer, and Life Insurance Markets, 1987–1993



Source: Susan Coronel and Diane Fulton, "Long-Term Care Insurance in 1993," *Managed Care & Insurance Operations Report* (Washington, DC: Health Insurance Association of America (HIAA), 1995); and personal communication.
Note: These data represent the estimated number of policies sold as of the date indicated and are derived from HIAA percentages. Long-term care insurance policies include individual, group or association, continuing care retirement communities, employer-sponsored, and accelerated death benefits specifically for long-term care.

active employees only and 2 percent to both active employees and retirees (table 3). Most likely to offer coverage were employers in the Northeast (23 percent), in the manufacturing industry (17 percent), and those with 500–999 employees (22 percent). Least likely to offer coverage were employers in the West (5 percent), employers in the transportation, communications, and utilities industries (0 percent), and employers with 200–499 employees (8 percent). Among those who did not offer coverage, 9 percent indicated they would consider offering it in the future.

Plan Types

Individual and group association policies are the most common LTCI products (chart 2) and have been available the longest. Individual policies are marketed on an individual basis rather than through an employer or other group. Group association LTCI policies are made available to members of nonemployment-based groups or associations that typically have elderly or near-elderly memberships such as the American Association of Retired Persons. These types of policies are targeted at elderly or near-elderly individuals for whom the prospect of LTC may seem imminent.

Employment-based plans are marketed to individual employers and are typically available to a firm's employees, their spouses, parents of employees and spouses, and retirees on a beneficiary-pay-all basis. These insurance plans have grown significantly over the past few years but are still uncommon relative to other types of employment-based insurance. For example, analysis of the April 1993 Current Population Survey indicates that 73 percent of workers aged 18–64 worked for an employer that sponsored a health insurance plan

Table 2
Employer-Sponsored Long-Term Care Plans Introduced Each Year, 1987–1993

Year	Total Number of Plans Introduced	Cumulative Total of Plans Introduced
1987	2	2
1988	5	7
1989	47	54
1990	81	135
1991	153	288
1992	218	506
1993	462	968

Source: Susan Coronel and Diane Fulton, "Long-Term Care Insurance in 1993," *Managed Care & Insurance Operations Report* (Washington, DC: Health Insurance Association of America, 1995).

Table 3

Percentage of Employers Offering Long-Term Care Insurance, by Region, Industry, and Number of Employees, 1993

	Percentage of Employers Offering Long-Term Care Insurance to:					Of Those Not Offering Long-Term Care, Percentage Who:		
	Active employees only	Retirees only	Both active employees and retirees	Total offering coverage	Do not offer coverage	Decided not to offer	May offer in future	Never considered it
Total	10%	0%	2%	12%	88%	3%	9%	87%
Region								
West	5	0	0	5	95	3	11	86
Midwest	7	0	5	12	88	0	10	89
Northeast	20	0	3	23	77	6	6	88
South	8	0	0	8	92	5	10	86
Industry								
Manufacturing	17	0	0	17	83	2	9	88
Wholesale/retail	8	0	5	13	87	0	11	89
Services	2	0	5	7	93	0	19	81
Transportation, communications, and utilities	0	0	0	0	100	12	0	88
Health care	14	0	0	14	86	1	1	98
Finance	2	0	2	4	96	1	2	96
Government	3	0	8	10	90	0	6	94
Other	13	0	0	13	87	11	11	77
Number of Employees								
10–49	10	0	2	11	89	4	12	84
50–199	13	0	3	15	85	0	0	100
200–499	7	0	1	8	92	1	4	95
500–999	14	0	8	22	78	7	7	86
1,000–4,999	10	2	10	21	79	12	24	64
5,000–9,999	5	0	10	15	85	19	34	47
10,000–19,999	7	1	8	15	85	15	42	41
20,000 or more	4	0	15	19	81	22	37	41
Under 500	10	0	2	12	88	3	9	88
500 or more	11	1	9	21	79	10	18	74

Source: Foster Higgins, *Tables: National Survey of Employer-Sponsored Health Plans, 1993* (New York, NY: Foster Higgins Survey and Research Services, 1994).

in 1993 (Yakoboski, et al., 1994). A separate Bureau of Labor Statistics study indicates that 6 percent of full-time employees in medium and large private establishments in 1993 were eligible for LTCI (U.S. Department of Labor, 1995). However, these policies have the potential to reach a large number of people because they are marketed not only to older retirees and parents of active workers but also to younger active workers and their spouses. Thus, the average age of employment-based LTCI enrollees is younger (aged 43) than enrollees in individual and group association plans (aged 68) (Coronel and Fulton, 1995).

LTC coverage sold as riders to life insurance policies are also fairly new and tend to attract younger enrollees. Life insurance policies with a LTC accelerated death benefit rider generally advance the death benefit (or a portion of it) to the insured in the event of terminal illness or a specified disease and have experienced rapid growth since their introduction. One study indicated that in 1987 there were no life insurance policies with a LTC rider, but that about 284,000 such policies had been sold by 1993 (chart 2).

Although the market is currently dominated by policies that are sold individually and through associations, employment-based plans offer several benefits over individual policies and could potentially dominate the market in the future. Group insurance can be less costly because of potential economies of scale in marketing and administration.[10] Employment-based groups generally have a particular advantage in this respect because there is a central mechanism for collecting premiums (i.e., payroll deduction). These factors, together with the reduced likelihood of adverse selection[11] when younger groups are enrolled, can make group plans less expensive than comparable coverage offered on an individual basis

[10] However, employment-based long-term care insurance is not as yet as heavily subscribed to as other types of employment-based insurance such as health and life insurance. Thus, group size may be small—even among large employers offering such coverage—and the advantages of economies of scale may not be able to be fully realized.

