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Increased life expectancy, reduced fertility rates, and the aging of the baby boom generation mean that the proportion of people at greatest risk of needing long-term care relative to the proportion who can provide physical and financial assistance will increase dramatically over the next several decades.



### **Long-Term Care Financing and the Private Insurance Market**

- ◆ The number of individuals with long-term care insurance policies grew from 815,000 in 1987 to nearly 2 million in 1990. The number of companies selling long-term care insurance nearly doubled over the same period, from 75 to 143.
- ◆ Nursing home expenditures totaled \$47.9 billion in 1989, of which fully 45 percent was financed through consumer out-of-pocket payments. Most of the remainder (43 percent) was financed through the Medicaid program.
- ◆ Although the long-term care insurance market is currently dominated by policies that are sold individually or through associations, employer-sponsored plans offer several benefits over individual policies and could potentially dominate the market in the future.
- ◆ Newer long-term care insurance policies no longer include many of the restrictions imposed on earlier products, such as limitations on preexisting conditions, prior hospitalization as a prerequisite for nursing home coverage, and/or skilled nursing care as a prerequisite for home- or community-based care.
- ◆ Ambiguity surrounding the tax treatment of long-term care insurance might be an impediment to the market for long-term care insurance—particularly employer-based group insurance. This possibility has led policymakers and private industry to call for clarification of the tax code.
- ◆ Currently the subsidy for out-of-pocket long-term care is limited to the dependent care tax credit and expenses paid from a dependent care spending account—both applicable only under specific circumstances.

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## ◆ Introduction

Long-term care refers to a broad range of health, social, and environmental support services and assistance that is provided by paid and nonpaid 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, and using the toilet or instrumental activities of daily living (IADLs) such as shopping, cooking, and housekeeping.

The likelihood of requiring long-term care increases with age. In 1984, 4 percent of the noninstitutionalized population under age 65 needed such assistance, while 21 percent of those aged 65–74 and 41 percent of the population aged 75 and over had chronic disabilities that caused them to require assistance with ADLs and/or IADLs. In 1985, 0.1 percent of the nonelderly population was institutionalized (173,000 individuals), compared with 1.2 percent of the population aged 65–74 (212,000), 5.4 percent of the population aged 75–84 (509,000), and 18.1 percent of the population aged 85 and over (597,000). Although older people are more likely than the nonelderly to require assistance with IADLs and ADLs, many young people need long-term care. In 1984, the number of noninstitutionalized individuals under age 65 who needed assistance with ADLs and/or IADLs (7.9 million) was approximately the same as the number aged 65 and older (7.5 million) who needed such assistance (Friedland, 1990).

Demographic trends—increased life expectancy,<sup>1</sup> reduced fertility rates, and the aging of the baby boom generation—mean that the proportion of people at

greatest risk of needing long-term care relative to the proportion who can provide physical and financial assistance will increase dramatically over the next several decades. The U.S. Census Bureau estimates that the number of elderly (aged 65 and over) in the United States will increase from 31.6 million in 1990 (13 percent of the population) to 71.6 million in 2080 (25 percent of the population). The population aged 85 and older—those most likely to require long-term care—is expected to double over the next 30 years, and the group over age 90 is expected to nearly triple (U.S. Department of Commerce, 1989). Higher divorce rates and lower birth rates may mean that fewer older people will have relatives they can call on for help. Moreover, the continued increase in female labor force participation, coupled with the trend toward delayed childbearing, means that daughters, the traditional providers of long-term care, will have competing work, child care, and long-term care demands.



**Nursing home care can cost more than \$25,000 annually, and the cost of intensive formal home care or adult day care can be equally high.**



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The financing of long-term care is an important issue because this care can be very costly. Although most long-term care is provided on an informal basis by family and friends, many individuals require formal paid care. **Nursing home care can cost more than \$25,000 annually, and the cost of intensive formal home care or adult day care can be equally high.** A recent study estimated that 43 percent of individuals who reached age 65 in 1990 would spend some time in a nursing home. However, the likelihood of spending one year or more in a nursing home was only 24 percent, and the likelihood of spending five years or more was only 9 percent (Kemper and Murtaugh, 1991).

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<sup>1</sup>The effect of increased life expectancy on the demand for long-term care is unclear. It depends on assumptions about how morbidity changes as life expectancy increases. For a full discussion, see Fries, 1980, Gruenberg, 1977, and Manton, 1986.

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**Under the current system of financing long-term care, most financing for institutional care comes from individual out-of-pocket expenditures or Medicaid, with Medicare paying less than 2 percent and private insurance accounting for less than 1 percent.** Medicaid provides comprehensive coverage for all types of nursing home care. Medicaid coverage for home and community care is growing but still is limited. However, in order to qualify for Medicaid, individuals must exhaust most of their assets, thereby facing potential impoverishment.

Medicare does not cover long-term care. Although Medicare payments accounted for 1.9 percent of nursing home expenditures in 1988, coverage is limited to skilled nursing care for recuperative purposes following hospitalization—not the nature of most long-term care needs. Private long-term care insurance currently accounts for only a small share of long-term care expenditures, but many business and government leaders believe that further development of the market could provide a viable alternative to the heavy reliance on Medicaid and out-of-pocket financing.

**Long-term care financing is an issue not only for individuals, families, and public policymakers but also for employers.** Workers increasingly are single parents or members of two-worker households who must cope with caring for children and for disabled elderly. In a recent survey of public attitudes on long-term care conducted by EBRI and The Gallup Organization, 26 percent of employed respondents indicated that a member of their family had received some kind of long-term care during the last five years (Employee Benefit Research Institute/The Gallup Organization, 1990). Of those, 46 percent said they or someone in their family had provided that care. Moreover, 31 percent of respondents in families that had provided long-term care claimed that a family caregiver had refused a promotion, reduced working hours, retired early, or stopped working specifically because of long-term caregiving responsibilities.

This *Issue Brief* examines the current system of long-term care financing and explores the emergence of

private long-term care insurance as part of this system. It describes the current system of financing and some of its limitations and analyzes the long-term care insurance market and issues associated with it. The *Issue Brief* addresses possible explanations for the small size of the current long-term care insurance market, regulation of long-term care insurance, and proposals to subsidize the purchase of long-term care insurance through the tax code.

### ◆ Current Sources of Financing

Long-term care comprises services provided by paid and nonpaid caregivers in institutional, home, and community settings. Because the majority of functionally dependent individuals receive long-term care on an informal basis from friends and family (U.S. Bipartisan Commission on Comprehensive Health Care, 1990), it is difficult to measure the total expenditures on this care. However, according to the U.S. Health Care Financing Administration (HCFA), nursing home expenditures<sup>2</sup> totaled \$47.9 billion in 1989, of which fully 45 percent was financed through consumer out-of-pocket payments. Most of the remainder (43 percent) was financed through the Medicaid program, with Medicare accounting for 7.5 percent,<sup>3</sup> other government programs accounting for 2 percent, and private insurance paying for 1 percent (chart 1).

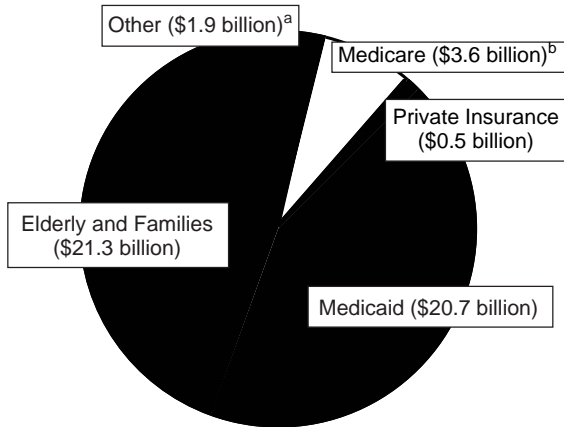
**In 1989, home health care expenditures totaled \$5.4 billion** (Lazenby and Letsch, 1990). Medicare

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<sup>2</sup>Nursing home expenditures as measured by HCFA include revenues of skilled and intermediate care facilities, Medicaid funding of intermediate care facilities for the mentally retarded (ICFs/MR), and Department of Veterans Affairs (DVA) funding for nursing care in DVA nursing homes. HCFA reports that 90 percent of the total estimated spending for nursing home care was for care in facilities other than ICFs/MR.

<sup>3</sup>In 1989, Medicare accounted for 7.5 percent of nursing home expenditures. This increase was the result of provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA) that became effective in 1989. The MCCA, which expanded Medicare's coverage of skilled nursing facility care, was repealed in December 1989. As a result, by 1991, Medicare's share of public spending is expected to return to levels consistent with those calculated for 1988 (Lazenby and Letsch, 1990).

