U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE EMERGING PRIVATE FINANCING SYSTEM

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Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract between HHS's Office of Disability, Aging and Long-Term Care Policy and Lewin/ICF, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, John Drabek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. His e-mail address is: John.Drabek@hhs.gov.

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INTRODUCTION

About half of all expenditures for long-term care services are not made with public dollars, but by individuals from their own pockets. Private spending for nursing home care for the elderly totalled about $19.0 billion in 1989, and private home care expenditures totalled another $2.4 billion.[1]

Most elderly persons who enter nursing homes do not receive coverage from Medicare, Medicaid or any other public program. Either they do not meet the criteria for Medicare SNF coverage (i.e., they did not enter a skilled facility directly from a hospital) or they have sufficient income and/or assets to disqualify them from Medicaid. In 1990, the average daily cost of a private nursing home stay was about $80 per day, $560 per week, $2,400 per month, or $30,000 per year. Although most nursing home stays are not long, even a three month stay could cost $7,000 to $8,000, not including other health care expenses such as drugs, physician visits, or physical therapy. A long nursing home stay can, of course, be financially devastating.

Many elderly persons are seeking ways to gain financial protection against the potentially high costs of long-term care. A number of private financing mechanisms are available which provide various levels of protection. Most possess the common characteristic of **pooling risks**. Risk pools are mechanisms by which individuals spread the costs of incurring a risk among all persons who contribute to the pool. For example, private long-term care insurance is a mechanism by which individuals create financial reserves (i.e. by paying premiums) which are used to pay the costs of those individuals in the pool who actually end up needing long-term care.

Risk pools also provide financial protection to those who do not use long-term care, for these persons are relieved of the worry that they will be financially ruined by the cost of an extended nursing home stay. In this manner, risk pools benefit *all* persons in the pool, not just those who actually use long-term care services.

Today, most elderly persons do not participate in long-term care risk pools and are therefore not protected from the potentially high cost of long-term care. There is a marked difference between the elderly's lack of protection from long-term care costs and the comprehensive protection which most elderly persons have against the costs of acute illness. Medicare provides broad coverage for most acute illnesses, particularly the costs of hospital care, and most elderly persons buy supplemental insurance (Medigap policies) for coverage of Medicare deductibles and co-payment requirements. As elderly individuals enter their late 70s and early 80s, many begin to realize that while Medicare is a comprehensive health insurance program for people who are in basically good health, it does not provide much help for people who need non-acute care for chronic conditions.

[1] Lewin/ICF estimates from the Brookings/ICF Long Term Care Financing Model.

Consequently, over the last decade, there has been growing interest in private sector approaches to financing long-term care. Although still emerging, private sector approaches are increasing in importance. These initiatives can be divided into two categories. Some approaches, such as private long-term care insurance, Continuing Care Retirement Communities (CCRCs), and social/health maintenance organizations (SHMOs), involve risk pooling. They pool the costs associated with long-term care over a broad population, most of whom will never incur substantial long-term care expenditures, thereby reducing the cost of long-term care to any one person.

Other approaches, such as home equity conversions and accelerated life insurance benefits, encourage people to save or to use their assets in new ways to finance their current or future long-term care needs. These are referred to as individual asset accumulation approaches.

Currently, less than five percent of the elderly participate in any private long-term care financing mechanism. Participants in risk pooling approaches include about 2.4 million purchasers of private long-term care insurance, about 250,000 persons who live in Continuing Care Retirement Communities, and about 15,000 persons who have enrolled in Social/Health Maintenance Organizations.

Participation in formal asset accumulation plans is much less frequent. Only about 5,000 elderly persons have sought home equity conversions. Moreover, not all home equity conversions are used to pay for long-term care. A small but unknown number of persons have used accelerated life insurance benefits to finance long-term care services (Figure 1).

This section describes the basic features of private long-term care financing mechanisms, recent trends in the market for these financial products, and some of the barriers which exist to future market growth. The chapter addresses the following specific questions:

- What private financing mechanisms are presently available and what are the basic characteristics of these products?

- What trends are emerging in marketing and sales of these products?

- What barriers exist to future market growth of private long-term care financing mechanisms?

FIGURE 1: Emerging Private Financing Mechanisms for Long Term Care		
Financing Mechanism	**Description**	**Number of Persons Covered**
Risk Pooled		
Long Term Care Insurance	Generally indemnity products covering nursing home and home care at a fixed rate per day or per visit after a deductible period.	2,400,000[a]
Continuing Care Retirement Communities	Closed community setting which offers independent housing supplemented by medical services and nursing home care.	230,000
Social HMOs	HMO variant which provides and manages some long term care as well as standard medical services.	15,000
Individual Asset Accumulation		
Accelerated Life Insurance Benefits	Option to permit persons with life insurance policies to receive accelerated death benefits in the event of terminal illness or confinement to a nursing home.	N/A
Home Equity Conversion Plans	Allows persons to borrow against the equity in their home and defer repayment of both the principal and interest until the house is sold.	5,000
a. Number of policies sold.		

LONG-TERM CARE INSURANCE

Long-term care insurance is a method for pooling the risk of long-term care costs. It is the most widely used private financing approach. The National Association of Insurance Commissioners (NAIC) defines long-term care insurance as "any insurance policy or rider which provides coverage for not less than twelve consecutive months on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital."[2] Thus, in contrast to general health insurance, long term insurance is distinguished by two major characteristics: (1) it provides coverage for extended care services (at least 12 months); and (2) it covers services not provided in acute care settings (i.e. hospitals).

Like other types of health insurance, long-term care insurance products can vary greatly in cost, covered benefits, and benefit criteria (definition of the "insured event"). Most long-term care insurance policies sold to date are indemnity products, which cover both nursing home stays and home care visits at a fixed rate per day or per home care visit. Typically, the policies will pay for between two and unlimited years in a nursing home, with a deductible period (e.g. no coverage for the first 20 to 100 days).

Long-term care insurance premiums are based upon the age of the purchaser. The age rated premiums can take two forms: (1) issue age premiums, where the premium charged is based upon the age at which an individual initially purchases insurance; and (2) attained age premiums, where the premium charged changes according to the age of the purchaser.[3] Both types of premiums can change based on the experience of the group (i.e., if more claims than expected are incurred premiums may be increased).

Characteristics of Long-Term Care Insurance Policies and Policyholders

One way to categorize long-term care insurance policies is according to how they are sold: (1) individual and group association policies; (2) employer-sponsored plans; and (3) riders linked with life insurance policies (Figure 2).

Approximately 85 percent of private long-term care insurance policies sold by 1990 were sold to individuals directly by an insurance company or through a group

[2] National Association of Insurance Commissioners, Long Term Care Insurance Model Act, Model Laws, Regulations and Guidelines, Vol.1, No.132.