LTCI is evolving in an environment of continuously changing regulations and uncertainty regarding the future direction of LTC policy, the cost of LTC, which services are most cost effective, and which design features are best suited to meet individuals' needs.

(Friedland, 1990).

In addition to the potential of group insurance to be less expensive, employment-based LTCI policies may make employees, retirees, and their families aware at an earlier age of the possible liabilities associated with LTC, when they can better afford to plan for LTC needs. Moreover, employment-based LTCI policies are generally negotiated by a benefits professional, who may be better informed than a lay person about the nuances of policy provisions and coverage limitations. Past reports citing the prevalence of sales abuses suggest that having a knowledgeable person conduct the search for the best policy can be particularly valuable (Consumer's Union, 1991; Shikles, 1991).

Plan Design

Private LTCI plans have changed significantly since their inception in the early and mid 1980s. LTCI policies have become less restrictive as they have evolved, and many of today's policies have additional provisions that make them more valuable to employees and other individuals than earlier policies. For example, many plans no longer require only a medical trigger to become eligible for benefits, and several insurers now offer policies that adjust the benefit for inflation. Many policies also now offer an optional rider that ensures that policyholders who have stopped paying premiums will nevertheless retain some of the benefit. These and other innovations give an indication of how much the private LTCI market has evolved. However, the most significant development relates to the flexibility included in current plan design.

LTCI is evolving in an environment of continuously changing regulations and uncertainty regarding the future direction of LTC policy, the cost of LTC, which services are most cost effective, and which design features are best suited to meet individuals' needs—especially given the increasingly diverse population in need of LTC services. The market has responded by creating plans that have several options and that, in some cases, can be custom tailored at the time care is needed. The "alternate plan of care" option provides the possibility of payment for nonstandard customized services not specified in the policy. Services may include alternative sites of care, facilities, and/or providers. Examples are care in a facility that is not a nursing home but that specializes in care for patients with Alzheimer's disease or modifying a residence to accommodate wheelchair access (Teachers Insurance and Annuity Association, 1993). Generally, a plan of care is developed that the insured, insurer, and provider agree on at the time care is needed. In addition, some plans now enable the individual to select from numerous options when purchasing a policy, such as the daily benefit amount , a maximum benefit amount, the type of care to be provided (e.g., nursing home only versus nursing home or other type of care setting to be determined at the time care is needed), or whether to include provisions such as inflation protection. This flexibility is a likely imperative to the survival of the LTCI market given the continually evolving LTC system.

These and other design features now commonly available—particularly in employment-based plans—include those listed in table 4. Much of the following discussion is based on review of individual employers' and insurers' current actual LTC policies for the individual and/or group markets. (Individual and group plan

[11] *Adverse selection refers to a phenomenon whereby people who believe they are likely to experience a certain event (in this case functional dependency) find insurance against the costs of that event more attractive than people who believe they are not likely to experience that event. Generally speaking, the risk of adverse selection decreases as the proportion of the group enrolled increases because enrollment begins to approximate random selection. This is less true for long-term care insurance than health insurance since individuals voluntarily choose and pay for group long-term care insurance, while health insurance is often mandatory.*

Table 4
Typical Coverage Offered by 1993 Leading Sellers

Services Covered	Skilled, intermediate, and custodial nursing home (13 out of 13) Home health care (13 out of 13) Adult day care (12 out of 13) Alternate care (12 out of 13) Respite care (11 out of 13)
Daily Benefit	$40–$200/day nursing home $20–$100/day home health care
Benefit Eligibility	Medical necessity only (0 out of 13) Medical necessity or ADLs[a] or cognitive impairment (13 out of 13)
Maximum Benefit Period	Unlimited nursing home (12 out of 15)
Deductible Period	0–20 days and 90–100 days
Preexisting Condition	6 months or less (13 out of 13)
Renewability	Guaranteed (13 out of 13)
Alzheimer's Disease Coverage	For aged 40–84
Age Limits for Purchasing	Yes (13 out of 13)
Waiver of Premium	Yes (13 out of 13)
Free Look Period	30 days (13 out of 13)
Inflation Protection of 5 Percent Compounded	Yes (13 out of 13)
Nonforfeiture Benefit	Return of premium or reduced paid-up (13 out of 13)
Marketing	Company or independent agents

Source: Susan Coronel and Diane Fulton, "Long-Term Care Insurance in 1993," *Managed Care & Insurance Operations Report* (Washington, DC: Health Insurance Association of America, 1995).
[a]Needing assistance with activities of daily living.

design features are not discussed separately.)

***Eligibility and Benefit Eligibility Triggers*—Many employment-based plans guarantee issue of insurance to active workers during an enrollment period with limited or no medical underwriting. Others (e.g., retirees, spouses, parents, and parents-in-law) are generally medically underwritten.**

Benefit eligibility is generally triggered when the insured is unable to perform or needs assistance with two out of five or three out of six or seven ADLs, depending on the insurer and insurer's definition of ADL. Eligibility may also be triggered based on cognitive impairment such as the need for supervision due to Alzheimer's disease.

Benefit waiting periods generally require the individual to wait between 20 days and 100 days from the time of meeting the criteria to the time of receiving payment for services received. The waiting period (often called the elimination period) may be based on a set number of days regardless of the receipt of services or may be based on services received. In the first case, the waiting period generally begins based on the date ADL dependence is ascertained. In the latter case, the waiting period usually begins based on the first day of services received. In general, the waiting period must be satisfied again if care is not received for a specified amount of time (for example, six months) (The Prudential, 1994).