Chart 1  
National Nursing Home Expenditures,  
by Source of Financing, 1989



Source: Helen C. Lazenby and Suzanne Letsch, "National Health Expenditures, 1989," *Health Care Financing Review* (Winter 1990): 1–26.

<sup>a</sup>Includes \$0.9 billion from other private sources (such as philanthropy), \$0.9 billion from other federal government programs, and \$0.1 billion from other state and local programs.

<sup>b</sup>1989 nursing home expenditures financed by Medicare (14.3 percent of public spending on nursing home care) reflect provisions in the Medicare Catastrophic Coverage Act of 1988 that became effective in 1989. By 1991, Medicare's share of public spending is expected to return to less than 4 percent.

Note: Numbers total to \$48 billion due to rounding.

accounted for \$2.1 billion, while Medicaid financed \$1.9 billion, out-of-pocket payments accounted for \$0.6 billion, private insurance paid \$0.4 billion, and other private sources paid \$0.3 billion.<sup>4</sup> These home care figures do not distinguish between medical care and long-term care. In addition, they exclude home care provided by non-Medicare-certified and facility-based home health agencies. Broader home health care industry definitions include supportive social services, respite care, and adult day care.

Although it is difficult to measure the cost of informally provided care, according to a recent report, the federal government would have to spend an estimated additional \$54 billion per year to replace the full-time

<sup>4</sup>Because of rounding, the components do not add to the total.

care currently provided by the families of 1.8 million adults suffering from Alzheimer's disease and other debilitating conditions (Alzheimer's Association of America, 1991).

## ◆ Public Sources of Financing

### Medicaid

Medicaid, the federal/state health insurance program for certain categories of poor individuals, is the single largest source of public financing for institutional long-term care. It financed 43 percent of nursing home care in 1989. In addition to an array of medical services, Medicaid covers all levels of institutional care<sup>5</sup> and provides limited coverage for home care and formal community-based long-term care. No other public or private program provides comprehensive coverage for long-term nursing home care.

In order to understand the potential for expanding private long-term care financing, it is important to know how Medicaid eligibility is determined. 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 groups, including those receiving cash welfare assistance, those receiving Supplemental Security Income (SSI),<sup>6</sup> the blind, and pregnant women and children in poor families.<sup>7</sup>

<sup>5</sup>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 in nursing homes and are the types of care most often needed by individuals with chronic disabilities.

<sup>6</sup>SSI is a means-tested, federally administered income assistance program that provides monthly cash assistance to needy aged, blind, and disabled individuals.

<sup>7</sup>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.

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Individuals with incomes too high for categorical Medicaid eligibility may qualify for Medicaid as medically needy if their medical and/or long-term care expenses exceed their incomes and if they have less than a state-specified amount of assets. Not all states have programs for the medically needy. In states that have these programs, individuals must first “spend down” their resources to a specified level that varies by state. Once assets are depleted to a state specified level (usually about \$2,000, excluding such assets as housing and personal effects), individuals are 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.<sup>8</sup> All remaining income (pensions, Social Security, etc.) in excess of a minimal amount disregarded for personal needs (usually \$30 per month) must be applied to the cost of care (U.S. Congress, 1988).

**A number of states (that may or may not have regular programs for the medically needy) have established a special income level to determine Medicaid eligibility for persons residing in nursing homes (or in need of home- or community-based care).** These persons are referred to as noncash categorically needy, and, like the medically needy, they have income in excess of cash welfare program standards. By federal law, the special income level can be no more than three times the basic SSI payment level (cash welfare level). States with programs for both medically needy and noncash categorically needy persons are able to avoid the spend-down computations and make individuals with incomes below the specified level automatically eligible (U.S.

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<sup>8</sup>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 recover the cost of care financed by Medicaid from the estates of deceased recipients if not needed for support of the spouse or dependent children. However, only 23 states and the District of Columbia recover benefits correctly paid from the estates of deceased Medicaid recipients, and many of the recovery programs are less effective than they could be (U.S. Department of Health and Human Services, 1988).

Congress, 1988). In states with only the special income level, individuals with income above that level cannot qualify for Medicaid assistance, regardless of the cost of their care.



**The spend-down process required for a person to qualify for Medicaid as medically needy has been a major target of criticism because it requires individuals to impoverish themselves.**



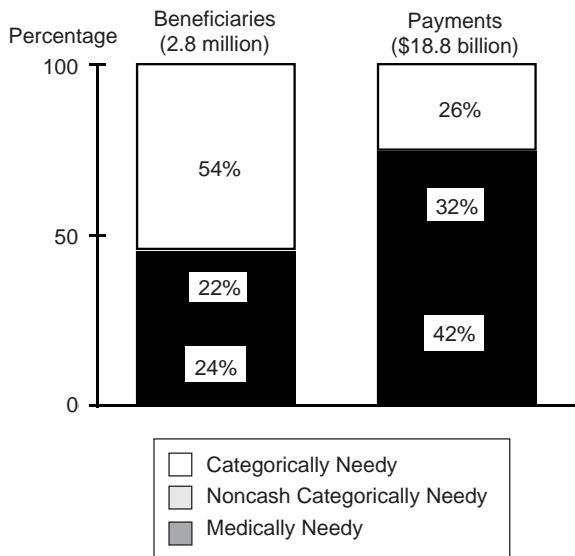
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Although the majority of elderly individuals covered by Medicaid are categorically eligible based on cash assistance, Medicaid nursing home expenditures are driven by coverage of elderly beneficiaries who do not receive cash welfare payments—the medically needy and the noncash categorically needy (U.S. Congress, 1988). This occurs because medically needy and noncash categorically needy persons by definition are eligible for Medicaid because they have high medical and/or nursing home expenses. The categorically needy, on the other hand, are eligible for Medicaid regardless of their need for care. In fiscal year 1990, the medically needy and noncash categorically needy, who represented only 46 percent of aged Medicaid beneficiaries, accounted for 74 percent of total Medicaid payments to aged beneficiaries (chart 2). Seventy-seven percent of their Medicaid expenses were for care in a skilled nursing facility or an intermediate care facility, while only 36 percent of expenses for the medically needy were attributable to nursing home care (U.S. Congress, 1988).

**The spend-down process required for a person to qualify for Medicaid as medically needy has been a major target of criticism because it requires individuals to impoverish themselves.** Spend-down may make it difficult for institutionalized individuals, a significant



**Chart 2**  
**Aged Medicaid Beneficiaries and Medicaid Payments**  
**for Aged Beneficiaries, by Eligibility Status,**  
**Fiscal Year 1990**



Source: U.S. Department of Health and Human Services, Health Care Financing Administration 2082 forms, fiscal year 1990.

number of whom recover from their disability, to reenter the community. Because individuals living in the community do not have all their living expenses covered by Medicaid (as they would in a nursing home), those who have spent down to Medicaid eligibility (either in a nursing home or the community) may have a financial incentive to remain or become institutionalized even when such care is not necessary or desired.<sup>9</sup>

<sup>9</sup>The Medicare Catastrophic Coverage Act of 1988 (MCCA) addressed the issue of impoverishment of a community spouse in cases where one member of a couple is institutionalized. Prior to the law, retainable assets were limited to \$1,900 (excluding the value of the home, furnishings, and personal effects) for the community spouse. The law required states to allow \$12,000 and permits states to allow up to \$60,000. The community spouse may also retain allowable income of between \$800 and \$1,500 per month. Although most provisions of MCCA have been repealed, the Medicaid community spouse changes were retained (U.S. Department of the Treasury, 1990; U.S. Congress, 1988).

Recent studies have revealed that spend down is not as prevalent as commonly believed (Liu, Doty, and Manton, 1990; Spence and Wiener, 1990; and Liu and Manton, 1991). Analyses of nursing home discharge data reveal that the incidence of asset spend down in nursing homes is approximately 10 percent among people who were admitted as private-pay patients. The incidence of nursing home spend down increases with the length of stay. Spend down is also more common among women, unmarried individuals, and people living alone prior to their admission to a nursing home (table 1). One study found that asset spend-down on noninstitutional long-term care is more common than spend down in nursing homes (Liu, Doty, and Manton, 1990).