[3] Attained age premiums have been prohibited by the National Association of Insurance Commissioners (NAIC) Model Regulation.

association.[4] At this early stage of market development, when both products and State regulation of long-term care insurance are rapidly changing, the "typical" policy varies according to the year it was purchased. In 1991, the policies offered by the 15 top-selling companies, who together accounted for four out of five of all policies sold, had the following characteristics:[5]

- All offered nursing home care, home care, and adult day care coverage;

- Nine plans provided additional alternative care benefits (a plan of nonconventional care and services developed by a physician that can serve as an alternative to nursing home care);

- Six plans provided additional respite care;

- None of the plans condition nursing home coverage on a prior hospital stay;

- Most (10) plans required physician certification of need and medically necessary care or need for assistance in specific activities of daily living (ADLs) or cognitive impairment to qualify for nursing home admission. Four plans triggered nursing home benefits based on medical necessity only;

- Most plans (nine of 15) offer home care benefits as a rider with up to unlimited coverage while the remaining plans offer the same maximum benefit period for nursing home and home care; and

- All plans offered ways to increase benefit payments over time, to protect against increases in the price of long-term care services. Of 15 sellers, 13 offer the NAIC 1991 Model regulation requirement that benefits increase at an annual 5 percent compounded rate for life with level premiums. Inflation adjustments were generally of three types: (1) annual percentage increases in benefit payments (e.g. 5 percent) with no premium increase; (2) benefits increase annually and the cost also increases annually; or (3) periodic options to upgrade the policy, where purchasers could pay higher premiums for desired increases in benefit amounts. The first method could possibly over protect or may not fully protect the purchaser from price inflation, while the second and third methods could lead to significant increases in premium costs over time.

[4] Policies marketed through group associations, such as the American Association of Retired Persons, the American Medical Association, and the American Bar Association. These are not true group plans but rather administrative arrangements in which individual policies are offered to all members of a particular group. The premiums for these policies do not differ significantly from premiums charged for individual plans with similar provisions.

[5] Summary description based on Health Insurance Association of America (HIAA), "Long Term Care Insurance in 1991." February 1993.

FIGURE 2: Types of Long Term Insurance		
Type	**Description**	**Percent of Policies Sold[1]**
Individual and Group Association	Products marketed and sold directly to individuals by insurance companies or through group associations, such as AARP, the AMA and the ABA.	85%
Employer-Sponsored	Generally administrative arrangements with employers to offer individual policies to employees, spouses and parents.	9%
Life Insurance Riders	Long term care coverage added to a life insurance plan which meets NAIC model guidelines for long term care insurance and uses the policy's life insurance value to provide for long term care expenses.	6%
SOURCE: HIAA, 1993 1. Policies sold as of December 1991.		

FIGURE 3: Typical Coverage Offered by Leading Sellers of Long Term Care Insurance[a]	
Feature	**Typical Coverage**
Benefits	
Services Offered	Skilled, intermediate, and custodial nursing home care. Home health care provided by RNs, LPNs, home health aides, and often adult day care. Alternate Care (9 out of 15) Respite Care (6 out of 15)
Daily Benefit	$40-$120 per day for nursing home care $20-$60 per day for home health care
Maximum Benefit Period	Two years to unlimited
Deductible Periods	0 to 100 days
Restrictions	
Preexisting Conditions	Six months
Benefit Eligibility[b]	Medical Necessity only (4 out of 15) Medical Necessity or needing assistance in ADLs or cognitive impairment (10 out of 15)
Premiums	
Average Annual Premiums[c]	Range from $477 to $7,675 depending on age of initial purchase and inflation and nonforfeiture features (see Table 1)
Inflation Adjustments	Generally offered in the form of five percent compounded for life or as a periodic upgrade option
a. Based on 15 plans representing 85 percent of the market. b. One company used medical necessity *and* needing assistance with ADLs or cognitive impairment. c. Average premium for plans providing four years coverage at $80 per day for nursing home care and a $40 per visit for home care with a 20 day deductible period. **SOURCE**: HIAA, 1993.	

Figure 3 presents the typical benefits, restrictions, and premium features of the 15 top-selling individual long-term care insurance policies being sold in 1991. The

characteristics of policies offered in 1991 do not necessarily represent the characteristics of policies which have actually been bought, since policy characteristics evolved rapidly throughout the 1980s and purchasers do not always choose all the features offered.

A survey of persons age 55 and older who purchased long-term care insurance in 1990 provides information on the characteristics of policies bought, not just offered.[6] The relevant findings from this survey include:

- Almost all policies (96 percent) covered at least two years of nursing home care, a little over one-half covered five or more years and one-third were lifetime policies.

- The average daily benefit was $72; approximately one-quarter chose less than $60/day; slightly less than one-quarter chose amounts exceeding $90/day; while the remaining one- half chose between $60 and $90 per day.

- Nearly two-thirds brought policies with deductible periods of 20 days or less.

- Less than two out of five purchasers (37 percent) opted to include home health care coverage.[7]

- Forty percent of purchasers chose some form of inflation protection when offered it.[8]

In addition to individual and group association policies, several other types of long-term care insurance coverage or related products are available, including:

- **Employer-Sponsored Plans**: Like group association plans, these are not true group plans but are mostly administrative arrangements by which individual policies are offered to company employees, and sometimes to their spouses and parents. However, in almost all cases, the employee, not the company, pays the full cost of the policy.[9] While rates may be lower because of lower administrative costs and the younger age of purchasers, there is little discounting of rates.

  Medical underwriting of employees is often required prior to purchase (and almost always required for spouses and parents), so that poor risks may be screened out. Policies can generally be taken with employees should they leave the company.

[6] Health Insurance Association of America, "Who Buys Long-term Care Insurance?" prepared by LifePlans, 1992. Information based on a survey of 8,363 purchasers who bought coverage from one of six companies.

[7] All the companies surveyed offered home health coverage.

[8] One company did not offer inflation protection.

[9] HIAA, 1993.

Information from December 1991 for 288 long term care insurance plans offered by employers indicates that almost 2.2 million employees or retirees (plus their eligible family members) had been offered the option to purchase long term care insurance. Of the 2.2 million employees, 72 percent were employees, their spouses, parents or grand parents, while the remaining 28 percent were retirees and their spouses. As of 1991, 202,500 policies had been sold. Eight insurers representing about 70 percent of all employer-sponsored enrollees across 146 plans, report 53 percent were active employees, 18.9 percent were spouses, 1.9 percent were parents or grandparents, 12.1 percent were retirees, and 5.3 percent were retiree's spouses. The average enrollment rate among active employees was 5.3 percent. In 1991, employer-sponsored plans represented nine percent of policies sold. The average age of active workers purchasing such plans was 43, much lower than the average age of persons buying individual policies.

- **Life Insurance Riders**: Life insurance riders provide long-term care coverage which meets National Association of Insurance Commissioners (NAIC) model guidelines through an addition to a life insurance plan.[10] For a small extra premium (generally between five and ten percent of the base premium) these life insurance riders will pay a percentage of the policyholder's death benefit each month that the policyholder needs long-term care. Death benefits are reduced accordingly. These life insurance riders are distinct from accelerated death benefits that advance the death benefit in a lump sum in the event of terminal illness, a specified disease, or nursing home confinement because: (1) they meet NAIC guidelines; (2) payments must be used for long-term care services; and (3) payments cannot be made in a lump sum. Life insurance riders are also only available on level-premium (whole-life) policies, not on term insurance.

  Riders represented less than six percent of all long-term care policies in 1991, up from one percent in 1989. Much of this increase is due to one insurer adding the benefit to all existing life insurance policies. The average age of purchasers was 37 years. The average face value of life insurance policies purchased in 1991 with this type of rider was $60,000. Such a policy would generate $1,200 per month in long-term care benefits for over four years.

Long-Term Care Insurance Prices

The cost of long-term care insurance generally depends on two major factors: (1) the age of the policyholder at initial purchase; and (2) the amount of coverage. Persons who buy policies when they are relatively young pay much less than persons who initially purchase policies at older ages. For example, as shown in Table 1, a policy covering the same benefits costs more than twice as much if purchased at age 65 than if purchased at age 50, and about eight times as much if purchased at age 79 instead of

[10] These regulatory guidelines for long term care insurance are discussed in detail in Section 4.3.4.

age 50. Lower premium costs for younger purchasers reflect both their lower risk of needing long-term care, and the opportunity for premium investments to build up financial reserves over time. Most premiums that are based upon age of initial purchase will not increase over time except if premiums are increased for all policies sold by that company in a State.

