Long-Term Services & Supports Feasibility Policy Note

Financing Long-Term Care: Can't We Just Do It with Insurance?

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This policy note raises questions about the accessibility and dependability of private long-term care insurance as Hawai'i families are forced to find resources to pay for long-term services and supports (LTSS). It explores how Hawai'i pays for long-term care. We start with some informal estimates of the way long-term care costs are covered by the most common payers in the community in the near term—now, or a year or two hence. These include Medicare, Medicaid, private long-term care insurance (LTCI) and families. Then we will follow the expenditure patterns for long-term care services over a much longer period of time, using the Urban Institute's Dynasim microsimulation model.

1. Results from the Hawai'i Urban Institute Long Term Care Financing Simulation Model

The Urban Institute model ages a population about whom we have very detailed knowledge and estimates the effects of randomly assigning life-events (health, disability, and so forth) to each person. Some population members will die early, some later. Some will become disabled, some will not. Some will be financially healthy, others not so.

The Urban Institute national model has been adjusted and re-weighted to reflect Hawai'i's population[1].

[1] Population–based micro-simulation models are generally weighted for the policy population to which they will be applied. In this re-weighting procedure, the age/sex population profile of the target state are used to set weighting parameters. In the instance of Hawaii and most states other than New York and California, ethnic breakdowns cannot be used reliably because the final numbers in the sample are small and produce unstable estimates. The weighting parameters adjust the mix of cases in the underlying base samples so that they reflect the target state in age distribution, gender, work status and similar population features. The adjustments are always done on the largest suitable set of population samples. In almost all cases, samples with the complexity and detail needed to simulate policies many years hence are from nationally funded, population encompassing data gathering projects. Projects of this sort include the Department of Health and Human Services *National Nursing Home Survey* (several years), Census *Public Use Micro-samples (PUMS)*, *the American Community Survey*, the *Survey of Income and Program Participation*, the Federal Reserve Board's *Survey of Consumer Finance*, the

The life expectancies of the cases in the model have been adjusted to life expectancies for Hawai‘i. Nursing home and other residential care options have been adjusted to reflect the supply of facilities in Hawai‘i.

The Urban Institute's model is a "microsimulation." It works by assigning life events to individual members of a large sample. The initial sample was drawn from the University of Michigan's *Health and Retirement Survey.* This national survey has been repeated as a panel study every two years for thirteen cycles on the initial sample of adult Americans approaching retirement age. As the members of the panel grow older and die, additional cohorts have been added to the study. The oldest cohort started in the panel in 1992. Because the survey captures people at a variety of ages, it is possible to project events for each person, according to the likelihood that he or she will experience an event. Becoming disabled so as to require assistance with an Activity of Daily Living (ADL) might be one such event. We know that some people become disabled every year, but the number is really very small. Estimating that number is easy—just multiply the number of people at each age by the risk of becoming disabled. Beyond that, though, simple averages won't predict who needs care, how much they are likely to need, the supports and funds available for them or any other condition of the support needed or supplied. Subsequent events (increased disability, recovery from an injury, receipt of a benefit) are conditional on the first event. To make matters more complex, medical and social benefit programs are *rule based*. That is, the award of a benefit (Medicare paying for a nursing home or other institutional stay) after hospitalization for a serious injury follows a well-defined set of rules. Thus, to see how a person benefits from a public program, his or her conditions must be tested against the program rules. The microsimulation model does that effectively.

The microsimulation allows us to trace the condition of a sample person after a sequence of events (retirement, injury, disability) and assign treatments or benefits based on the rules of a specific program. We can do this for each of the available social programs that speak to the issue at hand — and for us this is providing services and supports for frail elders to assist with ADLs. Using the microsimulation model, we can tally the number of people with different levels of disabilities over time, and the care they are likely to need as time goes on. And of course, if we can tally the time, we can also produce stable estimates of total costs for our community as the model is run many times to reflect the aging of the population.

2. Organization

First, we will review the way Long-Term Services and Supports are paid now without substantial policy changes or new initiatives. This will be an overall picture, including future projections. Next, we will comment briefly on the limits of Medicare funding for LTC and examine the distribution of Medicaid LTSS across the population. Both of these presentations rely on applying the rules of the two federal programs to determine the benefits paid for each simulation year. We will look briefly at who received the benefits using the Medicaid rules.