Although policies are now generally less restrictive than in previous years, several limitations may still apply, particularly for individuals who purchased a policy in years past and have not updated that policy. For example, some plans may still base benefit eligibility on physician certification of need and medical necessity rather than on the failure to perform ADLs or on the need for supervision based on a cognitive disability. Because much LTC is by definition not medical in nature, the medical necessity trigger can prevent people from qualifying for claims payment. Some plans may also require prior hospitalization as a prerequisite for nursing home coverage and/or skilled nursing care as a prerequisite for home- or community-based care. However, medical necessity triggers and prior hospitalization requirements are prohibited by current model regulations and are regarded as anticonsumer by regulators and consumer advocates. For the most part, these features are no longer included in current plan design. However, in past—as well as in current plans—definitions of ADL are not standardized; some insurers may clearly define each ADL, others may not, making eligibility less clear. Some insurers may also specify that the individual not be able to perform the ADL, as opposed to simply needing supervision with the activity, thereby making eligibility more restrictive.

Some plans may also include limitations on preexisting conditions, although such provisions are no longer common. Policies are much more likely to include a specified waiting period for benefits based on a preexisting condition (generally six months).

***Sites of Care*—Most plans now offer coverage for nursing home care and home- and community-based care. In addition, coverage is often now available in many nontraditional types of settings such as in adult day care centers** (see box).

Some plans give potential insureds the option of selecting a nursing home only provision or a more comprehensive plan that lets the individual decide on where care will be provided at the time care is needed. However, even though a policy may indicate that care at home is covered, there will be restrictions.

Many plans also now include a case management or care advisory provision. Case management is a form of utilization review. In some plans, it is mandatory that the plan of care be followed in order for benefits to be paid. Sometimes mandated case management is combined with premium reduction incentives. More often, plans include a care advisory provision. In this case, the plan of care does not need to be followed in order that benefits be paid but is there to assist the individual in identifying and sorting through care options. Care may also be monitored to ensure that the individual has access to care that meets the insured's needs. However, terms are not standard and are not used consistently; therefore, it is important to carefully interpret what type of care provision is being provided for in a given contract.

***Benefit Amounts*—Private LTCI plans now generally base benefit amounts on a *daily benefit maximum* with a corresponding *lifetime benefit maximum*. Generally, an individual is given several options regarding level of coverage. For example, an individual may select a daily benefit maximum of $50, $100, or $150 per day with corresponding lifetime benefit maximums of $91,250, $182,500, or $273,750.** Once the individual becomes eligible for benefits, the insurer would pay based on charges incurred up to the daily benefit maximum and based on site of care.[12] Nursing home care is generally paid at 100 percent of the daily benefit amount, while charges incurred for home health care and adult day care are generally paid at 50 percent of the daily benefit amount.

The level of benefits selected can significantly affect premiums. Thus, factors to consider in selecting a daily and maximum benefit amount should include, for example, the cost of services in the service area (table 5), what the individual can afford, and the type of care that will likely be needed. For example, if the individual has a good support system (i.e., family members in the area), adult day care and/or respite care benefits may suffice. Others may prefer—or need—nursing home care.[13]

Most plans now also include a *coordination of benefits* feature to prevent duplication of benefits. For example, if the daily benefit amount selected is $100 and an individual is receiving care at the cost of $90 per day in a nursing home and Medicare pays $19 for that care, then the LTCI plan would pay $71. The remaining $29 would still be available as part of the maximum lifetime benefit.[14]

***Inflation Protection*—Several insurers now offer policies that adjust the daily benefit maximum and lifetime benefit maximum for inflation. One type of**

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[12] However, some plans pay based on disability rather than on services received. With this type of policy, policyholders may use the money "as they see fit." For example, while many policies do not cover care provided by family members, a policyholder with a contract based on disability, rather than on service, would be able to use his or her per diem funds to pay a family member for care (Aetna, 1995).

[13] One study indicates that, for persons who reached age 65 in 1990, 43 percent will enter a nursing home at some time before they die. Of those entering a nursing home, 55 percent will have a total lifetime use of at least one year, and 21 percent will have a total lifetime use of five years or more. The authors of the study also projected that women are more likely to enter a nursing home than men (52 percent versus 33 percent). See Kemper and Murtaugh, 1991.

[14] The Health Care Financing Administration (HCFA) recently indicated that H.R. 5252, a technical amendment to OBRA '90 adopted in 1994 at the close of the 103rd Congress, could be interpreted as prohibiting the sale of insurance contracts that coordinate benefits with Medicare (Garner, 1995). If coordination is prohibited, this could reduce the amount of time benefits would be available to policyholders. In addition, this contradicts a provision in the proposed Contract with America Tax Relief Act of 1995 (discussed below) that would require long-term care policies to coordinate with Medicare to be qualified contracts for tax purposes.

Table 5
Median Daily Nursing Home Charges, 1991 and 1993

State	Intermediate Care	Skilled Care	Intermediate Care	Skilled Care
	1991		1993	
Alabama	$65	$68	$72	$75
Alaska	a	a	a	a
Arizona	69	80	75	85
Arkansas	54	59	55	63
California	85	90	75	94
Colorado	70	74	75	81
Connecticut	130	148	126	157
Delaware	80	91	87	86
Florida	78	85	85	90
Georgia	60	64	65	75
Hawaii	105	115	109	114
Idaho	72	76	79	75
Illinois	65	78	70	80
Indiana	71	86	73	90
Iowa	58	90	60	89
Kansas	52	74	55	70
Kentucky	64	80	66	87
Louisiana	51	59	64	74
Maine	99	124	114	141
Maryland	95	105	101	105
Massachusetts	125	135	134	145
Michigan	79	84	80	86
Minnesota	67	89	66	95
Mississippi	58	60	61	62
Missouri	55	62	60	66
Montana	68	82	74	84
Nebraska	58	68	60	78
Nevada	82	100	93	97
New Hampshire	108	150	120	133
New Jersey	116	122	118	122
New Mexico	75	111	74	138
New York	103	144	105	148
North Carolina	75	86	75	90
North Dakota	65	80	a	82
Ohio	80	93	85	100
Oklahoma	48	75	50	75
Oregon	76	118	76	116
Pennsylvania	90	97	95	101
Rhode Island	107	112	109	115
South Carolina	74	75	75	79
South Dakota	65	69	66	71
Tennessee	58	91	70	105
Texas	57	78	58	78
Utah	65	75	69	80
Vermont	90	100	102	116
Virginia	96	79	80	104
Washington	89	84	89	99
Washington, DC	178	178	91	94
West Virginia	74	76	75	85
Wisconsin	73	80	80	86
Wyoming	75	76	76	76

Source: CNA Nursing Home Cost Surveys.
[a]Data not available.