The cost of a long-term care policy which covered four years of nursing home care at $80 per day, and home care visits at $40 per visit, with a 20-day deductible, for a purchaser who was 65 years old, averaged $1,103 per year in 1991, or about $91.92 per month. In comparison, the average premium cost of individually purchased Medigap insurance, which about 40 percent of the elderly have, was about $70 per month in 1990, about $25 per month less.[11]

TABLE 1: Average Annual Premiums for Leading 4-Year Nursing Home Policies Paying $80 Per Day[a]

Age at Purchase	Base Plan		Lifetime 5% Compounded Inflation Protection	
	Without Nonforfeiture	With Nonforfeiture	Without Nonforfeiture	With Nonforfeiture
50	$477	$776	$852	$1,252
65	$1,103	$1,690	$1,781	$2,525
79	$3,989	$5,709	$5,627	$7,675

NOTE: Based on data from the 13 of the 15 leading long-term care insurance sellers. Non-forfeiture premium data available for 12 companies.
SOURCE: HIAA, 1993.

Adding inflation protection and nonforfeiture benefits significantly affect the price of long-term care insurance. Inflation protection adds between 40 and 80 percent to the price of long-term care insurance, with the higher increases occurring for younger persons. Nonforfeiture benefits return premiums paid, usually in the form of reduced benefits levels or period of coverage, to purchasers who discontinue paying premiums (lapse). This feature adds between 35 and 65 percent to the cost of policies.
For purchasers in 1990, the average annual premium paid was $1,071; persons age 55 to 64 paid $720, persons age 65 to 74 paid $1,068; and persons age 75 and over paid $1,740. Among these purchasers, one-fifth paid less than $500 annually and one-fifth paid $1,500 or more.[12]

Long-term care insurance prices also vary according to the amount of coverage offered by the policy. Coverage can vary in terms of the types of services covered, the amount of benefit paid for a service, the length of the deductible period, the length of coverage, and whether the policy offers inflation protection. But even examining policies with similar characteristics, one finds that annual premiums vary significantly.

[11] General Accounting Office. Medigap Insurance: Premiums and Regulatory Changes After Repeal of the Medicare Catastrophic Coverage Act and 1988 Lost Ration Data. Statement of Janet Shikles, Director, Health Care Financing and Policy Issues, Human Resources Division before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 13, 1990 (GAO/T-HRD-90-16).

[12] HIAA, 1992.

Using projections of long-term care utilization for the elderly from the Brookings/ICF Long-Term Care Financing Model, researchers from the Brookings Institution estimated the expected premium cost for a number of alternative prototype policies.[13] The estimated premium cost was then compared to some policies with similar characteristics which were currently on the market. As shown in Table 2, annual premiums for policies offering essentially the same benefit package at age 65 to 69 can vary two to three times over, from $587 to $1,604. These price differences could be due to a number of factors, including different estimates of assumed risk and the expected costs of nursing home care, and particularly home care; interest rate assumptions; and assumed lapse rates.

TABLE 2: Comparison of Unindexed Individual Policies (nursing home and home care)

Age Range	Prototype[a]	Amex[b]	SNA[c]	Penn Treaty[d]	PFL[e]	United American[f]
40-44	$217	$153	N/A	N/A	$135	N/A
50-54	324	192	$181	$264	198	$258
60-64	578	441	425	396	423	564
65-69	899	723	587	678	672	828
70-74	1,469	1,137	955	1,098	1,104	1,338
75-79	1,959	2,004	1,676	1,674	1,812	2,382
80-84	2,863	3,315	N/A	3,168	N/A	N/A

SOURCE: Joshua M. Wiener, Katherine M. Harris, and Raymond J. Hanley, Premium Pricing of Prototype Long-Term Care Insurance Policies. (Brookings Institution: Washington, D.C.) December 1990 and Lewin-VHI survey of insurance companies conducted October, 1992. [http://aspe.hhs.gov/daltcp/reports/prempric.htm]

a. $60 per day, 60 day deductible, 4 years of coverage and unindexed. Lapse rate assumptions: 15 percent a year for 3 years, 5 percent a year for 6 years, 2 percent a year for 10 years, and 0 percent thereafter.
b. $60 per day, 100 day deductible, 4 years of coverage, (3 years home care with 20 day deductible) and unindexed indemnity benefit. Policy prices for ages 42, 52, 62, 72, 77, and 82.
c. $60 per day, 90 day deductible, 4 years of coverage and unindexed indemnity benefit. Policy prices for ages 52, 62, 67, 72, and 77.
d. $60 per day, 90 day deductible, 4 years of coverage, (3 years home care coverage) and unindexed indemnity benefit. Policy prices for ages 52, 62, 67, 72, 77, and 82.
e. $60 per day, 100 day deductible (20 day deductible for home care), 4 years of coverage and unindexed indemnity benefit. Policy prices for ages 42, 52, 62, 67, 72, and 77.
f. $60 per day, 100 day deductible, 4 years of coverage, (2 years home care coverage) and unindexed indemnity benefit. Policy prices for ages 52, 62, 67, 72, and 77.

Another point which the Brookings analysis highlights is that comprehensive coverage for long-term care is expensive.[14] For example, a comprehensive policy that covers up to four years of nursing home and home care at an initial indemnity benefit for $60 per day, indexed for inflation on a compound basis, and with a full return of benefits when a purchaser discontinues paying premiums, would have an estimated premium

[13] Wiener, J., Harris, K., and Hanley, R. Premium Pricing of Prototype Long-Term Care Insurance Policies. (Brookings Institution: Washington, D.C.) December 1990. [http://aspe.hhs.gov/daltcp/reports/prempric.htm]

[14] Ibid.

cost of over $60 per month for purchasers between ages of 40 and 44. As the age of the purchaser increases, premiums can rise up to $400 per month for persons between 80 and 84. These analyses show that the exclusion of certain benefits can dramatically lower the cost of private long-term care insurance, making it more affordable to a larger number of elderly households. Purchasers have to decide how to balance the trade-off between depth of coverage and affordability in making the purchasing decision that is best for them.

Growth Trends in Long-Term Care Insurance

In 1988, private long-term care insurance financed only about one percent of all nursing home costs. In recent years, however, the private long-term care insurance market has grown quickly. In 1984, only twelve companies offered long-term care insurance and there were only 50,000 policies in force.[15] In 1991, more than 130 companies were marketing long-term care insurance and the number of policies sold exceeded 2.4 million (Figure 4).

Between 1986 and 1987, there was a substantial increase in the number of long-term care insurance policies sold, when a large number of new companies entered the market. In the same year, the National Association of Insurance Commissioners (NAIC) began recommending regulatory practices specifically for long-term care insurance.