The next topic will be the role of private LTC). We'll want to know who has it, who has kept it through

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University of Michigan *Panel Study of Income Dynamics (PSIDF)*, the Bureau of Labor Statistics' *Survey of Consumer Expenditures*, and the University of Michigan *Health and Retirement Study*.

the age at which they might need it, and who received the benefits when the time comes to pay for services.

The final segment will look at the effects of a proposed social insurance program to help Hawai'i residents cover basic costs of care when they become frail in terms of managing their activities of daily living.

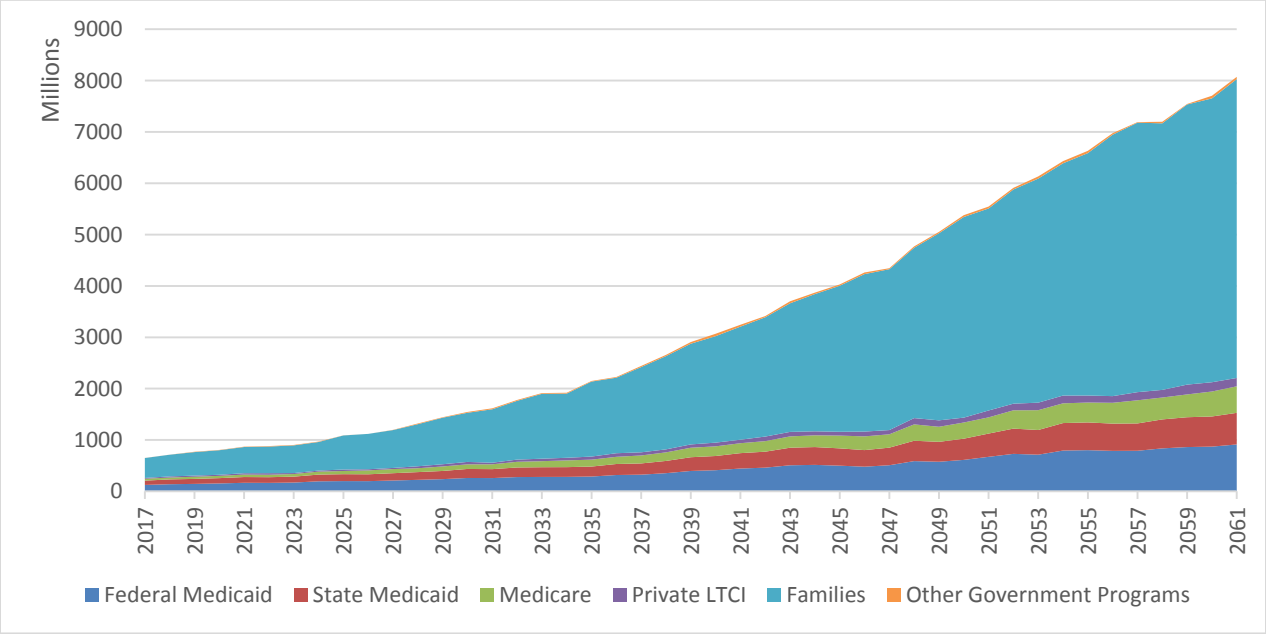
3. Who is paying for Long-Term Services and Supports (Long-Term Care)?

Short answer: we all are — whether we have loved-ones receiving care or not. Of course when we have a family member receiving care, we are contributing time, money and good counsel. When we do not have a family member receiving care, we support the public and private programs that eventually provide care. To paint this picture, we'll want to turn to a graph of the major components of care being paid now, and likely to be paid in the future (Figure 1). There are two major components of care—care in nursing homes or other institutions, and care received at home or in the community. We will illustrate the distribution of costs of nursing home or institutional care versus care at home.

3.1. Nursing Home and Institutional Care[2]

Three things are prominent in the projection of nursing home charges under current law: (1) Families pay the largest portion of care; (2) Medicare and Medicaid pays only a small portion of LTC costs compared to payments by families; and (3) Private LTCI pays a very tiny share of total costs.