**There is evidence to indicate that many individuals have been able to qualify for Medicaid by transferring or otherwise sheltering their assets rather than by exhausting them (i.e., spending down) (U.S. Department of Health and Human Services, 1989).<sup>10</sup> Consequently, some people with higher levels of income and resources may qualify for Medicaid nursing home care while preserving the bulk of their assets for themselves or their heirs. This amounts to a transfer of assets from the public sector to heirs of middle-income individuals who maneuver their assets to qualify for Medicaid (Moses, 1990).**

**Medicaid is also criticized because it provides a financial incentive to use institutional care even when community or home care may be more cost**

<sup>10</sup>Although data are generally lacking in this area, a 1989 study by the Office of the Inspector General of the U.S. Department of Health and Human Services found that people who were initially denied, but subsequently approved, for Medicaid nursing home coverage in Washington state possessed \$27.5 million in assets at the time of denial. At the time of Medicaid approval, it was determined that 80 percent of this money had been sheltered—59 percent was transferred to a spouse and 11 percent was transferred to adult children. Another 11 percent was considered exempt from Medicaid eligibility rules and only 8 percent was used to pay for long-term care. (The disposition of the remaining 11 percent was uncertain.) (U.S. Department of Health and Human Services, 1989).

Table 1  
Incidence of Spend Down in Nursing Homes,  
by Patient Characteristic

| Patient Characteristics        | Proportion of Total Discharges |                        | Proportion of Private-Pay Admissions Spend Down |
|--------------------------------|--------------------------------|------------------------|---|
|                                | Medicaid throughout            | Private-pay throughout |   |
| Total                          | 33.8%                          | 35.8%                  | 10.2%   |
| Previous Stay Experience       |                                |                        |   |
| No previous                    | 27.6                           | 38.8                   | 9.8   |
| Continuous <sup>a</sup>        | 49.1                           | 29.9                   | 10.5  |
| Real previous <sup>b</sup>     | 33.5                           | 34.9                   | 10.7  |
| Gender                         |                                |                        |   |
| Male                           | 30.2                           | 36.5                   | 7.5   |
| Female                         | 35.7                           | 35.5                   | 11.5  |
| Marital Status                 |                                |                        |   |
| Married                        | 23.7                           | 38.6                   | 7.1   |
| Unmarried                      | 37.1                           | 34.9                   | 11.2  |
| Age                            |                                |                        |   |
| 65–74                          | 37.4                           | 28.8                   | 7.6   |
| 75–84                          | 33.2                           | 36.5                   | 10.5  |
| 85–89                          | 31.5                           | 36.4                   | 10.2  |
| 90+                            | 34.3                           | 41.6                   | 11.4  |
| Race                           |                                |                        |   |
| White                          | 31.1                           | 37.8                   | 10.1  |
| Nonwhite                       | 59.1                           | 16.9                   | 12.3  |
| Previous Living Situation      |                                |                        |   |
| Alone                          | 22.8                           | 55.3                   | 12.9  |
| With others                    | 30.4                           | 49.9                   | 10.8  |
| Another facility               | 36.1                           | 30.0                   | 9.2   |
| Functional Status <sup>c</sup> |                                |                        |   |
| Dependent                      | 36.9                           | 32.9                   | 11.8  |
| Independent                    | 25.2                           | 44.0                   | 6.4   |
| Length of Stay                 |                                |                        |   |
| < 3 months                     | 24.1                           | 39.8                   | 1.7   |
| 3–6 months                     | 36.0                           | 30.9                   | 13.5  |
| 6 months–1 year                | 43.6                           | 34.7                   | 14.6  |
| 1–2 years                      | 46.9                           | 34.0                   | 17.2  |
| 2–3 years                      | 49.1                           | 31.5                   | 18.0  |
| 3–5 years                      | 47.7                           | 29.2                   | 29.7  |
| 5+ years                       | 46.2                           | 26.4                   | 31.9  |

Source: D. Spence and J. Wiener, "Estimating the Extent of Medical Spenddown in Nursing Homes," *Journal of Health Politics, Policy and Law* (Fall 1990): 607–626.

<sup>a</sup>Those having a nursing home stay within 120 days of their survey stay.

<sup>b</sup>Those who were in a nursing home more than 120 days prior to their survey stay.

<sup>c</sup>Functional status refers to dependence in mobility or continence.

effective. Until 1981, Medicaid provided limited assistance for nonskilled personal care and supportive services for noninstitutionalized chronically impaired individuals. The Omnibus Budget Reconciliation Act of 1981 (OBRA '81) authorized states to cover a broad range of home- and community-based services for persons who would otherwise be eligible for nursing home care or other institutional care under the state's Medicaid plan. Authorized services include case management, homemaker/home health aide services, personal care services, adult day health, respite care,<sup>11</sup> and other services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. However, the amount of income beneficiaries are allowed to keep when receiving Medicaid community-based care, is low and may be insufficient for contingencies. Because individuals residing in the community have living expenses in addition to long-term care expenses, community care may not be as financially attractive as institutional care, where all living expenses are covered.

### Other Public Programs

Aside from Medicaid, individuals may be able to receive long-term care from miscellaneous community-based programs financed through federal grants to state governments. These include Older Americans Act programs and Social Services Block Grant programs. Under Title III of the Older Americans Act, the Administration on Aging allocates funds to states for supportive services, including transportation, house-keeping, senior centers, services to individuals in long-term care institutions, group nutrition services, and home-delivered meals (U.S. Department of the Treasury, 1990). Under Title XX of the Social Security Act, the Social Services Block Grant program provides grants to states to be used at their discretion. Some Social Security Block Grant funds go toward home-based services. Statistics on the financing of long-term

<sup>11</sup>Respite care refers to long-term care provided by formal paid caregivers as temporary relief to informal caregivers.

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care through these and state- and community-funded services are difficult to obtain. However, recent state surveys have found that Medicaid spending represents only one-half of total public spending on home- and community-based long-term care (Doty, 1990).

Although Medicare, the publicly financed health insurance program for the elderly, does not cover long-term care, it accounts for about 2 percent of national nursing home expenditures. 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. In 1988, the Medicare Catastrophic Coverage Act (MCCA) expanded coverage for care in SNFs, but this and most of the act's other provisions were subsequently repealed.

### ◆ Private Sources of Long-Term Care Financing

#### *Out-of-Pocket*

**Most long-term care is financed out-of-pocket by recipients or their friends and families.** HCFA's tabulations of out-of-pocket spending on nursing home care represent only a portion of this spending on long-term care. Other out-of-pocket spending includes that for services provided by home health agencies, formal community-based services, and informal care provided by friends and family.<sup>12</sup>

Except for informally provided care, nursing home care—the most expensive type of long-term care—consumes the greatest amount of out-of-pocket spending. As shown in chart 1, **individuals spent \$21.3**

**billion on nursing home care in 1989.** Medicaid patients as well as private-pay patients spend significant amounts on nursing home care. An estimated 41 percent (\$8.7 billion) of 1989 nursing home expenditures came from the Social Security income of nursing home residents covered by Medicaid (Lazenby and Letsch, 1990).



**Subsidization of private individual long-term care expenses through the tax code has received considerable Congressional attention.**



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In addition to the costs of care provided by family and friends and of nursing home care, 13 percent of the elderly who receive noninstitutional long-term care pay for formally provided services (U.S. Department of the Treasury, 1990). These services include home care, help with personal care and homemaking, programs offered by senior centers, adult day care, meal programs, telephone monitoring, and special transportation.

**Encouragement of private individual long-term care expenses through the tax code has received considerable Congressional attention. Currently, the tax incentive for out-of-pocket long-term care 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 \$2,400 annually (\$4,800 for two or more qualified dependents). The tax credit is reduced one percentage point for each \$2,000 of the taxpayer's adjusted gross income above \$10,000 (but the credit does not fall below 20 percent) (Internal Revenue Code (IRC), Section 21). IRC Section 129 allows employers to

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<sup>12</sup>Expenditures on informal care provided by friends and family are equal to the sum of the caregivers' opportunity costs, i.e. the lost value of other activities that caregivers might have performed were they not providing care. This figure is very difficult to quantify, but the value of such care can be estimated based on what it would cost to substitute the least expensive available paid care. See Alzheimer's Association, 1991.



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sponsor qualified dependent care assistance programs (DCAPs). Under a DCAP, employees may deduct from income tax up to \$5,000 annually for the cost of providing qualifying dependent care. For both the dependent care tax credit and employer-sponsored DCAPs, *dependent* is defined as a child under age 13, a disabled spouse, or any dependent who is physically or mentally incapable of caring for him- or herself (IRC, section 21(b)).

### *Private Long-Term Care Insurance*

**Private insurance payments amounted to less than 1 percent of total spending on nursing home care in 1989** (Lazenby and Letsch, 1990). Long-term care insurance policies have only recently begun to include home and community benefits and are an equally insignificant source of financing for noninstitutional long-term care. However, the prevalence of long-term care insurance has grown rapidly in the last several years, and some observers believe that private insurance could play an important role in financing long-term care in the future. The following sections describe long-term care insurance and discuss some of the issues associated with it.