Much of the increase in the number of companies offering long-term care insurance has been the result of individual Blue Cross/Blue Shield plans entering the market. Unlike most of the policies sold by commercial insurers, Blue Cross/Blue Shield policies tend to pay a percentage of charges, up to a specified maximum, rather than paying a fixed amount per day. They also tend to give greater emphasis to linking eligibility for benefits (the insured event) to functional assessments of need (ADLs), rather than a physician's certification of medical necessity. Case managers are often used to conduct functional assessments. In 1989, the average age at initial purchase among Blue Cross/Blue Shield policyholders was 70 years. By the end of 1988, Blue Cross/Blue Shield plans represented about 10 percent of all insurers in the market, but held fewer than one percent of all policies in force.[16]

Long-term care insurance policies have improved considerably over the past five years, largely due to market pressures and the demands of State regulatory agencies. The first generation of long-term care insurance policies often paid benefits under limited circumstances. Faced with uncertainties and lacking actual experience with an insured population, insurers initially protected themselves against induced demand or "moral hazard" by imposing high deductibles, covering only skilled nursing care,

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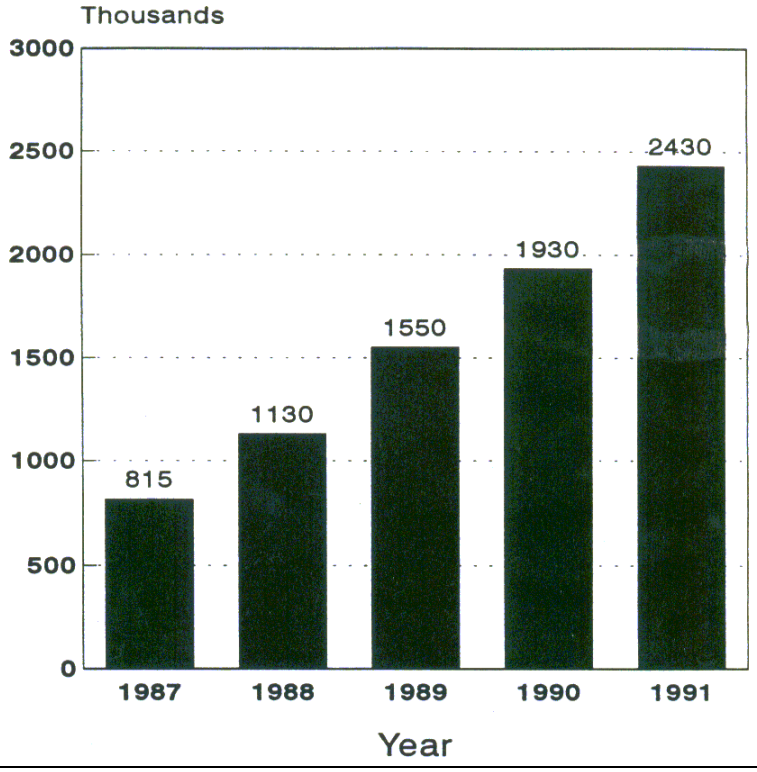
[15] Mark R. Meiners, "The State of the Art in Long-Term Care Insurance," National Center for Health Services Research, July 1983.

[16] Susan Van Gelder and Diane Johnson, "Long Term Care Insurance: A Market Update," Health Insurance Association of America (HIAA), November 1990.

requiring prior hospitalizations before providing nursing home benefits, and only covering home care that followed a nursing home stay.

FIGURE 4: Long-Term Care Policies Sold (1987-1991)



SOURCE: HIAA, 1992

As of December 1991, more than 2.4 million policies had been purchased, a growth in the market of over 500,000 policies in one year. About 100,000 of these policies were existing life insurance policies which added long-term care coverage in 1991. The number of policies sold has grown an average of 31.5 percent annually between 1987 and 1991. Long-term care policies include individual, group association, CCRC, employer-sponsored and accelerated death benefits specifically for long-term care.

To protect against adverse selection, insurers usually screened for health problems, did not sell policies to persons over age 80, and did not provide coverage for preexisting conditions and most mental illnesses. To protect against the general uncertainty of the future, insurers typically offered only fixed indemnity benefits that did not increase with inflation, and often reserved the right to unilaterally cancel policies.[17]

[17] Josh Wiener and Katherine Harris, "High Quality Private Long Term Care Insurance: Can We Get There From Here?" The Brookings Institution: Washington, D.C., May 1989.

The most popular long-term care insurance policies offered today no longer require prior hospitalization or higher levels of care to receive nursing home benefits. Most offer home care benefits, and nearly all offer inflation protection. Some policies even offer a compounded inflation adjustment for a fixed premium. Although these changes have improved the quality of the products on the market, they have also increased prices.

OTHER PRIVATE FINANCING MECHANISMS

Other emerging private financing mechanisms for long-term care include: life-care oriented arrangements, Social Health Maintenance Organizations (SHMOs), accelerated life insurance benefits, and vehicles to tap home equity.

Continuing Care Retirement Communities (CCRCs)

A growing number of elderly persons are electing to spend their last years of life in Continuing Care Retirement Communities (CCRCs). Most Continuing Care Retirement Communities combine supported housing (housing plus services) with a risk pooling feature for long-term care services. In CCRCs, the buyer usually pays a one-time entry fee and monthly charges to live in a closed community setting which offers independent housing supplemented by on-site medical care, supportive services such as housekeeping and meals, and nursing home care. CCRCs are distinguished from other housing options for senior citizens (such as rental units, assisted living facilities, or nursing homes) by the offer of a long term contract that provides a residence, supportive services, and guaranteed access to nursing care--a continuum of care. Many CCRCs offer long-term care benefits financed by risk pools that are created from entrance fees and monthly charges, although the amount of long-term care coverage varies from CCRC to CCRC. Other CCRCs do not offer any risk pooling for long-term care, but rather provide long-term care services on a fee-for-service basis.

In 1989, there were about 800 CCRCs in operation. There are three basic types of CCRCs, distinguished by the amount of long-term care coverage provided in the resident's contract. A 1988-89 survey of CCRCs by Ernst and Young for the American Association of Homes for the Aging (AAHA) estimated that:[18]

- About one-third of CCRCs offered extensive continuing care contracts that make available long term nursing care, fully paid through monthly fees (i.e., the community is obligated to provide care at no extra cost beyond the resident's monthly fee);

- A little over one-fourth offered modified continuing care contracts in which a specified amount of long term nursing care in each year or during a resident's lifetime is provided for little or no substantial increase in monthly payments. After the specified amount of nursing care (usually fewer than 15 days) is used, residents pay the full per diem rates for nursing care required, or, in some cases, a discounted per diem rate; and

[18] American Association of Homes for the Aging and Ernest and Young. Continuing Care Retirement Communities: An Industry in Action. Analysis and Developing Trends 1989, 1989.

- Nearly two-fifths (38 percent) of CCRCs offered fee-for-service continuing care contracts that included emergency and short-term nursing care, but guaranteed access to long term nursing care only at full per diem nursing care rates. This last type of CCRC arrangement for nursing care is not a true risk pooling mechanism because the users of nursing care are at full risk for its cost.

Entrance and maintenance fees for CCRCs vary depending upon the level of services and the size of the residential unit. In 1988, entrance fees ranged from an average of $38,000 for CCRCs which only guaranteed access to nursing care to an average of $109,000 for CCRCs with extensive nursing care contracts. According to the AAHA-Ernst and Young survey, the median entry fee was $47,500 in 1988. Monthly fees ranged between $600 and $1,600. Couples are generally charged an additional fee.

A recent trend in the CCRC market has been away from risk pooling financing approaches. This is partly to avoid the insolvency problems experienced by some CCRCs in the late 1970s and early 1980s because of poor actuarial estimates of long-term care utilization. Thus, many CCRCs are abandoning their long-term care insurance components and are simply providing long-term care services on a fee-for-service basis.[19]

Another trend has been for CCRCs to separately contract with a private insurer to provide long-term care coverage for its residents. In this manner, CCRCs delegate the actuarial risk for future long-term care utilization among their residents to a third-party, protecting their own financial position. As of December 1991, 170 CCRCs reportedly had contracts with commercial insurers. The average age of residents buying a long term care plan was 79 years. In these situations where coverage is optional, between 5 and 50 percent of CCRC residents had elected coverage.