Figure 1. Projected Nursing Home Charges under Current Law

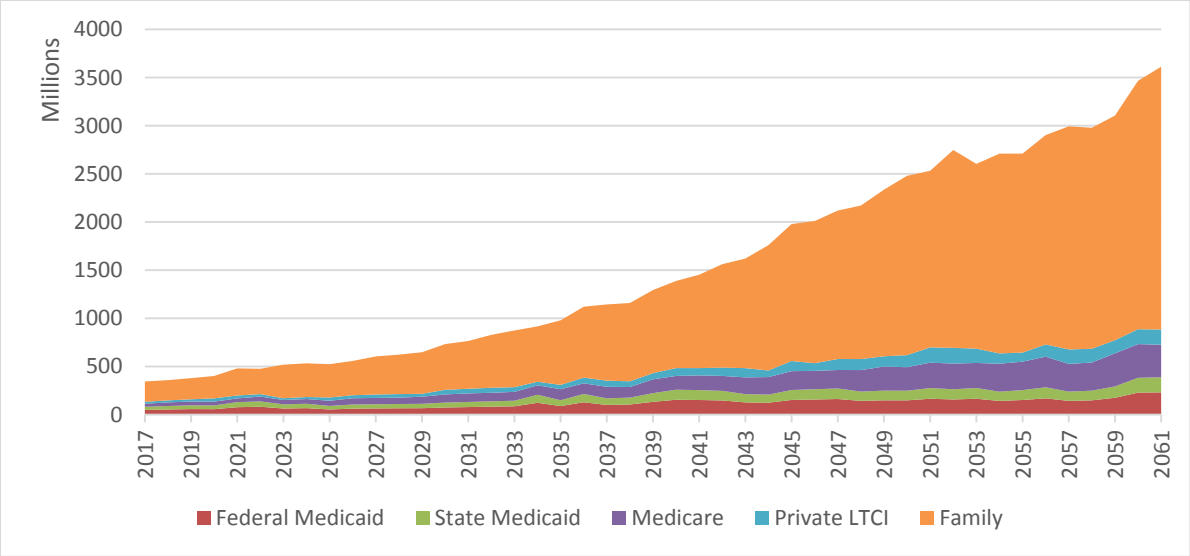


[2] Urban Institute Dynasim model run by Lawrence Nitz in July, 2015. This model was based on work done for the State of Hawaii under the supervision of Drs. Richard Johnson and Melissa Faverault in modeling the policy environment for Long-Term Services and Supports policy for the nation and the 50 States. Model File: LTSS_Simulation_HI_918_6_29_2015_lhn1.

3.2. Home and Community Care

Home and community care refers to services received in the patient's home. These are generally not medical or nursing services, but assistance for ADLs. The payment stream for home and community care in Figure 2 above also shows relatively small payments by Medicare and both state and federal Medicaid. Compared to family payments, private LTCI pays a thin sliver of benefits. The bulk of all costs are paid by families.

Figure 2. Projected Home Care Charges under Current Law



3.3. Notes on the Payment Sources: Policy, Practices and Rules

3.3.1. Medicare

The popular belief among many Americans is that Medicare will cover long-term services, such as nursing home care. More to the point is the fact that Medicare's coverage is generally restricted to care that is required to manage a medical issue for no more than 100 days. The Centers for Medicare and Medicaid Services give quite explicit guidance on what care in a nursing facility Medicare may cover[3].

Nursing home care: How often is it covered?

Medicare Part A (Hospital Insurance) may cover care given in a certified skilled nursing facility (SNF) if it's medically necessary for you to have skilled nursing care (like changing sterile dressings). However, most nursing home care is custodial care, like help with bathing or dressing. Medicare doesn't cover custodial care if that's the only care you need.

[3] http://www.medicare.gov/coverage/nursing-home-care.html, accessed on July 29, 2015.

In a similar spirit, Medicare covers health care at home, again under the clear stipulation that the care is a necessary part of medical treatment that has been prescribed by a physician[4].

It is the case that Medicare pays some of the costs associated with frailty for citizens 65 and older, but these costs are clearly marked for medical treatment or rehabilitative services. Even hospice and respite care are still connected to a set of medical issues, rather than custodial needs or assistance for frailty. It is reasonable to anticipate that barring any major change in Medicare policy, it will continue to provide a basis of assistance, but only to allay specific medical problems. Thus, contrary to popular belief, Medicare does not provide what we think of as long-term care for healthy, frail citizens.

Home health services: How often is it covered?

Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) covers eligible home health services like intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational services, and more. Usually, a home health care agency coordinates the services your doctor orders for you.
Medicare doesn't pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services
- Personal care

Who's eligible?