Table 6
Average Annual Premiums for Leading Individual and Group Association Long-Term Care Sellers, 1993

Age	Base Plan	Base Plan with Lifetime 5 Percent Compounded Inflation Protection	Base Plan with Nonforfeiture Provision	Base Plan with Both Lifetime 5 Percent Compounded Inflation Protection and Nonforfeiture Provision
50	$405	$770	$555	$1,080
65	1,086	1,896	1,434	2,525
79	4,372	6,033	5,432	7,713

Source: Susan Coronel and Diane Fulton, "Long-Term Care Insurance in 1993," *Managed Care & Insurance Operations Report* (Washington, DC: Health Insurance Association of America, 1995).
Note: This policy pays $100/$50 a day nursing home/home health coverage. It generally includes a 20-day elimination period and provides 4 years coverage.

inflation protection feature results in an automatic adjustment in the benefit, commonly 5 percent per year. Premiums for a policy with this feature will be considerably higher than for a policy without such a feature. A second type of inflation protection feature allows policyholders the option of increasing their benefit every so many years (for example, every three to five years) (Teachers Insurance and Annuity Association, 1993; The Prudential, 1994). In this case, premiums are lower from the outset, but the cost of any additional coverage purchased is based on age at the time the increase is selected. Some proposals have advocated that inflation protection be made mandatory, while others would require only that insurers offer the option of an inflation protection feature when a policy is initially sold.

***Premiums*—Premiums for LTCI vary substantially based on age and plan design. For example, Health Insurance Association of American survey data indicate that average annual premiums for leading individual and group association LTC sellers in 1993 ranged from $405 for individuals purchasing a base plan at age 50 to $7,713 for individuals purchasing a plan that included inflation protection and a nonforfeiture provision at age 79** (table 6). Other plan features, such as categories of care covered (nursing home care, home care, community care), daily benefit amount, maximum benefit duration, and deductible periods can also significantly affect premium amounts (National Association of Insurance Commissioners, 1993b). Because premiums are based on age at enrollment, the younger the individual, the lower the premium. Insurers generally attempt to set premiums such that they will remain level over the individual's lifetime. Thus, premiums do not increase based on aging or use of benefits. In addition, policies are guaranteed renewable; thus, as long as premiums are paid, coverage cannot be canceled.

However, premiums may rise over time because rates generally can be increased on a class basis if claims are higher than expected. And, because the LTCI market is such a new market, it is difficult to set premiums accurately. Little long-term claims insurance experience yet exists and may not for many years to come since many of those who currently hold LTCI will likely not use it for many years. Insurers are encouraged by current legislative proposals to enter the field of LTC financing in order to provide an alternative to public-sector financing. They are also encouraged to keep premiums level. Yet, the actuarial basis for developing premiums and statutory reserves is limited.[15]

***Nonforfeiture*—As is increasingly common in private disability insurance, many LTCI policies now include optional nonforfeiture features. Nonforfeiture provisions prevent the policyholder from forfeiting his or her full benefit in the event of a voluntary policy lapse.**[16]

[15] *The introduction of private long-term care insurance and a discussion of future long-term care costs also raises the issue of moral hazard. Moral hazard refers to a change in behavior that is caused by the existence of insurance coverage. Once insured, some individuals will use more covered services than they would have used under similar circumstances without insurance coverage. It is particularly difficult to ascertain the long-term costs associated with the introduction of long-term care insurance because so many of our current long-term care needs are provided informally by family members. As with the introduction of Medicare in the 1960s, there is a risk that costs will be undervalued, leading to solvency issues similar to those currently faced by the Medicare program.*

[16] *A study conducted by the Health Insurance Association of America (HIAA) in February 1993 found an average termination rate of 8.5 percent. That is, 8.5 percent of policies issued in 1990 and earlier by the surveyed companies were found to be terminated in 1992. A subsequent HIAA study found that approximately 44 percent of terminated policies were replaced, 26 percent were terminated due to affordability problems, 10 percent were terminated because the insured "didn't need long-term care," 7 percent were terminated due to death of the insured, 5 percent were terminated due to dissatisfaction with the policy, and 8 percent were terminated for "other" reasons (Health Insurance Association of America, 1993a, 1993b).*

The majority of functionally dependent individuals receive LTC on an informal "unpaid" basis from friends and family, making it difficult to measure the total value of this care.

Nonforfeiture benefits can take many different forms and may vary with an insured's age, claims history, and the duration the policy has been in force. These benefits may be included in the policy on a voluntary basis, with a higher premium assessed for those purchasing the option.

One type of nonforfeiture provision continues coverage at a reduced benefit level if a minimum number of payments has been made. For example, one employer plan provides that if the insured has paid premiums in the LTCI program for 10 consecutive years and then voluntarily discontinues premium payments, the individual will retain coverage of 30 percent of the original daily maximum benefit. For each year beyond the 10th year that the insured continues to pay premiums, the amount of the reduced coverage is increased by 3 percent, up to a maximum reduced coverage of 75 percent of the daily maximum benefit (IBM, 1994). Some plans, rather than reducing the daily benefit amount, provide for a shortened benefit period. For example, in one plan, if a shortened benefit period nonforfeiture rider has been in effect for at least five years at the time the policy lapses, coverage is continued based on the same benefits in effect at the time of the lapse; however, the policy maximum is reduced (Transamerica Life Companies, 1995).