Most CCRC residents are over the age of 75; the average age is 81. The majority of residents are single (73 percent) and female (76 percent). Most new enrollees to CCRCs are not disabled when they first enter the CCRC, but may require increasing levels of service as they age.

Almost all CCRCs are nonprofit organizations, although more for-profit CCRCs have entered the market in recent years.[20] Many of the new for-profit communities under construction by hotel chains, nursing home operators, and real estate developers are luxury rental and condominium complexes marketed to elderly with high incomes and assets.[21] These communities tend to place the financial obligation and risk of long-term care on the residents themselves.

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[19] T. Lewin, "How Needs and Market for Care Have Changed." New York Times, December 2, 1990.

[20] Consumers Union, "Communities for the Elderly." Consumer Reports (Washington, D.C., February 1990) pp.122-131.

[21] T. Lewin, "How Needs and Market for Care Have Changed."

Approximately 250,000 elderly persons are in CCRCs, less than one percent of the elderly population. The future growth of the CCRC market remains unclear. Although many of the better CCRCs have long waiting lists, others have become insolvent, and the residents of these CCRCs have incurred large financial losses. Also, given the high cost of most CCRCs, it is unlikely they will become a long-term care solution for the majority of elderly persons. However, as with other private financing mechanisms, we are still witnessing the initial phases of a new approach to meeting the elderly's long-term care needs, and we are likely to see continued evolution in the CCRC market over the next decade.

Social Health Maintenance Organizations (SHMOs)

Another risk pooling method for long-term care is provided by four Social Health Maintenance Organizations (SHMOs) which have been in operation since 1985 under a demonstration sponsored by the Health Care Financing Administration (HCFA). These experimental programs are similar to HMOs, except that SHMOs provide and manage long-term care benefits, as well as standard medical services, within their capitated financing structures. SHMOs pool capitation payments from Medicare, Medicaid and member premiums and provide both acute and long-term care to a broad cross-section of the elderly with diverse needs. Key features of SHMOs are:

- the availability of a comprehensive array of acute and chronic, ambulatory, in-home and inpatient services from a single provider organization;

- enrollment of both functionally impaired and non-impaired elderly persons in order to pool long-term care risks and maintain affordable premium payments for members;

- a coordinated case-management system to ensure both the appropriateness and the cost-effectiveness of service use; and

- financing via prepaid capitation payments.[22]

Evaluations of the initial years of the SHMO demonstration showed that the sites generally were not able to keep expenses below revenues, although financial performance generally improved each year.[23] Losses were primarily attributable to high marketing and administrative costs associated with initial start-up, not to excessive service utilization. By 1989, the SHMOs had entered a new phase of tightened management and reduced costs that they hoped would lead to future profitability. As of 1988, about 16,000 persons were enrolled at the four SHMO sites. Monthly premiums

[22] Charlene Harrington and Robert Newcomer, "Social Health Maintenance Organizations as Innovative Models to Control Costs, Generations, XIV(2), Spring 1990.

[23] W. Leutz, J. Malone, M. Kistner, T. O'Bar, J. Ripley and M. Sandhaus, "Financial Performance in the Social Health Maintenance Organization, 1985-1988." Health Care Financing Review Vol.12(1):9-18, Fall 1990.

for enrollees ranged from $25 to $57. Under OBRA 1990, Congress mandated that up to four additional sites be added to the SHMO demonstration program.

The SHMO sites provide less long-term care coverage than most private long-term care insurance policies. Annual chronic-care benefit limits at the four sites ranged from $6,500 to $12,000 per year. In comparison, the average annual cost of nursing home care is in the range of $30,000. Thus, the SHMO capitation plans do not provide financial protection from the costs of extended nursing home stays. In the SHMOs, greater emphasis is placed on home and community-based services, case management, and other utilization control mechanisms which help to reduce nursing home utilization.

Outside the SHMO demonstration, other HMOs have yet to adopt the SHMO financing concept, partly due to general difficulties in the Medicare HMO program. Enrollment of Medicare beneficiaries into HMO plans has been slow for a variety of reasons, including the ongoing debate over the adequacy of Medicare HMO capitation payments. Until more elderly persons enroll in HMO plans in general, HMOs are not likely to expand into the long-term care insurance market, by offering supplemental long-term care coverage for an additional premium cost.[24]

Another capitated demonstration program for long-term care services has been operated by On Lok, a community-based provider of comprehensive care in San Francisco, California, since 1983. On Lok, unlike the SHMO sites, does not operate on a long-term care insurance model because it only enrolls elderly individuals who are already functionally impaired and in need of long-term care. Most clients are Medicaid eligible and On Lok receives a relatively high capitation rate from the California Medicaid program for its enrollees, comparable to the average monthly cost of Medicaid-financed nursing home care. In FY 1989-1990, the monthly Medicaid capitation rate was $1,420, or over $17,000 per year.[25]

The emphasis in the On Lok demonstration is more on controlling per capita long-term care costs through alternative service programs and more efficient service delivery mechanisms, centered around the core service of adult day care. For example, On Lok recipients average much shorter hospital stays than other Medicare beneficiaries in San Francisco. Under OBRA 1986, Congress mandated the replication of the On Lok demonstration, called the Program for All-inclusive Care for the Elderly (PACE). As of January 1991, eight PACE replication sites had been selected by HCFA.

Accelerated Life Insurance Benefits

A very new approach to financing long-term care services is accelerated life insurance benefits. This approach allows elderly persons to convert existing universal or

[24] Jay Greenberg, Long Term Care Group, Natick, Massachusetts, personal communication, January 1991.

[25] M.L. Ansak, "The On Lok Model: Consolidating Care and Financing." Generations Vol.14(2):73-74, Spring 1990.

whole life insurance policies into long-term care coverage through a lump sum payment of accelerated death benefits in the event of a terminal illness, a specific disease, or confinement to a nursing home.

For example, if an elderly person has a life insurance policy that pays $50,000 to a designated beneficiary upon his or her death, an accelerated death benefit allows the policyholder to receive a reduced benefit prior to death to help pay for nursing home care. The benefit is generally reduced by the amount of interest that would otherwise be earned on the cash value of the policy between the accelerated date of payment and the estimated date of death (e.g. one year). Because policyholders merely receive payments that would have otherwise gone to the beneficiary of the policy in the event of death, there is no risk pooling component in this financing approach; it is rather an individual asset accumulation approach.

Recent estimates are that 60 percent of the elderly have some life insurance, the vast majority of which is permanent (i.e. whole life) rather than term coverage. Unfortunately, the value of most of these policies is small: in 1984, 80 percent of the elderly had less than $10,000 worth of coverage, 14 percent had between $10,000 and $25,000, and only six percent had $25,000 or more in life insurance (Table 3).[26]

Many observers believe that because the need for life insurance decreases with age, the current generation of elderly persons has deliberately maintained only small amounts of life insurance, sufficient to cover burial expenses. Future generations may be more motivated to maintain higher amounts of life insurance if they realize that it could be useful in paying for long-term care.

Home Equity Conversion (HEC) Plans

Another potential source of private financing for long-term care is the equity which the elderly have built up in their homes. Although many of the elderly have accumulated significant amounts of home equity, gaining access to that equity without actually selling their homes can be difficult. Many cannot obtain home equity loans because they do not have sufficient income to pay off the loan. In addition, some lenders are more reluctant to extend loans to the elderly because they do not want to risk the negative publicity associated with foreclosing a loan on an elderly borrower, should that be necessary.