All people with Part A and/or Part B who meet all of these conditions are covered:

- You must be under the care of a doctor, and you must be getting services under a plan of care established and reviewed regularly by a doctor.
- You must need, and a doctor must certify that you need, one or more of these:
    - Intermittent skilled nursing care (other than just drawing blood)
    - Physical therapy, speech-language pathology, or continued occupational therapy services. These services are covered only when the services are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively. To be eligible, either: 1) your condition must be expected to improve in a reasonable and generally-predictable period of time, or 2) you need a skilled therapist to safely and effectively make a maintenance program for your condition, or 3) you need a skilled therapist to safely and effectively do maintenance therapy for your condition.
- The home health agency caring for you must be Medicare-certified.
- You must be homebound, and a doctor must certify that you're homebound.

You're not eligible for the home health benefit if you need more than part-time or "intermittent" skilled nursing care. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.
Note: Home health services may also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment, or injectable osteoporosis drugs.

[4] http://www.medicare.gov/coverage/home-health-services.html, accessed on July 29, 2015.

3.3.2. Medicaid

Initially, Medicaid-covered LTC covers only for stays in a nursing home or similar facility, and only for persons with very limited assets (generally $2,500, excluding the family home and a car)[5]. The bulk of the patient's income was committed to helping cover the cost of care. Exceptions and allowances were made for a spouse living at home. Over time, the states, working with The Center for Medicare and Medicaid Services (CMS), developed "waiver" programs in which assistance could be provided for care at home or in the community for people who were Medicaid qualified. These programs brought about a dramatic expansion of services, particularly in states and communities with limited populations of nursing home and institutional beds available.

The effect of the changes in eligibility categories, particularly those termed "MAGI – Excepted" is that persons eligible for institutional or community LTSS in Hawai'i may not be restricted from Medicaid services on the basis of income alone. Instead, a procedure for post-eligibility assessment of income will establish a cost-share of their income which will be applied to LTC costs. This cost share is based on the individual's income after deducting specific personal allowances and (as appropriate) the costs of maintaining a spouse in the community. While the language of the Hawai'i Med-Quest rules is complex, it is clear that those with more income may make substantial contributions to their cost of care, but may not be shut-out entirely[6].

3.3.3. Long Term Care Insurance

For at least four decades, some have held out the hope that private LTCI would become the financial instrument for savings families from unanticipated catastrophic costs of long-term care. Figures 1 and 2 suggest that it has not done so, and under current conditions is unlikely to become the panacea once expected. We shall examine why this hope has not been delivered in this section.

How many people buy and hold LTCI?

LTCI is typically purchased by people in their 50's or 60's. Some people lapse every year, while others are newly insured. Using a very small lapse rate[7] (1.5% per year) to model the best possible opportunity for maintaining LTCI coverage, we estimate those holding LTCI at the age of 65 to be almost constant, on the order of at most 14% of the population, as illustrated in Figure 3.

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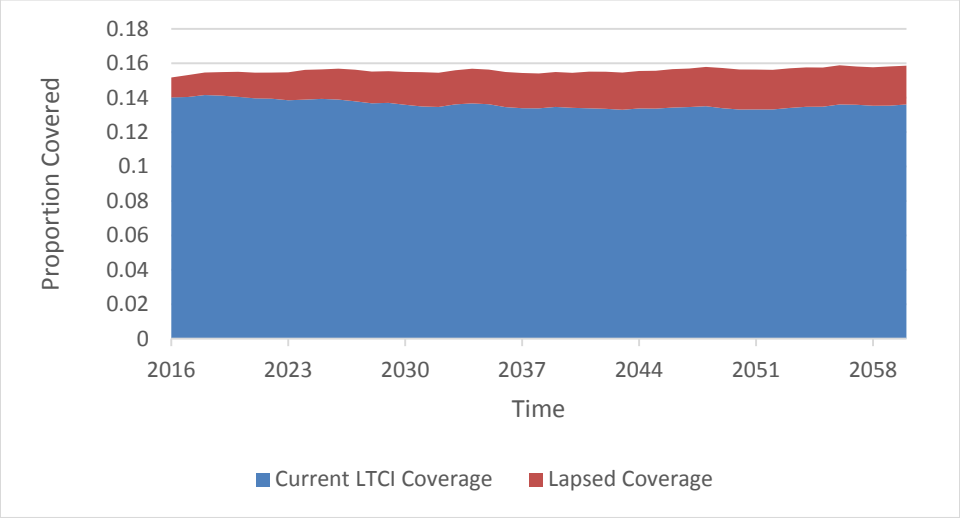
[5]The current asset standards in Hawaii are set out in detail in the Department of Human Services administrative rules: http://humanservices.hawaii.gov/wp-content/uploads/2013/10/HAR-17-1725.1-ASSETS-FOR-MAGI-EXCEPTED-Final-Standard-LB090913-2.pdf, accessed on July 29, 2015.