### ◆ **Private Long-Term Care Insurance: An Emerging Source of Financing**

At present, private insurance is only a nominal source of long-term care financing, but it has received a great deal of attention from private industry, academic, and public policymakers. The major problem with financing long-term care (as with financing health care) is that the potential costs of this care may be greater than an individual's available financial resources. Therefore, a financing mechanism in which the risk of such a situation can be pooled (i.e., insurance) may represent an attractive alternative to individual financing. For that reason, many business, academic, and government leaders believe that private long-term care insurance holds significant promise for helping to meet the current and future challenge of paying for long-term care.

Private long-term care insurance emerged in the early 1980s and has grown rapidly in recent years. **The number of individuals with long-term care insurance policies grew from 815,000 in 1987 to nearly 2 million in 1990** (Health Insurance Association of America, 1991a and 1991b). **Similarly, the number of insurance companies selling long-term care insurance nearly doubled over the same period, from 75 to 143.** Despite the growth of the market, fewer than 4 percent of the elderly and 1 percent of the population overall are enrolled currently in a long-term care insurance policy. By contrast, 75 percent of the nonelderly population has private health insurance coverage (Foley, 1991b).

### *Plan Types*

There are several types of long-term care insurance products. Individual policies and group association policies are the most common (table 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 long-term care policies are made available to members of a nonemployer-based group or association that typically has an elderly or near-elderly membership 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 long-term care may seem imminent.

**Employer-based group products are newer and are currently less prevalent than individual and group association policies.** Employer-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 policies have grown significantly over the past few years but are still uncommon relative to other types of employment-based insurance. **As of year-end 1987, only two employers sponsored long-term care plans. By the end of 1990, this number had grown to 81, and an additional 51 companies were scheduled to offer long-term care plans during 1991**

(Health Insurance Association of America, 1991b). Employer-based long-term care insurance enrollees are younger, on average, than enrollees in individual and group association plans, because many are active workers and their spouses (table 2).

Long-term care policies sold as riders to life insurance policies and life insurance policies with provisions for accelerated death benefits are also fairly new introductions to the market and also tend to attract younger enrollees. Long-term care riders to life insurance use the policy's life insurance values to provide for long-term care expenses. Long-term care riders to a life insurance plan typically pay 2 percent of the death benefit each month, up to 50 percent of its total value, if long-term care services are needed prior to death (Health Insurance Association of America, 1991a). Life insurance policies with accelerated death benefits advance the death benefit (or a portion of it) to the insured in the event of terminal illness or a specified disease (Health Insurance Association of America, 1991a). **Like employer-sponsored plans, long-term care life insur-**

**ance riders and life insurance with accelerated death benefits have experienced rapid growth since their introduction in the marketplace. In 1987, there were no such policies, but by 1990, 22,810 individuals had long-term care coverage as a rider to a life insurance policy** (Health Insurance Association of America, 1991b). It is estimated that at least one million life insurance policyholders now have either a long-term care rider or a policy with an accelerated death benefits provision (American Council of Life Insurance, 1991).

**Although the market is currently dominated by policies that are sold individually and through associations, employer-sponsored plans offer several benefits over individual policies and could potentially dominate the market in the future.** Group insurance is less costly because of economies of scale in marketing and administration. Employer-based groups 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 when enrolling younger

Table 2  
Long-Term Care Policy Holders: Average Age and Percentage of Total, by Plan Type, 1990

| Plan Type                         | Number of Policy Holders | Percentage of Total Policy Holders | Average Age of Policy Holder |
|-----------------------------------|--------------------------|------------------------------------|------------------------------|
|                                   | (thousands)              |                                    | (years)                      |
| Total                             | 1,906                    | 100%                               | 69                           |
| Individual                        | 1,429                    | 75                                 | 72                           |
| Group—Association                 | 315                      | 17                                 | 69                           |
| Group—Employment                  | 133                      | 7                                  | 43                           |
| Life Insurance Rider <sup>a</sup> | 23                       | 1                                  | 52                           |
| CCRC <sup>b</sup>                 | 6                        | c                                  | 80                           |

Source: Health Insurance Association of America, *Long-Term Care Insurance: A Market Update* (Washington, DC: Health Insurance Association of America, 1991), and unpublished information.

<sup>a</sup>Does not include accelerated death benefits.

<sup>b</sup>Continuing Care Retirement Communities (CCRCs) merge the financing and delivery of long-term care. They can provide long-term care insurance, or long-term care itself, as well as a residence. The community is typically located in a campus-like setting that includes apartments or townhouses, a central eating and recreation facility, and a nursing facility (Friedland, 1990). As of December 1990, 6,499 individuals had purchased long-term care insurance through a CCRC.

<sup>c</sup>Less than 1 percent.

groups, make group plans 20 percent to 30 percent less expensive than comparable coverage offered on an individual basis (Friedland, 1990a).<sup>13</sup>

In addition to being less expensive, employer-based long-term care insurance policies may make employees, retirees, and their families aware of the potential liabilities associated with long-term care at an earlier age, when they can better afford to plan for long-term care needs (table 3). Moreover, employer-based long-term care insurance 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. Recent 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

Long-term care insurance policies offer coverage on an age-based level premium that depends on such plan features as categories of care covered (nursing home care, home care, community care), daily benefit (generally from \$50 to \$200 for nursing home care and one-half the nursing home benefit for home or community care), maximum benefit duration or dollar limit (two

<sup>13</sup>When the purchasers of insurance policies know more about the extent of their own risk than do the insurance providers, adverse selection may result. Adverse selection refers to a phenomenon whereby people who know 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 know they are not likely to experience that event. Insurers attempt to mitigate the costs of adverse selection by carefully screening applicants for health problems, family history of health problems, and behavioral items during the application process. Generally speaking, the risk of adverse selection decreases as the size 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 usually mandatory. However, the costs of adverse selection are still less with a working group because the likelihood of being able to predict long-term care needs is lower among younger individuals.

Table 3  
Average Annual Premium at Selected Ages for  
Employer-Sponsored Long-Term Care Plans<sup>a</sup>

| Age   | Annual Premium <sup>b</sup> |
|-------|-----------------------------|
| 30    | \$ 125                      |
| 40    | 176                         |
| 50    | 328                         |
| 65    | 1,108                       |
| 79–80 | 4,438                       |

Source: Health Insurance Association of America, *Long-Term Care Insurance: A Market Update* (Washington, DC: Health Insurance Association of America, 1991).

<sup>a</sup>Generally, for a plan providing \$80 per day for nursing home care, a 90-day deductible period, and 5 years of nursing home coverage.

<sup>b</sup>Includes data from six insurers for ages 30 and 40 and seven insurers for ages 50, 65, and 79–80. Premium data were not available for two of the insurers surveyed. Premiums are level (i.e., they remain at the level shown over the course of the insured's lifetime).

years to lifetime), and deductible periods (10 days, 20 days, and 90 days are common)<sup>14</sup> (Health Insurance Association of America, 1991b).

Long-term care insurance 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 than earlier policies. For example, **several insurers now offer policies that adjust the nursing home benefit for inflation or allow the policyholder to purchase increased benefits as nursing home costs increase. Most group policies allow the policyholder to convert to an individual policy should he or she leave the group.** Many policies include a provision that allows policyholders to stop paying premiums after a specified number of days (usually 90) in a nursing home. Nonforfeiture provisions, although not widespread, prevent the policyholder from forfeiting his or her full benefit if the policy

<sup>14</sup>Deductibles for long-term care insurance refer to a period of time that the policyholder must wait after a claim is made before coverage begins, rather than a specific dollar amount as is common with health insurance.

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lapses. One type of nonforfeiture provision continues coverage at a reduced benefit level if a minimum number of payments has been made. Another type allows partial recovery of premiums paid (National Association of Life Underwriters, 1991; Health Insurance Association of America, 1991b). Although policyholders may value them, policies with such features cost more.

**Newer policies no longer include many of the restrictions imposed on the earliest long-term care insurance products**, such as prior hospitalization as a prerequisite for nursing home coverage and/or skilled nursing care as a prerequisite for home- or community-based care. In addition, limitations on preexisting conditions are declining, and policies are more likely to have lifetime benefits. Most new plans offer coverage for nursing home care and home- and community-based care as well as for needs that result from Alzheimer's disease and other organic impairments. Virtually all policies are now guaranteed renewable.

Although many new policies have fewer limitations than earlier ones, restrictions are still prevalent. For example, although some plans pay a benefit if the participant requires assistance in a specified number of ADLs, most plans base benefit eligibility on physician certification of need and medical necessity. Because much long-term care is by definition not medical in nature, the medical necessity trigger can prevent people from qualifying for claims payment.