Home equity conversion plans--also known as reverse mortgages--enable elderly homeowners to tap their home equity without principal or interest payments until the house is sold, often after death. There are generally two types of reverse mortgages: (1) fixed-term loans which generally make payments from 5 to 15 years; and (2) open-ended loans which make payments until death, institutionalization, or the resident moves out of the house. Thus, if one spouse of an elderly couple entered a nursing

[26] Lewin-ICF estimates based on an analysis of SIPP data.

home, a reverse mortgage could be used to pay for nursing home care for months or years. Then, later on, when the house was sold, the loan would be paid back, along with accumulated interest.

TABLE 3: Distribution of Elderly Person by the Face Value of Life Insurance Held in 1984	
Percent of Elderly Persons with Life Insurance	63%
Of Elderly Person with Life Insurance, the Percent with face value of:	
Less than $10,000	80%
$10,000 to $24,999	14%
$25,000 or more	6%
SOURCE: Lewin-ICF tabulation of Wave 4 of the 1984 Survey of Income and Program Participation Program (SIPP).	

While home equity conversion plans have existed since the 1970s, only about 500 had been made as of 1985. Between 1985 and 1990, the number of home equity conversions grew considerably. By 1990, at least 75 HEC programs were in existence covering some 38 States, and approximately 5,000 reverse mortgages had been written.[27] Although most of this growth took place in the private sector, about one third of existing reverse mortgages have been sponsored by public and foundation programs.

TABLE 4: Distribution of Elderly Person by Family Income and Home Equity (in 1990 dollars)					
Annual Family Income	**Home Equity**				
	None	**$1 - $24,999**	**$25,000 - $49,999**	**$50,000**	**Total**
<$10,000	43%	21%	23%	13%	100%
$10,000 - $29,999	19%	12%	30%	39%	100%
$30,000+	11%	4%	18%	67%	100%
Total	25%	14%	26%	35%	100%
SOURCE: Lewin/ICF estimates based on the 1984 SIPP.					

One attractive feature of HEC plans is that they are available to many elderly persons with relatively low incomes. Many elderly persons have low incomes and few financial assets, but relatively large amounts of home equity. For example, as shown in Table 4, 36 percent of the elderly with annual incomes below $10,000 have $25,000 or more in home equity. In existing HEC plans, the typical borrower is a 75-77 year old single female living alone with an annual income between $8,000 and $11,000.

Although there has been growth in HEC vehicles over the past five years, participation in HEC plans is still low. One factor affecting consumer demand for HEC plans is that many elderly are reluctant to place their homes at risk. Many of today's elderly grew up during the Depression, when many homes were lost due to failed institutions.

[27] James Firman, Kenneth Scholen and Bronwyn Belling: "Home Equity Conversion Loans for Low-Income Seniors; An Analysis of Recent Developments," United Seniors Health Cooperative, February 1990.

Another factor is that, in most States, the home remains a protected asset under Medicaid. Thus, most elderly persons can qualify for Medicaid long-term care coverage without having to tap their home equity. Rather than use their home equity to pay for long-term care, they can keep these assets while on Medicaid, and then pass them on to their children in their estates.

BARRIERS TO THE GROWTH OF PRIVATE FINANCING METHODS

While there has been considerable growth in private financing mechanisms for long-term care in recent years, less than five percent of the elderly have used one or more of these mechanisms to protect themselves from the financial risk of long-term care. Why is this so? Affordability is clearly not the only issue, for most analysts estimate that between 10 and 40 percent of the elderly could afford to purchase long-term care insurance.

This section discusses the potential barriers to private financing methods. These barriers can be divided into two categories: (1) demand factors; and (2) supply factors (Figure 5). Most barriers are associated with all of the emerging forms of private financing, and many of the potential barriers could be eliminated or reduced through public and private sector strategies.[28]

Barriers Facing Potential Consumers

The decision to protect oneself against the risk of needing long-term care services is a personal one. Some persons are highly risk averse and will spend large amounts of money to protect themselves. Out of fear, they may buy products of low value, or more protection than they need, or duplicative protection. At the other extreme, some persons refuse to entertain the possibility that they will become disabled and need long-term care, particularly in a nursing home. These individuals would probably not buy insurance or enroll in a CCRC, regardless of the product's value.

The vast majority of the elderly, however, lie between these two extremes. For them, the basic decision of whether to buy protection relates to their perceived value of the product, its *price*, and whether they can afford it. Is this insurance policy worth the premium cost? Will it really cover the long-term care services I am going to need? Can I afford to buy it, given my other expenses? Is this CCRC the right place for me to spend the remaining years of my life?

[28] See ICF Incroporated, "Private Financing of Long Term Care: Current Methods and Resources," submitted to the Office of the Assistant Secretary for Planning and Evaluation, DHHS, January 1985. [http://aspe.hhs.gov/daltcp/reports/prvfines.htm]

FIGURE 5: Barriers to Private Financing	
Consumer Demand Barriers	**Supply Barriers**
• Lack of Information/Misperceptions of Consumers • Delayed Preparation for Long Term Care Needs • Affordability • Inability to Use Resources • Uncertain Value of Products • Misleading Marketing Practices	• Lack of Data for Pricing the Risk • Uncertainty of Tax Status • Lack of a Developed Group Market to Lower Costs • Inconsistent Regulations Across States
Barriers Unique to Long Term Care Insurance	
• Complexity of the Product and Lack of Standard Terminology • Rapidly Changing Product Lines • Lack of Clarity of Benefit Triggers/Premium Increase Provisions • Long Lag Time Between Purchase and Benefit Payment	

The market for private financing products is still maturing and there are many reasons why consumers may not be buying them. Some of these are discussed below:

Misperceptions About the Risks of Long-Term Care and/or Public Coverage

Many elderly persons underestimate their risk of needing long-term care. They do not realize that two out of five individuals turning age 65 in 1990 will enter a nursing home before they die, and about one in five will be in a nursing home for a year or more.[29]

Many elderly persons also mistakenly believe that Medicare or Medigap policies will cover the cost of a nursing home stay.[30] Medicare only covers short-term post acute-care stays. Others do not understand that they must spend nearly all of their income and assets before they can qualify for Medicaid assistance, and that even after they qualify for Medicaid, they must still contribute nearly all their income toward the cost of their care.

Delayed Planning for Long-Term Care Needs

Many people do not think about preparing for their future long-term care needs until they are too old to purchase affordable insurance, too old to start saving, or too disabled to gain access to risk pools. Most companies do not sell insurance to persons over age 84 (if they did, the price would be close to the cost of nursing home care itself).

Except for the very wealthy, preparing for long-term care requires saving for the future. Current income must be reduced to protect against future financial risks (i.e. being disabled and needing formal care). It is difficult enough for people to plan for

[29] On the other hand, it can be legitimately argued that some persons may correctly perceive that their own risk for needing formal long-term care is less than average, for example, if they have many family and friends who are available and willing to care for them at home.

[30] R.L. Associates, The American Public Views Long-Term Care. A survey conducted for AARP and the Villers Foundation (Princeton, N.J., October 1987) p.7 and HIAA, "Who Buys Long-Term Care Insurance?" p.25.

retirement, but even more difficult to plan for events that will probably not occur until one reaches the age of 80 or 85. Many elderly persons do not realize their need to plan for long-term care until an illness or disabling condition forces them to, by which time they have become an uninsurable risk.