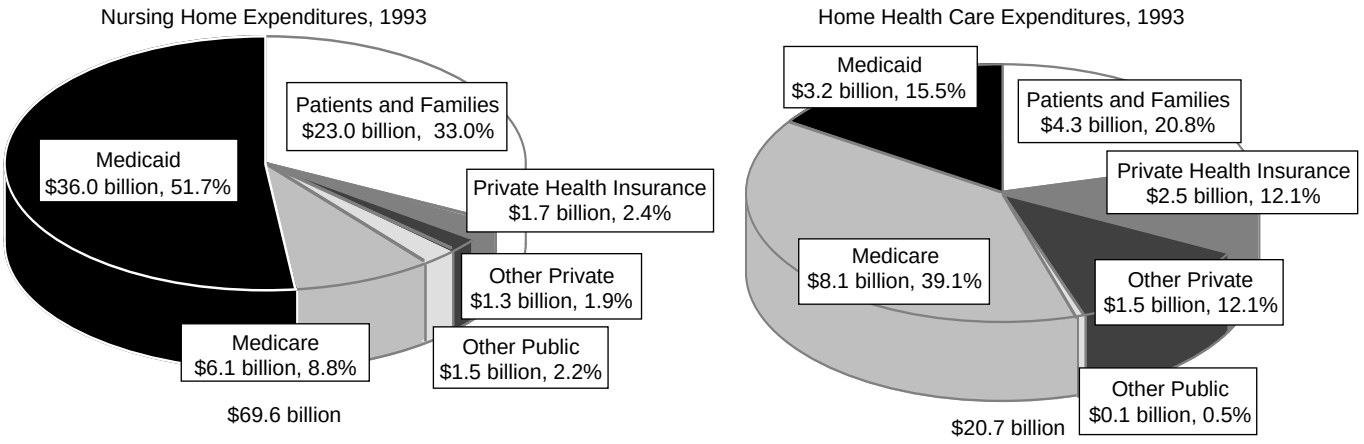
Another type of nonforfeiture benefit allows partial recovery of premiums paid in the event of voluntary lapse of the policy. For example, one employer plan provides that for every year the policy is in force, 5 percent of the premium will be refunded in the event of a voluntary lapse (less any benefits that have already been paid). Thus, for example, if the policy has been in force for one full year, 5 percent of the premium would be refunded; if the policy has been in force for two full years, 10 percent would be refunded. The individual is entitled to a 100 percent refund if the policy is in force for 20 or more years (The Prudential, 1994).

While a nonforfeiture provision may be effective for the person who does not want another LTC policy, for the buyer who wants to exchange one policy for another, a nonforfeiture provision is of only limited value (McNamara, 1995). On the group side, policies may be upgraded through the same insurer, or reserves may be transferred to a new insurer who will then upgrade the policies. By transferring reserves, credit is given such that the upgraded policies may be based on the age at which coverage was originally purchased rather than at the more expensive rate based on the insured's current age. Some larger employers may be able to negotiate when establishing their plan to provide for upgrades and to ensure that funds will be transferred to another insurer on request. If this is not done, the insurer may refuse to transfer reserves. Then, if the employer does decide to move to a new insurer, individuals in the plan are required to decide whether they want to pay the higher premium or leave the group plan in order to remain with the original insurer.

Although not specifically a type of nonforfeiture benefit, another design feature sometimes included in a policy provides that a portion of the premium may be returned to the insured's estate in the event of death. For example, one employer plan provides that if the insured dies on or before his or her 65th birthday, an amount equal to all contributions paid up to the time of death, less any benefits paid, will be paid to the insured's estate. If the individual covered under the plan dies between his or her 65th and 75th birthday, the estate receives an amount equal to all contributions paid up to the 65th birthday, reduced by 10 percent for each year after the 65th birthday and less any benefits already received (J.P. Morgan & Co., 1994; Prudential, 1994). Many policies also now include protection against unintended lapse through the designation of an alternative party who would be notified in the case of a missed premium payment before the policy lapses.

Some companies may also offer "paid-up" policies. These policies entitle the insured to the full amount of benefits if premiums have been paid for a certain

Chart 3
National Nursing Home and Home Health Care Expenditures by Source of Funds, 1993



Source: Katharine R. Levit, et al., "National Health Expenditures, 1993," *Health Care Financing Review* (Fall 1994): 247–294.
Note: These data represent nursing home and home health care expenditures from the National Health Accounts. They include expenditures for acute care—generally not considered long-term care—as well as expenditures for custodial care. The data do not include an additional $4.1 billion furnished by facility-based (generally in hospitals) home health agencies, long-term care costs incurred outside of home health agencies or nursing homes, or costs for informal—"unpaid"— long-term care.

amount of time (for example, for 20 years or 30 years). Once the policy is "paid-up," no additional payments are required (American Association of Retired Persons, 1995).