[6] The income rules are defined in detail in the Department of Human Services administrative rules: http://humanservices.hawaii.gov/wp-content/uploads/2013/10/HAR-17-1724.1-INCOME-FOR-MAGI-EXCEPTED-Final-Standard-LB090913.pdf, accessed on July 6, 2015.

[7] From the 1990s through about 2000, LTC insurers tended to use expected lapse rates of 14% or so the first year, followed by 13% the second year, declining over time. This meant that 14% of the policy buyers would quit payments at the end of the first year, another 13% of those at the end of the second year, and so on. After ten or twelve years, the company would expect only half or less of the initial pool of buyers to be around to eventually claim a benefit. If people do not quit, then the company would have to provide funds to pay befits, should they make claims.

Figure 3. Estimates of LTCI holdings, 2017-2060[8]



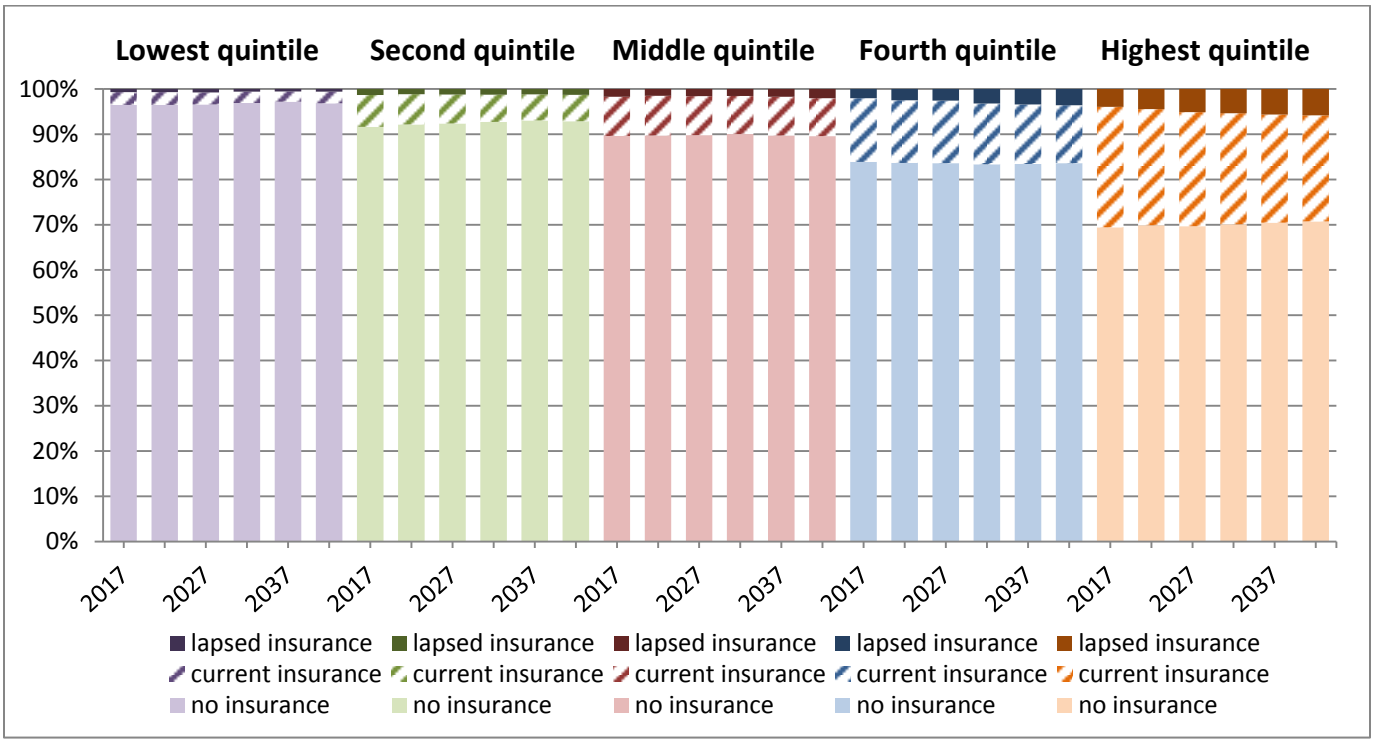
Another way to view this picture is by dividing the population by income. Do all income groups have an equal chance of buying some level of LTCI? Or, is the product concentrated in a particular population segment? Figure 4 illustrates the percentage of the population with no LTCI, with current LTCI at age 65, or with lapsed LTCI.