Consumer Confusion About Products

Few people will buy products they do not understand. Many private financing mechanisms, such as long-term care insurance, are legal contracts that can be quite complicated regarding what services are covered under what circumstances and at what payment rate. Unlike health insurance, potential buyers do not have a sophisticated sponsor (e.g. an employer, the Medicare program) to buy it for them. Each product is different, may use different technical terms, or terms that the potential consumer does not even understand. Consumers may be uncertain how particular products compare with each other.

Many policies contain vague language that makes it unclear under what conditions benefits will be paid and under what circumstances premiums may increase.[31] For example, some policies state that benefits will be paid for a "medical necessity" with no explanation of what constitutes a medical necessity. Other policies that trigger benefits based upon the policyholder's disability status do not explain how disability will be determined and who will make the determination. Also, policies offering "level premiums" that are "guaranteed renewable" still may have increased premiums as long as premiums are increased for all purchasers in a category.

Long-term care insurance products are changing rapidly in response to consumer demand. The policies offered in 1991 differ considerably from those offered before 1987. Many elderly persons may be aware that the private insurance market is evolving and are waiting until the market matures before buying a policy. Also, persons who have already bought policies may be confused about whether it would be prudent to up-grade their current policy to a better product, even though they would be subject to underwriting provisions again and a higher age-rated premium cost.

Affordability

Many elderly cannot afford long-term care insurance premiums that average almost $100 per month at age 65, or the entry and maintenance fees of CCRCs. Many elderly persons may believe that it is more important to use their available income to buy Medigap insurance instead of long-term care insurance. One advantage of Medigap insurance is that it provides immediate benefits in the same year in which it is purchased, rather than delayed benefits in the distant future. In the future, the increased financial resources of the elderly, along with increased opportunities to purchase insurance at earlier ages should expand the market for private financing mechanisms.

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[31] James Firman, "Consumer Concerns with the Evolving Market for Private Long Term Care Insurance," Testimony before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce; May 3, 1990.

Inability to Use Resources

Individuals may have adequate financial resources but are unable to use them to pay for long-term care. For example, working-aged persons are unable to use their vested pension assets to buy insurance; most elderly persons are unable to tap into the equity of their homes; and most non-elderly persons are unable to use their group purchasing power through their employer to obtain long-term care insurance.

Uncertain Value of Products

In addition to being confused about private financing products, many consumers may have an underlying lack of confidence in the insurance industry in general. In addition to having confidence in the product, they must have confidence in the insurer. In this regard, reliable insurers offering products of good value are hindered by disreputable companies selling products of poor value.

Many long-term care insurance products are ambiguous in regard to the circumstances under which benefits will be paid (i.e. how exactly will the need for long-term care be determined and who will make the determination?). Indeed, much of the language used in policies gives the impression that insurers have significant leeway to deny payment for filed claims if they choose to. Faced with this uncertainty, buyers must have confidence that submitted claims will be paid when services are needed. This requires both confidence in the integrity of the insurer to pay claims, and in the future financial solvency of the company as a whole. For example, if the insurer has actually underestimated long-term care utilization among its policyholders (and therefore underpriced premium costs) it will not have the financial reserves to pay future claims, regardless of its intentions. Given the immaturity of the private long-term care insurance market, there is no industry track record on which potential consumers can base their trust.

Misleading Marketing Practices

In some cases, dishonest and/or ignorant insurance agents, or disreputable insurance companies or CCRC representatives, may employ fraudulent or misleading marketing practices. Congressional hearings and investigations by consumer groups have revealed problems with the marketing, sale, and payment of benefits of long-term care insurance.[32] Media reports of fraudulent marketing practices, denial of claims, premium increases, and policy cancellations have raised many elderly individuals' fears of being the targets of consumer abuse. Although these practices may be few and far between, consumers must have confidence that adequate regulatory mechanisms are in place to protect them from fraudulent suppliers in the marketplace.

[32] Hearings on the Regulation and Sale of Long Term Care Insurance, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, May 2, 1990.

Barriers Facing Suppliers

In addition to factors which inhibit potential consumers from buying products, other factors are inhibiting suppliers from entering the market, increasing market penetration, and improving their products. These include:

Lack of Data for Pricing the Risk of Long-Term Care Use

In order to price their products correctly, insurers (and CCRCs) must be able to estimate future long-term care utilization rates by those who are buying the products (policyholders). Since private insurance and CCRCs are relatively new products, insurers cannot examine historical claims experience to predict future utilization rates. Without data to accurately predict future long-term care use among their policyholders, insurers risk the possibility of not having sufficient financial reserves to pay future claims. A number of CCRCs have gone bankrupt precisely for this reason.

Medicaid is the largest long-term care insurance program currently in operation, and therefore Medicaid data provide the best source of information for estimating long-term care use among the elderly. However, Medicaid insurance for long-term care differs significantly from private insurance coverage. The insured population is vastly different (Medicaid recipients are poor), low Medicaid payment rates in many States may limit access to services, and high Medicaid co-payment requirements (i.e. all income except $30 per month) may reduce utilization rates. Nursing home utilization rates among a privately insured population are likely to be different from the rates observed in the Medicaid insured population.

Of particular concern to insurers is whether nursing home use will increase dramatically as a result of insurance coverage (moral hazard), and whether persons who buy long-term care insurance or enter CCRCs are more likely to use long-term care services than those who do not (adverse selection).[33]

The lack of good data for developing actuarial estimates is compounded by the fact that both CCRCs and long-term care insurance companies enter into long term agreements with residents and policyholders. There are significant uncertainties associated with pricing products which may not be used for 30 years. Over this time horizon, small differences in mortality, interest rates, disability rates, or the availability of nursing home beds can make a large difference in the number and amount of benefits that will have to be provided. This uncertainty has led some insurers to limit their risk by obscuring the events which trigger benefits (ambiguously defining the "insured event" as previously discussed) or by employing conservative underwriting practices (to protect against adverse selection).

[33] Theresa Fama and David L. Kennell. "Should We Worry About Induced Demand for Long Term Care Services?" Generations Vol.14(2):37-41, Spring 1990.

Uncertainty of Tax Status

The uncertain tax status of accelerated life insurance payments and long-term care insurance benefits has prevented some insurers from entering the market. At present, it is not clear whether benefits paid out prior to death under an accelerated life insurance rider will receive the same preferential tax treatment that death benefits currently receive. Insurers and employers are also reluctant to widely offer long-term care insurance in a group market, largely because of the uncertainty of the tax laws concerning long-term care insurance reserves and the deductibility of premiums. Insurers would like the IRS or Congress to clarify the treatment of long-term care insurance so that it is treated more like other accident and health insurance products.

The Lack of a Developed Group Market to Lower Costs

Insurance companies have large group markets for health insurance, disability insurance, and life insurance. Large group markets, particularly employee-based groups, substantially reduce marketing and overhead costs. Group markets also spread risks over larger populations, thereby reducing the possibility of adverse selection.

Long-term care insurance currently does not have the advantage of having large group markets to market to; the great majority of policies are sold on an individual basis. In 1991, employers offered long-term care insurance to almost two million employees, spouses, retirees, and parents of employees, where the purchaser was responsible for the full cost of the policy. To date, 200,000 policies have been sold representing only nine percent of all policies.[34]

The Lack of Consistent Regulation Across States

The regulation of insurance and CCRCs is primarily a State responsibility. As a result, the requirements that must be met by companies offering long-term care insurance or wishing to establish CCRCs vary from State to State. This situation can make it more costly for companies to expand their market because often different products must be designed to meet the specific regulatory requirements of each State. Some companies may decline altogether to enter a particular State if they believe that regulatory requirements are so stringent that the market cannot be made profitable. Alternatively, stringent regulation in some States may limit product availability to only the highest-priced products, limiting the size of the market, and reducing opportunities for middle-class elderly persons to purchase less expensive products that still offer good value.