### ***Potential Market for Long-Term Care Insurance: Why Isn't the Current Market Bigger?***

As mentioned, **only 4 percent of the elderly and 1 percent of the total population currently are covered by private long-term care insurance**. Various studies have suggested that long-term care insurance is not an affordable option for most elderly individuals (Friedland, 1990b; Rivlin and Wiener, 1988; Families USA Foundation, 1990).<sup>15</sup> However, depending on

assumptions, estimates reveal that up to one-half of the population aged 45–64 could afford long-term care insurance (Friedland, 1990a). Several explanations have been offered to explain why more nonelderly individuals have not purchased long-term care insurance.

The most common explanation is that impediments to the long-term care insurance market have resulted in market failure. This idea has caused policymakers to consider various types of government intervention, including regulation and subsidization. While there is some evidence to indicate that certain market imperfections do exist, the absence of coverage among those who can afford it does not necessarily imply market failure—the decision not to purchase long-term care insurance might be rational even under perfect market conditions.

### ***Market Failure***

Three types of circumstances lead to market failure: supply impediments, demand impediments, or structural impediments (Pauly, et al., 1990).<sup>16</sup> Insurers may be reluctant to offer long-term care insurance because of adverse selection; moral hazard;<sup>17</sup> and uncertainty about future home care and nursing home prices and use rates, disability rates, and mortality rates. While

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coverage, whether affordability is based on income and assets or income only, and what percentage of income (or income and assets) is considered affordable (5 percent or 10 percent are common). The wide variation in results reflects the high sensitivity to assumptions. For a thorough discussion of these assumptions, see the above studies and Friedland, 1990b.

<sup>16</sup>If insurers value products more highly than their cost, economic theory holds that markets for such products should emerge. Supply impediments, such as high risk, may keep suppliers from offering a product even if well-informed customers would be willing to pay an amount sufficient to cover the supplier's actual costs. Demand impediments, such as a lack of information, may keep consumers from purchasing a product at a price that covers costs even though suppliers offer it. Structural impediments keep otherwise willing consumers from buying products that suppliers offer.

<sup>17</sup>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.

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<sup>15</sup>Estimates of the proportion of the population that can afford insurance vary according to the definition of long-term care

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these issues are similar to those faced by insurers offering other types of insurance, they are particularly significant for long-term care because needs are difficult to define and may not arise for decades after a policy is purchased.

Although the existence of many insurers offering long-term care insurance suggests that insurers are willing to enter the long-term care market, the foregoing uncertainties may have resulted in the delay or absence of desirable products. Insurers overcome their inability to predict future long-term care claims by offering policies with limited benefits that are priced high enough to cover any remaining uncertainty. Moreover, insurers are permitted to raise premiums to all policyholders if they experience unpredicted losses from claims.

Impediments to *demand* for long-term care insurance may also exist. For example, individuals who have some wealth to protect may mistakenly believe that Medicare already provides such coverage (U.S. Bipartisan Commission on Comprehensive Health Care, 1990; Rivlin and Weiner, 1988; Friedland, 1990a). In a 1990 public opinion survey conducted by EBRI and The Gallup Organization, 47 percent of respondents and 57 percent of those aged 18–34 answered “true” or “don’t know” when asked if Medicare currently pays for long-term care for the elderly (Employee Benefit Research Institute/The Gallup Organization, Inc., 1990). In addition, individuals may be unaware of the risk of needing long-term care and/or the associated costs. Thus, they may underestimate the value of long-term care insurance policies.

Structural impediments to the long-term care insurance market include the high costs of administering long-term care insurance and the presence of Medicaid as the payer of last resort. Currently, marketing and administrative costs make individual long-term care policies significantly more expensive than employer-based group policies. These costs may be high enough to deter potential buyers. The existence of the Medicaid program may also impede the development of the long-term care insurance market. Medicaid, as a

comprehensive insurance policy with a deductible equal to most of a beneficiary’s assets, provides a close substitute, at zero price, for private long-term care insurance coverage (Pauly, 1990).

### *Rational Nonpurchase in a Perfect Market*

**While it is likely that the market for long-term care insurance is *not* functioning perfectly, at least one researcher has pointed out that even if it were, rational individuals might still choose not to purchase such coverage.**<sup>18</sup> Long-term care insurance coverage serves primarily to protect assets, which in many cases are likely to be bequests. Therefore, such protection may have no value for certain individuals, depending on their family circumstances or marital status (Pauly, 1990).

In addition, the value placed on long-term care insurance may vary widely, depending on the relative desire for the type of care covered by insurance and the presence or absence of alternatives to such care (i.e., informally provided care). Another explanation for the rational nonpurchase of long-term care insurance, according to Pauly, is that the presence of coverage for specific long-term care services may encourage children or other family members who might otherwise have provided informal care in the home to substitute formal and/or institutional care. A potential beneficiary who does not prefer this outcome may be justified in not purchasing such coverage.

While there are limited data to determine which of the foregoing explanations best accounts for the relatively small size of the current long-term care insurance market, the explanation is likely to be a combination of these factors.<sup>19</sup> Policymakers considering subsidies for

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<sup>18</sup>This section draws from Mark V. Pauly, “The Rational Nonpurchase of Long-Term Care Insurance,” *Journal of Political Economy* (February 1990): 153–168.

<sup>19</sup>Ambiguity about the tax treatment of long-term care insurance may be another reason that it is not as prevalent among workers as other types of insurance. Issues of long-term care insurance tax treatment are discussed in detail later in the paper.



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long-term care insurance should be particularly aware of these potential obstacles to a private market.

### ◆ Issues of Consumer Protection and Regulation of Long-Term Care Insurance

Long-term care insurance policies have evolved over the past several years in response to regulations. Nonetheless, several policy features and insurer underwriting and marketing practices are objects of public criticism. **The National Association of Insurance Commissioners (NAIC), an organization of state insurance commissioners that proposes standards for states' insurance laws, first set standards for long-term care insurance in 1986 and has amended them annually. However, NAIC standards are not binding; state regulatory agencies hold the actual authority for insurance regulation and enforcement.** Insurers that sell the majority of long-term care policies have adjusted their policies to reflect many of the NAIC standards (Health Insurance Association of America, 1991b). However, states have been slower to adopt NAIC standards as law, and some insurers have not voluntarily conformed to NAIC standards (Shikles, 1991). According to a study conducted by the General Accounting Office (GAO), insurance companies and states have been particularly lax about NAIC disclosure standards that help protect consumers from unfair or deceptive marketing practices.<sup>20</sup> Moreover, questions have been raised about various long-term care insurance issues currently not addressed by NAIC, such as the lack of industrywide definitions and terms.

In response to these issues, long-term care insurance regulation has recently captured the attention of federal policymakers. **The federal government has tradition-**

**ally left the issue of insurance regulation and enforcement to the states,** although it has intervened in the Medicare supplemental insurance (Medigap) market. (Medigap and long-term care insurance are entirely different products, but are often compared because both primarily serve the elderly.) This section outlines the NAIC standards for long-term care insurance, examines insurer compliance and state regulation, and considers proposed legislation for federal regulation of long-term care insurance in terms of consumer protection and consumer choice.

#### NAIC Standards

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 long-term care insurance standards have provisions for policy design and insurance company marketing and underwriting practices.

**The NAIC model standards for long-term care insurance prohibit certain plan features, including preexisting condition exclusion periods longer than six months; 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 long-term care 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. The NAIC standards also contain minimum provisions for home health care benefits, including prohibition against covering only

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<sup>20</sup>Between April 1990 and February 1991, GAO reviewed 44 long-term care insurance policies for sale by 27 insurers in 8 states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). The insurers were randomly selected from the universe of insurers with policies approved for sale in each state.

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services by registered or licensed practical nurses or limiting coverage to services provided by Medicare-certified agencies or providers (Pomeroy, 1991).

Another plan design issue that NAIC is addressing but has not yet adopted is nonforfeiture provisions. **Currently, a NAIC task force is developing model standards for nonforfeiture benefits, which allow insured individuals whose policies lapse to recover a portion of their paid premiums or to receive a reduced benefit.** The task force preliminarily has determined that nonforfeiture provisions should be offered to all purchasers, and it is developing one or more nonforfeiture standards to be adopted by NAIC in 1991 (Pomeroy, 1991).