The sets of bars on the extreme left represent the lowest fifth of the income distribution, the next set the second fifth, and so on. The bars on the far right represent the highest fifth of the income distribution. Two observations emerge here: first, there is very little change over time—the 2042 profile (green) looks just like the 2017 profile (blue); second, only in the fifth quintile—the set of bars to the extreme right, is any substantial portion of the population insured. The lowest 60%of the population by income has minimal LTCI, and the 60th-80th percentile still is only half as likely to be insured as the upper quintile[9].

[8] Urban Institute Dynasim model run by Lawrence Nitz during July, 2015. This model was based on work done for the State of Hawaii under the supervision of Drs. Richard Johnson and Melissa Faverault in modeling the policy environment for Long-Term Services and Supports policy for the nation and the 50 States. Model File: LTSS_Simulation_HI_918_6_29_2015_lhn1

[9] The income quintiles reported in the Urban Institute model change over time—representing larger amounts of money in later years. The current division of income in quintiles for Hawaii is:: ((lowest= -$8200-$25,700) (2nd=$25,701--$49,999) (3rd-$50,000-$77,400) (4th=$77,401-$118,999) (highest=$119,000-$885,000). Computed from the American Community Survey, 2014.

Figure 4. Distribution of LTCI holdings by Hawai'i Income Quintiles.

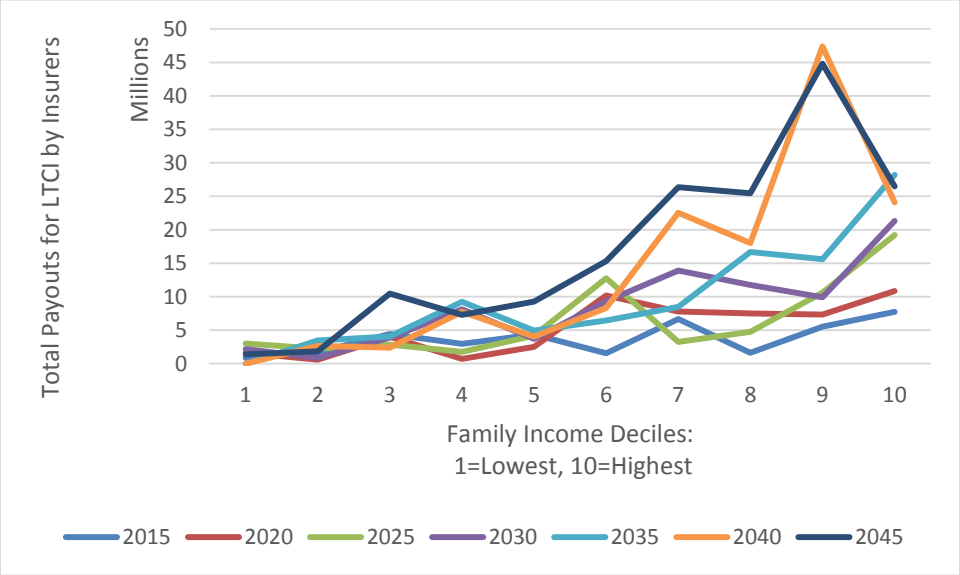


Who is likely to draw the benefits from Private LTCI?

Drawing benefits from a LTCI policy depends on a web of events: (1) someone has to buy a policy while still healthy and free of apparent disability – that is, the buyer must pass the insurer's "underwriting" standards with respect to health and apparent risks; (2) the buyer has to hold this policy until he or she reaches an age at which disabilities might begin to occur; (3) the buyer's disabilities must meet the insurance contract trigger events (for example, needing stand-by assistance in 2 of 5 ADLs or cognitive impairment); and (4) the insurance company must certify that the claim of disability meets the insurance contract requirements.