***Waiver of Premium*—Many policies now include a provision that allows policyholders to stop paying premiums after a specified number of days of care in a nursing home. Some policies include a waiting period such as 60 days from the day payments are first made to the day premiums are waived.**

Financing Sources

The majority of functionally dependent individuals receive LTC on an informal "unpaid" basis from friends and family, making it difficult to measure the total value of this care (U.S. Bipartisan Commission on Comprehensive Health Care, 1990). In a 1993 EBRI/Gallup poll, 59 percent of respondents who indicated they had a family member receiving LTC said they were providing that care (Employee Benefit Research Institute, 1993). However, **data from the U.S. Health Care Financing Administration's national health accounts indicate that of the $884.2 billion in total health expenditures in 1993, $90.3 billion (10.2 percent) was spent on nursing home care and on care received from home health agencies** (chart 1). Medicaid financed the largest proportion of this care ($39.2 billion or 43.4 percent), followed by out-of-pocket payments from patients and families ($27.3 billion or 30.2 percent), Medicare (14.2 billion or 15.7 percent), and private health insurance ($4.2 billion or 4.7 percent). Of the $90.3 billion, nursing home expenditures totaled $69.6 billion in 1993, of which 33 percent was financed through consumer out-of-pocket payments (chart 3). Most of the remainder was financed through the Medicaid program (51.7 percent), with Medicare accounting for 8.8 percent, other public and private programs accounting for 4.1 percent and private insurance paying for 2.4 percent. Home health agencies accounted for $20.7 billion, of which 39.1 percent was financed through Medicare, 15.5 percent through Medicaid, and 20.8 percent through out-of-pocket payments.[17]

Trends

While expenditures for nursing home care have risen from $20.5 billion in 1980 to $69.6 billion in 1993, they have remained fairly constant as a proportion of total national health expenditures

[17] *The data do not include an additional $4.1 billion furnished by facility-based (generally in hospitals) home health agencies, long-term care costs incurred outside of home health agencies or nursing homes, or costs for informal—"unpaid"— long-term care.*

Table 7
National Health Expenditures (NHE) in Nursing Home and Home Health Agencies, Selected Years 1960–1993

Year	Total NHE	Nursing Home Expenditures					Home Health Expenditures				
		Total	Medicaid	Medicare	Out of pocket	Other	Total	Medicaid	Medicare	Out of pocket	Other
	($ billions)										
1960	$ 27.1	$ 1.0	$ 0.0	$0.0	$ 0.8	$0.2	$ 0.0	$0.0	$0.0	$0.0	$0.0
1980	251.1	20.5	11.0	0.4	7.8	1.3	1.9	0.3	0.7	0.3	0.7
1990	696.6	54.8	26.3	2.4	22.3	3.8	11.1	2.1	3.0	2.7	3.3
1991	755.6	60.8	31.0	2.9	22.8	4.1	13.2	2.5	4.3	2.9	3.6
1992	820.3	65.5	33.7	4.5	22.9	4.4	16.8	2.8	5.9	3.7	4.4
1993	884.2	69.6	36.0	6.1	23.0	4.5	20.8	3.2	8.1	4.3	5.2
	(as a percentage of total NHE)		(as a percentage of total nursing home expenditures)				(as a percentage of total NHE)	(as a percentage of total home health expenditures)			
1960	100.0%	3.7%	0.0%	0.0%	80.0%	20.0%	0.0%	na	na	na	na
1980	100.0	8.2	53.7	2.0	38.0	6.3	0.8	15.2	34.4	15.8	34.7
1990	100.0	7.9	48.0	4.4	40.7	6.9	1.6	19.2	27.1	24.3	29.4
1991	100.0	8.0	51.0	4.8	37.5	6.7	1.7	18.8	32.2	22.0	27.0
1992	100.0	8.0	51.5	6.9	35.0	6.7	2.0	16.8	35.2	22.0	25.9
1993	100.0	7.9	51.7	8.8	33.0	6.5	2.4	15.5	38.8	20.7	25.0

Source: Katharine R. Levit et al., "National Health Expenditures, 1993," *Health Care Financing Review* (Fall 1994): 247–294.

over this same time period (table 7). As a proportion of all expenditures for nursing home care, Medicaid has remained fairly constant, with Medicare accounting for an increasingly larger proportion and out-of-pocket costs accounting for an increasingly smaller proportion.

Home health care expenditures have also risen over time (from $1.9 billion in 1980 to 20.8 billion in 1993). However, unlike nursing home expenditures, home health care expenditures have risen as a proportion of total national health expenditures, rising from 0.8 percent in 1980 to 2.4 percent in 1993. **As a proportion of all home health care expenditures, both Medicaid and out-of-pocket expenditures have declined since 1990, whereas Medicare has accounted for an increasingly larger proportion.**

Out-of-Pocket

A large proportion of LTC is financed out-of-pocket by recipients or their friends and families. National health account data indicate that $27.3 billion, or 30.2 percent, was spent by patients and their families on nursing home and home health care in 1993 (chart 1). Additional amounts spent in nontraditional LTC settings, such as for adult day care and respite care as well as, for example, costs for help with personal care and homemaking, meal programs, and special transportation would increase this amount but are difficult to determine.

Nursing home care—the most expensive type of LTC—consumes the greatest amount of out-of-pocket spending. As shown in chart 3, individuals spent $23 billion on nursing home care in 1993 and an additional $4.3 billion on home health care.

Initiatives to encourage the financing of LTC by private individuals through the tax code have received considerable congressional attention. Currently, the tax incentive for out-of-pocket LTC is limited to the dependent care tax credit and expenses paid from a dependent care spending account—both applicable only under specific circumstances. The dependent care tax credit allows individuals who incur dependent care expenses (so that they can be gainfully employed) a 30 percent tax credit for expenses up to a maximum of $2,400 annually ($4,800 for two or more qualified dependents). The tax code also allows employers to sponsor qualified dependent care assistance programs (DCAPs) that allow employees to deduct from income up to $5,000 annually on a pre-tax basis for the cost of providing qualifying dependent care.

Public Policy

During the last three Congresses several bills were introduced to address the issue of LTC. Legislation introduced in the 102nd Congress dealt primarily with establishing standards for

purposes of consumer protection (Horkitz, 1991). In the 103rd Congress, nearly every comprehensive health reform bill introduced included LTC provisions. The proposals included consumer protection provisions, a provision extending the same federal tax treatment to LTC expenditures as applies to other health care expenditures, and improvements in Medicaid coverage for institutional care. Several proposals would have allowed penalty-free withdrawals from retirement plans (such as individual retirement accounts (IRAs) or 401(k) plans) to purchase LTCI. The LTC provisions died with the demise of comprehensive health reform efforts at the end of 1994.