**Insurers generally have adopted NAIC standards more quickly than the states have mandated them, but most policies still do not conform to all the NAIC standards.**



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The NAIC standards address several insurer marketing practices. Under the NAIC model, insurers must establish auditable standards for marketing, including fair and accurate comparisons of policies. In addition, NAIC calls for insurance agents to identify any existing long-term care coverage that an applicant has, assure that excessive insurance is not sold, and notify applicants of coverage limitations and a senior counseling program if one exists in the state. Agents must also deliver a detailed outline of coverage to all prospective applicants at the time of initial solicitation, deliver a buyers' guide prior to sale, and refrain from high-pressure sales tactics. In addition, the NAIC model standards include an optional limitation on agent commission that prohibits payment of first-year com-

missions that are substantially greater than renewal commissions (Pomeroy, 1991).<sup>21</sup>

The NAIC standards also include specifications for certain underwriting practices. For example, individual policies must meet at least a 60 percent loss ratio.<sup>22</sup> Insurers must also provide certain protections against post-claims underwriting—a practice that involves denying claims based on technical details not explicitly requested or provided on the application form. These protections include keeping records of such denials and reporting them to insurance commissioners. The NAIC task force is also developing rules to assure that existing policyholders have an opportunity to upgrade their coverage if their insurer improves the policies it offers to the public (Pomeroy, 1991).

### *Insurer Compliance*

**Insurers generally have adopted NAIC standards more quickly than the states have mandated them, but most policies still do not conform to all the NAIC standards** (Shikles, 1991). Specifically, GAO found that none of the 44 policies it reviewed met all NAIC disclosure standards. For example, 20 did not ask if the applicant was already covered by Medicaid, and 42 did not ask whether applicants had owned another long-term care insurance policy in the past year or who had sold it to them. In addition, GAO found that of 37 policies offering home health care benefits, 10 contained restrictive provisions that are prohibited in the NAIC model. Specifically, five had step-down provisions, and five required a physician to certify that without home health care institutionalization would be

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<sup>21</sup>This provision is aimed at reducing the financial incentive for insurance agents to churn business. Agents are said to churn business when they repeatedly sell insurance that replaces existing coverage. While replacing policies may be appropriate in certain circumstances, churning generally refers to instances in which such behavior is motivated by the high first-year commission generally paid on policy sales.

<sup>22</sup>The loss ratio is the dollar amount of claims an insurer pays as a proportion of the premiums it takes in for a particular type of insurance policy.

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necessary. With respect to inflation protection, only 1 policy met the NAIC standard, and 10 policies did not offer inflation protection.

### **State Regulation**

While states generally have moved to mandate NAIC long-term care insurance regulations, many lag behind the NAIC amendments, and many do not conform to NAIC standards. According to GAO, 11 states have no minimum standards for long-term care insurance. Among those that have standards, 19 have not prohibited prior hospitalization requirements; 40 have not adopted standards for home health care benefits, inflation protection, or disclosure requirements for post claims underwriting; and 18 states still allow exclusions for Alzheimer's victims.

### **Issues Not Addressed in Current NAIC Standards**

**Other criticism of long-term care insurance centers on the absence of industrywide standard definitions of eligibility and benefits and the use of medical necessity triggers, which require a physician to certify that long-term care is medically necessary. Both of these situations may effectively reduce the proportion of claims that an insurer must pay.**

Another issue not yet formally addressed by NAIC involves the lack of long-term care policies with nonforfeiture features. Although IBM recently implemented a group long-term care plan that includes such a feature, the majority of policies still exclude nonforfeiture clauses. This is a significant issue because long-term care insurance policy lapses have been common, compared with lapse rates for other types of insurance, and insurers expect even higher rates as the market matures. **A recent report cited an average first year long-term care insurance lapse rate of 18 percent and an overall lapse rate of 16 percent, with the rate ranging from 4 percent to 50 percent for individual insurers** (Health Insurance Association of America, 1991b). By comparison, the overall voluntary termination rate of ordinary life insurance policies in 1989 was

8.8 percent—18.6 percent for policies in force for less than two years and 6.7 percent for policies in force for at least two years (American Council of Life Insurance, 1991). GAO reported that, on average, insurers expect the lapse rate for long-term care insurance to be 60 percent after 10 years (Shikles, 1991).<sup>23</sup>

Although a policy with nonforfeiture provisions costs more than a similar policy without such provisions, a nonforfeiture option may be desirable for several reasons. For example, state regulators may permit insurers to raise premiums uniformly to policyholders on the basis of adverse claims experience, subjecting policyholders to unpredictable premium increases that may leave them unable or unwilling to continue paying the premium.<sup>24</sup> Without a nonforfeiture provision, an individual whose policy lapses because of premium increases would be unable to recover any paid premiums or partial benefits. Another reason a nonforfeiture provision may be desirable is that most policyholders who bought policies several years ago are unable to switch to improved policies currently marketed by their insurer without forfeiting the paid premiums.

### **Proposed Federal Legislation: Consumer Protection and Consumer Choice**

**On April 17, 1991, Sen. David Pryor (D-AR) and Rep. Ron Wyden (D-OR) introduced companion bills S. 846 and H.R. 1916, the Long-Term Care Insurance Consumer Protection Act. These proposals would regulate various plan features and marketing practices, and would provide for increased consumer**

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<sup>23</sup>One insurer expected an 89 percent lapse rate after 10 years. These figures are based on approximately 20 insurers' responses to a question about *expected* (as opposed to actual) lapse rates. GAO felt that insurers' future expectations were significant, given that the market is still young.

<sup>24</sup>This problem may be exacerbated by deliberate underpricing of policies for competitive purposes (Shikles, 1991). On the other hand, this and other policy limitations may help to encourage insurers to offer long-term care insurance despite the uncertainties they face about future costs. There may be a tradeoff between consumer interest and availability of long-term care insurance.

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**information.** Plans would be required to have mandatory nonforfeiture benefits, broad definitions of home health care, and maximum one-time six-month preexisting condition exclusionary periods and would be prohibited from requiring prior institutionalization for the receipt of benefits. In addition, the bills have provisions that would prohibit high pressure sales tactics and inappropriate sales. The proposals also provide for improved consumer information by requiring insurers to make available policy-specific information and an outline of coverage with standard definitions and terminology as well as requiring states to make insurer compliance information available to customers. In addition, the bills authorize \$20 million for states to establish long-term care insurance counseling programs. The federal government would oversee state compliance with the proposed standards.

A major difference between the two bills is that H.R. 1916 includes a provision for mandatory inflation protection, while S. 846 requires only that insurers offer the option of an inflation protection feature when a policy is initially sold. In addition, the Wyden bill (but not the Pryor bill) addresses the issue of agent commission structure, mandating that first-year agent compensation for sale of a long-term care insurance policy not exceed 200 percent of the compensation in subsequent years. The Wyden bill also requires insurers to allow policyholders to upgrade existing policies that do not meet the new standards to policies that meet them, increasing the premium only to the extent that it reflects new benefits.

**Comprehensive long-term care legislation (S. 1693), introduced August 2, 1991, by Sens. Lloyd Bentsen (D-TX), Bob Packwood (R-OR), David Pryor (D-AR), Robert Dole (R-KS), and John Chafee (R-RI), also contains consumer protection provisions. The bill would require long-term care insurance contracts to satisfy certain consumer protection requirements to qualify for favorable tax treatment.**

Under the bill, plans would be required to adopt NAIC model standards relating to guaranteed renewability

and noncancelability, preexisting conditions, prior hospitalization, prohibitions on limitations and exclusions, continuation or conversion of coverage, disclosure, post-claims underwriting, minimum standards for home health care benefits, inflation protection, and probationary periods. In addition, the bill would require NAIC to promulgate and certify nonforfeiture requirements to the Secretary of the Treasury before January 1, 1993. The bill explicitly provides flexibility to NAIC in determining the type and extent of nonforfeiture benefits and the extent to which those benefits would have to be offered or provided under long-term care insurance contracts. However, it does require the NAIC to at least mandate that insurers offer policyholders an opportunity to obtain a type of nonforfeiture benefit.

**Another bill, H.R. 2378, introduced May 17, 1991 by Rep. Terry Bruce (D-IL), the Consumer Protection Standards for Long-Term Care Insurance Act of 1991, overlaps the Wyden/Pryor proposal but does not include sales and marketing standards. The bill calls for mandatory inflation protection and nonforfeiture provisions as well as mandatory coverage for Alzheimer's victims.** In an attempt to reduce unintentional policy lapses, the proposal also mandates the designation of an alternative payor who would be notified in the case of a missed premium payment before the policy lapses.