[34] HIAA, 1993.

Regulation of Private Long-Term Care Insurance

As with other insurance products, States are responsible for the regulation and monitoring of long-term care insurance. There are three primary areas of State regulation:

- Prior approval of policies to be marketed, based on criteria of policy readability, standardization of policy terms, and minimum benefit requirements;

- Monitoring marketing and business practices to protect consumers from unfair or deceptive acts under unfair trade practice regulations; and

- Premium rate review and efforts to ensure solvency of companies selling policies.

State legislatures have considerable leeway in establishing minimum standards for benefit plans, financial reserves, solvency, loss ratios, cancellation of policies, and other regulatory requirements. Because long-term care insurance is a relatively new product, there is little uniformity in its regulation across States. Insurers, therefore, must tailor their products to the regulatory provisions of each State.

Most States have based their regulation of long-term care insurance on model standards developed by the National Association of Insurance Commissioners (NAIC). In 1986, the NAIC, in conjunction with the Department of Health and Human Services (DHHS) and insurance representatives, developed a model act, which outlines recommended minimum requirements for long-term care insurance in legislative language. In 1987, this was followed by model regulation, which spelled out in greater detail the provisions of the model act.

The NAIC attempts to balance the need for adequate consumer protection with the need to encourage flexibility and innovation in the development of a new market.[35] To some extent, it is reasonable for the market, rather than regulators, to determine what is a good product. At the same time, consumers must be protected from clearly inferior products and fraudulent marketing of inferior products.

In the last few years, the NAIC has reviewed the model act and regulation about every six months, and several revisions have subsequently been issued. States do not always amend their own legislation or regulation as often as the NAIC updates the model act because State adherence to the NAIC model legislation is voluntary. Also, some States only partially adopt the NAIC guidelines. Therefore, even in States that have adopted "the NAIC model act," standards may differ from the most recent NAIC model act. The most important standards in the January 1993 NAIC Model act and regulation are presented in Figure 6.

[35] Earl Pomeroy (President of the National Association of Insurance Commissioners), testimony before the subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, May 2, 1990.

Before the development of the NAIC model act, only a few States had specifically regulated long-term care insurance. By 1992, 49 States had statutes and/or regulations governing long-term care insurance, and 44 of these had adopted some form of the NAIC model act or regulation. However, as of November 1992, most States did not have legislation or regulation in place that conformed to the most recent revisions of the NAIC model act and regulations, although some lag between approval of model standards by the NAIC and State adoption of the standards is to be expected. For example, only Utah and Michigan had prohibited attained age rating for long-term care insurance.

Information on the number of policies currently in force which meet current NAIC standards is not available. In general, the top-selling policies currently offered meet the most recent NAIC standards. Most of the major companies in the long-term care insurance market--those companies marketing the 15 top-selling products and which account for 80 percent of all policies sold--market on a national basis. In general, these companies design a product that adheres to NAIC standards and then alter the product on a State-specific basis to conform to particular State provisions, which may be more or less stringent than NAIC standards.

The NAIC currently is considering two issues related to long term care insurance: 1) mandating nonforfeiture benefits; and 2) premium stabilization. Mandating nonforfeiture benefits would ensure that purchasers who discontinued paying premiums their policy (lapsed) would receive some of their prefunded premiums. As indicated earlier, it would also probably increase premiums between 35 and 65 percent. Premium stabilization is an effort on the part of regulators to encourage companies to accurately price their products. The main methods of stabilizing premiums are not permitting premiums to increase more than a specified percentage and establishing improved criteria for regulators to evaluate rate requests.

Although States may adopt the NAIC model act and model regulations for governing the sale of private long-term care insurance, this is no assurance that regulatory requirements are actually enforced. In a Congressional investigation in 1991, the insurance departments of all 50 States were contacted about their efforts to enforce long-term care insurance regulation. The investigation's findings were that "the majority appear to know little about what is going on in their States...and although they rely heavily on complaints to monitor companies selling long-term care insurance, few have organized complaint gathering systems. Regulators lack clear actuarial standards and centralized data on companies and agents."[36] The Subcommittee felt State insurance departments are "understaffed and under-informed, and their ability to resolve problems and willingness to reach out-of-State offenders is distinctly limited."[37]

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[36] Representative John D. Dingell, Chairman of the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives. Introduction to hearing on long term care insurance, May 2, 1990.

[37] Ibid.

FIGURE 6: Key Long Term Care Insurance Provisions in the NAIC Model Act and Regulations (January 1993)

Prior Approval of Policies

- Preexisting condition exclusion periods of longer than six months are prohibited.
- Policies may not exclude or limit benefits for persons with Alzheimer's Disease.
- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Policies may not make nursing home or home care benefits contingent on a prior hospital stay.
- Conditioning eligibility for benefits provided in an institutional care setting on the receipts of a higher level of institutional care ("step down") is prohibited.
- Minimum standards for home health care benefits are prescribed if a policy provides home health care services (home health care services are distinct form post-confinement home health benefits), including prohibitions against tying benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
- Individual policies must be guaranteed renewable--which means that policies may not be individually canceled due to the age or diminishing health status of the insured--or noncancellable--which means that premiums will be level unless the inflation protection feature permits increases. Group products must provide for continuation or conversion of coverage.

Monitoring Marketing and Business Practice

- Purchasers have a 30 day "free-look" period during which they may return the policy for a full refund.
- Purchasers must be *offered* the opportunity to purchase a product with inflation protection compounded annually at a minimum of five percent and must sign a statement rejecting inflation protection.
- Post-claims underwriting (checking a policy holder's medical history only after a claim is filed, instead of when the application is taken) is limited by denying payment based on technicalities or omission of information that was not requested on the application.
- A "Shoppers Guide" approved by NAIC must be delivered to applicants.
- Agents must make an effort to determine the appropriateness of a policy.
- Insurers and agents must adhere to fair marketing standards and prohibitions against twisting (knowingly misrepresenting or fraudulently comparing insurance policies or insurers to convert an existing policy or initiate a new policy), high pressure sales tactics, and cold lead advertising (marketing which is not represented as a solicitation) or face monetary penalties.
- Companies must report recisions and lapses. Companies must also file advertising materials and out-of-state group policies.

Premium Rate Control and Solvency Requirements

- Companies are required to have reserves and to meet an expected premium-to-loss ratio of at least 60 percent for individual and group policies.
- Attained age or duration rating is prohibited.

CONCLUSIONS

In recent years, a growing number of private financing mechanisms for protecting elderly persons from the potentially high costs of long-term care have emerged. These mechanisms include private long-term care insurance, CCRCs, SHMOs, home equity conversion plans, accelerated life insurance benefits, and others. Presently, we are still in the initial phases of market development of these products, and both the products and the market are changing rapidly.

This section has discussed both demand and supply factors which serve as barriers to the continued growth of the private financing market. Some of these barriers, such as lack of consumer awareness and the lack of data for developing sound actuarial estimates, will be mitigated over time, with or without policy interventions. However, other barriers, such as the uncertain tax status of private long-term care insurance, and the absence of an adequate regulatory environment, may require new public initiatives at both the Federal and State levels. There are a variety of public policy initiatives in the areas of consumer education, market regulations, tax policy, data base development, and long-term care research that would help to ensure the future viability and growth of private financing methods.