This chain of events is not simple because it extends over many years — a buyer of LTCI at the age of 60 must, in all likelihood, hold the policy well through the age of 85 — without missing payments. In the current Urban Institute model, we assume a lapse rate of 1% per year. This is exceptionally low, but this means that in the second year of an initial 100 buyers, only 99 will continue holding the policy. At this rate of lapse, in 20 years, only 81 will still be insured. Because the probability of purchasing and holding LTCI varies by income, it is useful to look at the likelihood of benefits by income. Paying benefits mostly to those who have high income raises the question of what benefit the LTCI policy brings to people without such income. Figure 5 illustrates the total payments received by each income decile.

Figure 5. Benefit Payments by Income Decile, 2020 through 2045[10]



Again, as in the graph of purchases, there is more coverage in later years, but the greatest amount of the increment is among people in the 80th to 100th percentiles — the upper one-fifth of the income distribution. Private LTCI appears to provide protection for those in the upper income groups. It is worth asking about those with lower income[11].

Several sets of circumstances complicate LTCI for lower income people. One is the fact that at low enough income and assets, the person qualifies for Medicaid coverage for LTSS. Because care needs typically start well before a person reaches the trigger value of needing help with 2 or more ADLs, family income and assets will be committed before many benefit programs kick in. In an article in *Forbes*, Howard Gleckman of the Urban Institute noted that for many people private LTCI provides coverage already available from Medicaid[12]. Further, according to a Society of Actuaries study[13], it is not apparent why households with less than $25,000 in assets or more than $2,000,000 should buy LTCI.

Low purchase probability: it is difficult to set aside funds to purchase a private LTCI policy. There always seem to be—and actually are more critical needs for most families. The Kaiser Family Foundation study identified key pieces of family security that should be in place for every family before

[10] The income deciles reported in the Urban Institute model change over time, representing larger amounts of money in later years. The current division of income in deciles for Hawai'i is: (lowest=-$8,200...$13,899), (2nd=$13,900...$25,699), (3rd=$25,700...$37,899), (4th=$37,900...$49,999), (5th=$50,000...$62,299), (6th=$62,300...$77,399), (7th=$77,400...$94,999), (8th=$95,000...$118,990), (9th=$119,000...$160,249), (highest=$160,250...$884,710). Computed from the American Community Survey, 2014.

[11] Randy Desonia reviews the prospects for lTCI in The Promise and the Reality of Long-Term Care Insurance, National Health Policy Forum Background Paper, July 31, 2004. Http://www.nhpf.org/library/details.cfm/2457.

[12] http://www.forbes.com/sites/howardgleckman/2012/01/18/should-you-buy-long-term-care-insurance-maybe-not/

[13] http://www.actuarialfoundation.org/pdf/research-pen-long-term-care.pdf, accessed July 28, 2015.

purchasing LTCI, including health insurance for everyone in the household, savings for children's education, retirement savings, a disability policy for working adults, and life insurance to cover the eventuality that a breadwinner would die leaving dependents[14]. Only on completing these needs is private LTCI seen as an appropriate investment.

Higher lapse rates: in insurance language, a lapse involves stopping payments for an insurance policy. A few policies include provisions to protect the funds, paid to date, should someone fail to make payments. Many polices do not include such protections. In areas such as term life insurance, purchased to cover risks while children are young, the coverage is often lapsed when the children are no longer dependent—the insurance policy has served its intended purpose of covering risks of an unexpected early death. In the case of LTCI, however, there is little expectation that anyone will use the benefit in their early middle-age. The benefit is intended to be used at more advanced ages—in the buyer's 70's and 80's. Because the policies charge level premiums, the money paid in early years provides the assets to pay benefits in later years. In other words, early year premiums are higher than the risks of that age, and later year premiums are lower than the risk posed at higher ages. Under these circumstances, dropping a policy after paying into it for many years extinguishes the policy-holder's claim on future benefits.

Most Americans have relatively few liquid assets, as illustrated by a *Health Affairs* study reproduced in Figure 6[15].

Figure 6. Distribution of Annual Income in 2000 Dollars, All Elderly, 2000, 2015 and 2030

	Liquid assets		
	2000	**2015**	**2030**
$0–$9,999	55%	45%	39%
$10,000–$24,999	12	11	12
$25,000–$99,999	13	11	10
$100,000–$199,999	9	11	13
$200,000–$299,999	4	6	7
$300,000 or more	7	15	19

A lapse after 10 years by a household in the highest asset categories (average age-specific LTCI premium of $2225 for ages 55-64)[16] would imply a loss of $22,000 or so in assets from a base of

[14] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/private-long-term-care-insurance-who-should-buy-it-and-what-should-they-buy-report.pdf.