**These consumer protection bills include certain provisions that may be construed as regulating consumer choice.** The primary focus of consumer protection is to assure policyholders that they receive the value for which they have contracted and are paying premiums. There is little disagreement that provisions to improve consumer information, such as those to standardize definitions and outlines of coverage and to eliminate misleading or inappropriate sales, serve the objective of consumer protection. However, some policymakers argue that provisions mandating specific policy features, such as inflation protection and nonforfeiture provisions, do not protect consumers but rather restrict consumer

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choice. Mandating that every policy contain specified features limits consumer choice and might lead some individuals to pay for options that they may not otherwise value highly enough to choose. On the other hand, some observers argue that it is the government's job to determine what long-term care insurance policies must include in order to protect adequately against the risk of needing long-term care. These issues will likely be addressed as consumer protection proposals are debated.

### ◆ The Taxation of Long-Term Care Insurance

The tax code does not explicitly recognize long-term care. Therefore, the tax treatment of long-term care insurance premiums and benefits is ambiguous. Ambiguity surrounding long-term care insurance tax treatment might be an impediment to the market for long-term care insurance—particularly employer-based group insurance. This possibility has led policymakers and private industry to call for clarification of the tax code. This section describes the prevailing treatment of long-term care insurance under the current tax code, discusses bills introduced during the 102nd Congress to clarify the tax treatment of long-term care insurance, and introduces some criteria against which these proposals might be evaluated.



**Underlying the tax treatment of long-term care is the issue of whether or not long-term care falls under the IRC definition of medical care.**



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### *Current Tax Treatment of Long-Term Care Insurance*

**Underlying the tax treatment of long-term care is the issue of whether or not long-term care falls under the**

**IRC definition of medical care.** According to the IRC, the cost of medically necessary services and associated meals and lodging are deductible from individual income tax to the extent that they exceed—when added to all other medical expenses—7.5 percent of a taxpayer's adjusted gross income (AGI). IRC section 213(d) defines medical care as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease; for the purpose of affecting any structure or function of the body; for transportation primarily for and essential to medical care; or for insurance (IRC, section 213(d)). Most long-term care and nursing home care does not appear to meet the medically necessary criteria. However, it is difficult to distinguish between medical and nonmedical long-term care expenses.

**The ambiguity concerning long-term care in the tax code leads to questions not only about how to treat long-term care expenses but also about the treatment of long-term care insurance.** If long-term care were deemed to be medical, long-term care insurance 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 long-term care insurance claim is filed (whether under an individual or employer-sponsored policy), would not be included as taxable income to the beneficiary. However, since long-term care has not been thus defined, most employers have avoided the problem altogether either by not sponsoring a long-term care policy or by offering one on an employee-pay-all basis.<sup>25</sup> Individuals purchasing long-term care insurance either on an individual basis

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<sup>25</sup>The assumption that long-term care premiums must be included in the taxable income of employees may impede the development of the group long-term care insurance market because employers may assume that other forms of compensation that are tax-preferred (e.g., health insurance and pensions) will be more valuable to most employees. In addition, employers may refrain from offering long-term care insurance out of concern that their interpretation of the tax treatment will be contrary to an eventual ruling. A misinterpretation could require the payment of back taxes or result in uncertainty regarding the recovery of past surplus tax payments.



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or as part of an employer-based plan use after-tax dollars, which has been assumed to guarantee them tax-free claims payments consistent with general rules of insurance taxation.<sup>26</sup>

Before April 10, 1989, the tax treatment of earnings on long-term care reserves held by insurers was also ambiguous. Under IRS Revenue Ruling 89-43, reserves established by an insurance company under a level premium, guaranteed renewable group long-term care policy are generally considered life insurance reserves for income tax purposes. This means that increases in such reserves, to the extent that they are within the limits prescribed under the income tax law, are deductible in determining the life insurance company's taxable income. Generally, this treatment enables the insurance company to set aside reserves for future unaccrued claims (within the prescribed limits) on a deductible basis and enables such reserves to grow on a substantially tax-free basis (U.S. Department of the Treasury, 1990).<sup>27</sup>

### ***Proposed Tax Treatment of Long-Term Care Insurance***

**Many bills have been introduced in the 102nd Congress that would clarify the tax treatment of long-term care insurance.** In general, the proposals encourage the purchase of long-term care insurance by allowing one or more of the following:

- same tax treatment of long-term care insurance that applies to accident and health insurance,

- tax exemptions or credits for individual long-term care insurance premiums,
- penalty-free and tax-exempt withdrawals from IRAs for the purpose of purchasing long-term care insurance,
- tax-exempt conversion of life insurance values to long-term care insurance, and
- tax-free receipt of accelerated death benefits (table 4).

Other provisions in these bills include tax incentives for long-term care expenses other than insurance, income tax credits for individuals who provide long-term care to family members, and a tax exemption for the gain from the sale of the principal residence if used (by individuals aged 55 and older) to purchase long-term care insurance. Most tax preferences related to long-term care insurance are contingent on the purchase of a policy that meets certain minimum standards (qualified plan).

**Each of the comprehensive long-term care insurance proposals introduced over the past six months includes a provision to treat long-term care insurance the same as accident and health insurance for purposes of taxation.** As mentioned, such a provision would mean that premiums paid by an employer on behalf of an employee would not have to be included in the employee's gross income, and that benefits received when a long-term care insurance claim is filed would not be included as taxable income to the beneficiary. Most of these bills also contain a provision that allows long-term care insurance to be included in a cafeteria plan.<sup>28</sup>

Legislation (S. 1693) clarifying the tax treatment of private long-term care insurance and benefits was

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<sup>26</sup>However, at least one employer has permitted employees to elect long-term care insurance under a cafeteria plan on a pretax basis. Presumably, these employees have not paid taxes on claims payments, but what the official ruling would be on this is uncertain. An interesting example of interpretation of the IRC is the case of IBM's group long-term care policy in which IBM contributes 20 percent of the premium from an employer fund on a tax-exempt basis to the employee. Here, there appears to be an implicit assumption that 20 percent of what a long-term care insurance policy buys is medical.

<sup>27</sup>This may also explain the virtual absence of policies that are not guaranteed renewable.

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<sup>28</sup>Except for 401(k) arrangements, the tax code explicitly prohibits flexible benefits plans from offering benefits that provide deferred compensation. Whether or not employers should be able to offer long-term care insurance as part of a cafeteria plan centers on the issue of whether long-term care insurance is a form of deferred compensation. For a comprehensive discussion of cafeteria plans, see Foley, 1991a.

Table 4  
Selected Bills Amending the Tax Code with Respect to Long-Term Care Insurance, 102nd Congress, 1st Session

| Bill                 | Sponsor  | Date Introduced    | Treats Like Accident and Health Insurance | Tax Exemptions or Credits for Insurance Premiums | Penalty-Free, Tax-Exempt Withdrawal from IRAs for LTC Insurance | Tax-Exempt Conversion of Life Insurance Values to LTC Insurance | Tax-Free Accelerated Death Benefits |
|----------------------|--|--------------------|---|--|---|---|-------------------------------------|
| S.1693               | Bentsen (D-TX)                                 | 8/2/91             | X   |  |   | X   | X                                   |
| S. 1668              | Packwood (R-OR)                                | 8/2/91             | X   |  |   | X   | X                                   |
| S. 1122<br>H.R. 2446 | Specter (R-PA)<br>Ritter (R-PA) <sup>a</sup>   | 5/22/91<br>5/22/91 | X   | X  | X <sup>b</sup>  | X   | X                                   |
| S. 1021<br>H.R. 1693 | McCain (R-AZ) <sup>a</sup><br>Gradison (R-OH)  | 5/9/91<br>4/10/91  | X   |  |   | X   | X                                   |
| H.R. 2174            | Kennelly (D-CT)                                | 5/1/91             | X   | c  | X <sup>d</sup>  |   |                                     |
| S. 284<br>H.R. 134   | Bradley (D-NJ) <sup>a</sup><br>Kennelly (D-CT) | 1/30/91<br>1/3/91  |   |  |   |   | X                                   |
| S. 314<br>H.R. 415   | Cohen (D-ME)<br>Rhodes (R-AZ)                  | 1/31/91<br>1/4/91  | X<br>X                                    |  | X<br>X <sup>b</sup>   |   | X                                   |

<sup>a</sup>Companion bill to the bill listed above, with the same provisions.

<sup>b</sup>And from 401(k) plans.

<sup>c</sup>Does not amend the tax code but calls for a premium subsidy program for low-income individuals to be financed by Medicaid.