Thus far in the 104th Congress, the House passed the Contract With America Tax Relief Act of 1995 (H.R. 1215). This act includes a provision to treat LTCI or plans in the same manner as accident or health plans for purposes of the employee and employer tax exclusion, encouraging the growth of LTCI. The bill also provides that LTC *services* be treated as medical care, allowing individuals' expenses in excess of 7.5 percent of gross income to be deducted from income.[18] The bill would allow for the exclusion from gross income amounts withdrawn from individual retirement plans or 401(k) plans for the purchase of LTCI. The provision has bipartisan support in the Senate; however, the 10-year cost is estimated at $17.8 billion. An offset would be needed in order for the provision to pass in the Senate.

Other bills that deal with expanding IRAs would allow distributions from certain accounts for the purchase of LTCI or services. However, the cost of implementing expansion of such proposals could preclude passage. Yet another bill proposes establishing federal standards for LTCI. However, some contend that federal standards would preempt state regulatory authority and that regulation should ultimately rest with the states.

Still to be dealt with is the overall issue regarding the future of the LTC delivery and financing system in the United States (Wiener, 1994). Should this system be private, public, or should mechanisms be implemented that bolster the current public/private sector mix? It is likely that some legislation with regard to LTC will pass during the 104th Congress—particularly legislation relating to private LTCI. However, as is the case with health insurance, due to cost implications and lack of consensus regarding the optimum overall structure required to finance and deliver care, broad legislation to expand coverage—particularly public coverage—is not likely in the near term.

The Taxation of LTCI

The current tax treatment of LTCI premiums and benefits is ambiguous and may be an impediment to the market for employment-based group LTCI.

Proponents of changing the tax code argue that the ambiguity concerning LTC leads to questions not only about how to treat LTC expenses but also about the treatment of LTCI. If LTC were deemed to be medical, LTCI premiums paid by an employer on behalf of an employee would be tax deductible to the employer and would not have to be included in the employee's gross income. In addition, the benefits received when a LTCI claim is filed (whether under an individual or employment-based policy), would not be included as taxable income to the beneficiary. However, since LTC has not been thus defined, most employers have avoided the problem altogether either by not sponsoring a LTC policy or by offering coverage on an employee-pay-all basis. Individuals purchasing LTCI either on an individual basis or as part of an employment-based plan use after-tax dollars, which has been assumed to guarantee them tax-free claims payments consistent with general rules of insurance taxation.

Opponents of tax incentives for private LTCI contend that such incentives benefit only

[18] *Long-term care benefits would be taxable if they came through a cafeteria plan and could not be reimbursed through a flexible spending account.*

those with higher incomes, as they are the people who have assets to protect, and that the federal revenue lost to tax deductions might be better spent on, for example, a LTC home care block grant to the states (American Association of Retired Persons, 1995; Wiener, 1995).

In general, recent legislative proposals that have called for clarifying the tax treatment of LTCI involve one or more of the following:

- same tax treatment of LTCI that applies to accident and health insurance,
- tax exemptions or credits for individual LTCI premiums,
- penalty-free and tax-exempt withdrawals from IRAs or 401(k)s for the purpose of purchasing LTCI or services,
- tax-exempt conversion of life insurance values to LTCI, and
- tax-free receipt of accelerated death benefits.

If LTCI were to receive the same tax treatment as accident and health insurance, employees receiving employment-based LTCI benefits would benefit from tax-exempt premium payments. The benefits paid to them would also be tax exempt, similar to those paid by health plans. To date, the only other tax-preferred prefunding (prefunding without immediate taxation of interest) of health benefits is through a separate account in a tax-qualified retirement plan (a 401(h) account) or through a 501(c)(9) voluntary employee beneficiaries association (VEBA). These accounts have been used by the largest private employers but not on a widespread basis because of significant regulatory limitations.

Proposals that would provide for penalty-free, tax-free withdrawals from IRAs or 401(k)s recognize that economic security is a lifelong need, although such withdrawals would reduce retirement savings. Tax-free conversions from life insurance to purchase LTCI affect the future economic security of insureds' dependents over time by allowing current use of insurance proceeds.

Provisions for tax-free accelerated death benefits generally make benefits available to an individual when a doctor has determined that he or she has 12 months or less to live. In some cases, this provision also applies to accelerated death benefits that are triggered by certain specified diseases or permanent confinement to a nursing home.

Tax policy is often used to promote specific social and economic goals. The proposed policies for the tax treatment of LTC can be evaluated in terms of their tax cost versus their social benefit (keeping in mind who bears the cost and who benefits). Tax policies can also be evaluated in terms of the public LTC expenditures associated with the policy relative to the expenditures that would accrue without it. For example, a proposal to treat LTCI the same as health insurance for tax purposes has an associated tax cost because it reduces current federal revenues. However, this cost could be lower than the cost that would be incurred if Medicaid became responsible for payment in the absence of private insurance. The adoption of tax incentives would encourage purchase of individual or employment-based LTCI. Such a proposal could further certain social and economic goals, including increased risk pooling, preservation of assets, and potential reduction in Medicaid expenditures.

Regulation of Long-Term Care Insurance

LTCI policies and the LTCI market have continued to evolve over the past several years, adjusting to state regulations and consumers' preferences. The National Association of Insurance Commissioners (NAIC) has played a part in the development of the private-sector LTCI market. The NAIC is an organization of state insurance commissioners that proposes standards for states' insurance laws. NAIC adopted the Long-Term Care Insurance Model Act in December 1986 and the Long-Term Care Model Regulation in December 1987. Both have been amended annually since their adoption to include additional provisions. Current NAIC LTCI standards have provisions for policy design and insurance company marketing and underwriting practices.