<sup>d</sup>Penalty free but does not include a provision for tax-free withdrawals for the purchase of long-term care insurance. However, expenses relating to qualified long-term care are treated as medical expenses.

introduced August 2, 1991, by Senate Finance Committee Chairman Lloyd Bentsen (D-TX), ranking minority member Bob Packwood (R-OR), David Pryor (D-AR), Robert Dole (R-KS), and John Chafee (R-RI). The bill would provide that certain services (defined as “qualified long-term care services”) that are provided to chronically ill individuals would be treated as medical care for purposes of the medical expenses deduction. Although the legislation avoids explicit subsidies for long-term care insurance, it would entitle long-term care insurance policies that adhere to specified standards to the same tax treatment as accident and health insurance. Therefore, employer-paid premiums would not be included in employees’ income. The bill would also exclude from income accelerated payments from life insurance for people with terminal illness. The sponsorship of the two most senior members of the Senate’s tax-writing committee makes this bill the most

likely vehicle for any tax clarification legislation in this Congress.

Separate legislation (S. 1668) introduced August 2 by Sens. Packwood and Dole contains similar tax-related provisions. In addition, the bill would clarify that reserves set aside by insurance companies to pay benefits under qualified long-term care insurance policies are tax deductible.

Each of these comprehensive proposals also amends IRC section 213(d) to make long-term care expenses (including insurance) deductible if—when added to all other medical expenses—they exceed 7.5 percent of the taxpayer’s AGI. However, some proposals include tax credits or exemptions explicitly for long-term care insurance premiums. Companion bills S. 1122 and H.R. 2446, introduced by Sen. Arlen Specter (R-PA)

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and Rep. Don Ritter (R-PA), for example, allow a 28 percent tax credit for qualified long-term care insurance premiums paid for family members. The tax credit is reduced by one percentage point each for \$1,000 by which the taxpayer's AGI exceeds \$25,000, and if it is taken, the qualified expenses cannot be added into the amount for a medical expense deduction.



**Many of the legislative proposals regarding long-term care call for long-term care insurance to receive the same tax treatments as accident and health insurance.**



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Proposals that provide for penalty-free, tax-free withdrawals from IRAs and tax-free conversions from life insurance to purchase long-term care insurance vary in their limitations. For example, the tax exemption may be limited to insurance purchased for the taxpayer or it may also be available for family members. In addition, eligibility for such exemptions may be limited to individuals who have reached age 59<sup>1/2</sup>. The Specter/Ritter proposal increases from \$2,000 to \$4,000 the annual tax-exempt amount that qualified individuals can contribute to an IRA.

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.

### ***Evaluation of Tax Proposals***

Tax policy is often used to promote specific social and economic goals. The proposed policies for the tax

treatment of long-term care can be evaluated in terms of their tax burden versus their social benefit (keeping in mind who bears the burden and who benefits). Tax policies can also be evaluated in terms of the public long-term care expenditures associated with the policy relative to the expenditures that would accrue without it. For example, a proposal to treat long-term care insurance the same as health insurance for tax purposes has an associated tax expenditure (and burden), and its adoption would subsidize those who purchase individual or receive employer-sponsored long-term care insurance. Furthermore, it might encourage the substitution of formal for informal or more efficient sources of care unless the policies pay benefits according to a disability model (i.e., disability triggers payment as opposed to specific services).<sup>29</sup> However, such a proposal may also further certain social and economic goals, including increased risk pooling, preservation of assets, and potential reduction in Medicaid expenditures for those who are not poor. Quantification and comparison of the costs versus the benefits of such a policy need to be carefully considered to develop appropriate public policy, but they are beyond the scope of this paper.<sup>30</sup>

The proposals have also been evaluated in terms of their consistency with other provisions in the tax code for benefits and/or insurance. While benefits received from insurance plans have traditionally been tax free (assuming contributions are made with taxable dollars), distributions from retirement savings plans that allow tax-favored accumulation of capital on the contributions (e.g., IRAs, qualified pensions), have always been taxed. In addition, distributions from employer-sponsored insurance benefits whose premiums are excluded from the employee's taxable income (e.g., disability

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<sup>29</sup>Long-term care insurance that pays a fixed dollar amount based on specified disabilities (two or three ADLs, for example), regardless of whether and what type of long-term care is purchased, would allow individuals to choose among all options equally.

<sup>30</sup>See Rivlin and Weiner, 1988; Health Insurance Association of America, 1991b; U.S. Department of the Treasury, 1990; Friedland, 1990a; and Moran and Weingart, 1988 for discussions evaluating such proposals.

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insurance) are taxable on receipt. However, benefits paid from employer-sponsored health insurance are not taxable. **Many of the legislative proposals regarding long-term care call for long-term care insurance to receive the same tax treatments as accident and health insurance.** If it were treated this way, employees receiving employer-sponsored long-term care insurance benefits would enjoy the same tax-exempt premium payments and nontaxation of interest on accumulating plan deposits that are characteristic of qualified pension plans. The benefits paid to them would also be tax exempt, similar to those paid by health plans. A 1990 report by the U.S. Department of the Treasury that addressed the financing and tax treatment of long-term care points out that such treatment would be almost without parallel anywhere in the tax code (U.S. Department of the Treasury, 1990).<sup>31</sup>

Proposals to clarify the tax treatment of long-term care insurance and to provide tax incentives for long-term care expenditures are not new. They were recommended by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) in conjunction with comprehensive public financing (U.S. Bipartisan Commission, 1990), and they have been introduced in previous sessions of Congress. To date, none of the current proposals has generated significant action. Given the current environment of fiscal restraint, it is unlikely that any of the proposed bills will become law in the near future because they all involve a loss of tax revenue. In order to succeed, these proposals would have to include a politically acceptable source of financing to offset the tax loss. Moreover, the magnitude of tax revenues associated with each proposal is hard to predict, making it difficult to ensure adequate financing.

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<sup>31</sup>Technically speaking, such treatment is *not* without exception. The only tax-preferred prefunding (prefunding without immediate taxation of interest) of health benefits is through a separate account in a tax-qualified pension plan (a 401(h) account). However, these accounts have not been widely used in the past because of various limitations (U.S. Department of the Treasury, 1990) and because prefunding of retiree health benefits was not required. For further discussion, see Davis, 1991.

## ◆ Conclusion

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

Aside from informal care provided in the community, the current system of financing long-term care depends on the Medicaid program and individual financing. Issues confronting this system include the potential depletion of personal assets, a bias toward institutionalization, and rules that allow relatively wealthy individuals to become eligible for Medicaid. Furthermore, states are currently suffering from serious budget deficits and have been forced to make changes to Medicaid that may threaten beneficiaries' access to quality care. **Many leaders regard long-term care insurance as a potential alternative to Medicaid and out-of-pocket financing for those who can afford it.**

Theoretically, long-term care insurance is an item for which individuals with assets to protect should be willing to pay: the chances of having extended long-term care needs are small, while the cost of such a need is extremely high. However, for a variety of reasons only a small proportion of those who can afford long-term care insurance have actually purchased it. For those 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), long-term care insurance may never be worth the price. Others, however, may lack information on the probability of needing such care, may mistakenly believe that they are already covered by Medicare or health

insurance, or may be dissatisfied or mistrustful of policies that are currently available.

Consumer protection for long-term care insurance policies may help to expand the number of policyholders by ensuring that they actually receive the coverage they believe they have purchased. Although NAIC sets standards for long-term care, adherence is voluntary and the authority for regulation and enforcement lies with the states. While many insurance companies have adjusted their plans to reflect certain NAIC standards, many states have not enacted laws reflecting the most recent amendments to NAIC long-term care insurance standards. There also is evidence that some companies do not comply with NAIC standards—particularly in the area of standards for marketing practices. Consequently, there are several proposals to regulate long-term care standards at the federal level. These proposals provide for standardization of definitions and terms and generally would strengthen consumer information. However, certain provisions included in these proposals might restrict consumers' choices with the intent of providing consumer protection.

**The lack of clarification of long-term care tax treatment may be an impediment to the widespread development of the long-term care insurance market—particularly the employment-based market.**

There are currently several clarification proposals that would encourage long-term care insurance through tax incentives. Many of these proposals would treat long-term care as health care for tax purposes, thereby allowing tax exemption of employer-sponsored benefits. Others would stimulate private financing of long-term care by allowing tax-free distributions from IRAs or life insurance for long-term care expenses or the purchase of long-term care insurance. Generally, tax incentives for private long-term care insurance benefit the nonpoor, as they are the people who have assets to protect. On the other hand, it is possible that the stimulation of private financing might produce greater social benefits than costs. Despite the problems with the current system of financing long-term care, proposals to alter the system must be carefully evaluated in

terms of the burden they impose versus their economic and social benefits.

This *Issue Brief* was written by Karen Horkitz of EBRI with assistance from the Institute's research and education staffs.

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