Insurers that sell the majority of LTC policies have adjusted their policies to reflect many of the NAIC standards.

The NAIC model standards for LTCI prohibit certain plan features, such as exclusion of coverage for Alzheimer's disease; limiting coverage to skilled nursing care or providing significantly less coverage for lower levels of care; prior hospitalization requirements for coverage; and conditioning eligibility for LTC on the receipt of a higher level of care—step-down (e.g., conditioning home care coverage on prior nursing home care). The NAIC standards also prescribe certain plan features. These include a 30-day period during which policyholders can cancel a policy and recover any premium paid; guaranteed renewable coverage for individual policies and continuation or conversion of coverage for group plans; and the opportunity to purchase a product that protects against inflation by increasing the benefit level by at least 5 percent, compounded annually. Most recently, the NAIC passed regulations requiring mandatory nonforfeiture provisions. The NAIC standards also contain minimum provisions if home health care benefits are purchased, including prohibition against covering only services by registered or licensed practical nurses or limiting coverage to services provided by Medicare-certified agencies or providers (National Association of Insurance Commissioners, 1993a, 1994). NAIC standards are not binding; state regulatory agencies hold the actual authority for insurance regulation and enforcement.

Insurers that sell the majority of LTC policies have adjusted their policies to reflect many of the NAIC standards. However, not all states have adopted NAIC standards as law,[19] and some insurers may not voluntarily conform to NAIC standards**.** Moreover, questions have been raised about various LTCI issues currently not addressed by NAIC, such as the lack of industrywide definitions and terms.

The federal government has traditionally left the issue of insurance regulation and enforcement to the states, although it has intervened in the Medicare supplemental insurance (Medigap) market.

Public/Private Partnerships

Currently, the Medicaid programs in Connecticut, New York, Indiana, and California have entered into experimental partnerships with private insurers selling special types of LTC policies. These programs enable individuals who have purchased a specialized "partnership" private LTCI policy and who have exhausted their benefits to maintain some of their assets while becoming eligible for Medicaid. This is an experimental program of the Robert Wood Johnson Foundation. It was initiated in 1987 as a way to encourage burgeoning private LTCI programs and because of a lack of confidence that the public sector has sufficient tax revenues to meet this country's current and future LTC needs. Approximately 20 other states are also now looking into the possibility of implementing such a program (Teachers Insurance and Annuity Association, 1993; Callahan, 1994).[20]

Proponents of the programs indicate that neither the government nor employers can finance the needs of the U.S. LTC population, and that such partnerships strengthen options currently available to individuals. The program could save public-sector dollars and de-

[19] As of January 1995, the NAIC reported that Alaska, the District of Columbia, Guam, Hawaii, New Hampshire, and New Mexico had taken no legislative action with regard to long-term care insurance regulation. Maine, Minnesota, South Dakota, and Washington had long-term care related legislation and/or regulations that differed significantly from the NAIC model regulations. All other states had regulations similar to those outlined in the NAIC Long-Term Care Insurance Model Regulation (National Association of Insurance Commissioners, 1994). For a further discussion of state-by-state compliance with NAIC regulations, see Susan Coronel, State Compliance with Key NAIC Provisions *(Washington, DC: Health Insurance Association of America, 1995).*

[20] The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) recognizes the partnership programs now in operation in Connecticut, New York, Indiana, and California. The act also recognizes a future program in Iowa and Massachusetts. However, while other states may proceed with partnership programs, they must recover the cost of care from the estates of all persons receiving services under Medicaid. Thus, asset protection for these individuals would only be in effect while the insured is alive (University of Maryland, 1994).

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crease current and future financial pressures on the Medicaid program (Callahan, 1994). The program may also reduce incentives for people to shelter their assets in order to qualify for Medicaid (Callahan, 1994).

Advocates of government LTC financing criticize the program for not being available in all states and indicate that because states' Medicaid programs vary, the asset protection feature is not portable. They also argue that the program subsidizes the insurance industry. Some also disagree with the assertion that this type of partnership has the ability to save public-sector dollars (Callahan, 1994).

Conclusion

Although a large proportion of LTC is provided on an informal basis by family and friends, many individuals require formal care either in the community or in an institutional setting, which can be quite expensive. The need for LTC services is most prevalent among the elderly. However, individuals of all ages may need LTC services. Moreover, demographic trends such as an aging population, an increased female labor participation rate, and delayed childbearing may mean a reduction in traditional sources of informal LTC. These factors have caused leaders in business, academia, and government to be concerned about financing LTC.

Aside from informal care provided in the community, the current system of financing LTC depends on the Medicaid program and individual financing. Issues confronting this system include spiraling costs associated with LTC services that may threaten beneficiaries' access to care. Other issues include the potential depletion of personal assets, a bias toward institutionalization (which may not always provide the most cost-effective or desired type of care available), and the ability of some individuals who transfer assets to become eligible for Medicaid. Many leaders regard private LTCI as a way to increase access to financing and as a potential alternative to Medicaid and out-of-pocket financing. As a recent innovation, this method of financing care currently accounts for only a small proportion of expenditures. However, tax incentive measures, plan design improvements, and population aging may encourage more Americans to purchase coverage. Some analysts believe that taxpayer financed public social programs should simply be expanded.

The largest barrier to the expansion of the private LTCI market is the lack of public readiness to use assets to insure against the relatively low probability of need. Public education is very much needed. Until it occurs and the public is ready to pay either through premiums or taxes, it is unlikely that the goals of adequate coverage, universal access, and affordability through risk pooling will be achieved.

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