[15] doi: 10.1377/hlthaff.2015.0786. Health Aff August 2015 vol. 34 no. 8 1263

[16] Congressional Research Service. Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress. http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/R40601_01162013.pdf

$300,000 or more. A lapse after 10 years by a household in the $0 to $24,999 asset group (56% of the 2015 population) would be a loss about the size of all of their assets.

An additional driver of policy lapse is a history of premium increases for whole sets of policies. The Congressional Research Service estimates that the premium changes from 1995 to 2010 for 55-64 year-olds was 71%, and for 70 to 74 year-olds it was 51%. The premium increases can be attributed to assuming high lapse rates, but experiencing lower lapse rates; assuming low levels of use, but experiencing higher levels; and assuming higher interest rates than could be obtained in the long run. This is a problem because the high interest the company assumed it would be receiving, if not that it received, leaves the firm with insufficient reserves to pay promised benefits. The firm must then petition state insurance commissioners for rate increases. Commissioners are very reticent to decline the premium increase requests because of the risk of underfunding all the policies that have been written for that product. Faced with a substantial premium increase, possibly right after retirement, many policy holders do not feel they can continue their LTCI policy — i.e., they lapse. Lee and Jensen identify eight major drivers of lapse in LTCI policies: marital status of divorced/separated/never-married; self-reported health poor; monthly premium less than $50; monthly premium unknown; inflation protection unknown; coverage unknown; coverage restricted to either nursing home or in-home care; and having used LC and received LTCI benefits[17].

Confusion about program benefits: the LTCI policy is complex, and differs from other common forms of insurance because of the time span involved and the array of details and options of policies. The comparison on the opposite end of the insurance spectrum is probably auto insurance: a policy covers events that occur suddenly, involve personal injury, property damage, or both, and are paid for one year at a time. The insurer needs to price only for the next year, not 30 years into the future, and interest earnings in the short-term will be limited in any event.

Richard Frank reviews the LTCI purchasing decision facing the typical consumer[19]:

> The demand for protection against the risks of LTSS involves making purchasing decisions today against events that might occur decades in the future. Consumer information will be incomplete because of uncertainty about the future that is shared by all market participants. Decisions about LTCI also involve the potential for large financial and emotional losses (like the loss of independence and the specter of living with disability), choices that are costly to reverse (LTCI policies typically do not include non-forfeiture of benefits), as well as inexperience in making such choices when they are presented (Kunreuther et al. 2002)[20]. LTCI products also tend to be complex; they typically offer numerous specific design choices such as inflation protection, time limits on benefit duration, daily amounts of benefits, and durations of elimination periods (LTCI jargon for deductibles). These design choices require fairly sophisticated financial calculations and the assessment of multiple risks (mortality, disability, level and duration of disability) over multiple decades; these are very difficult assessments to make even if information were readily available.

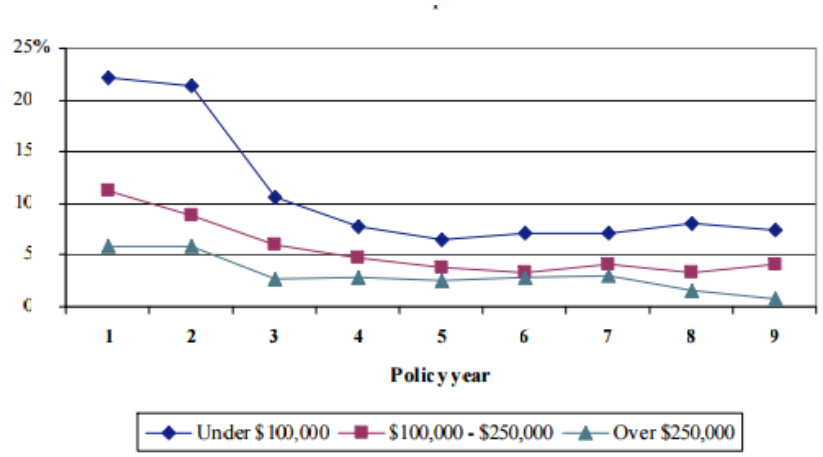
[17] Yong Li and Gail A. Jensen, "Why Do People Let their Long Term Care Insurance Lapse? Evidence from the Health and Retirement Study, Applied Economic Perspectives and Policy, 2012 34(2): 220-237.

[19] Richard Frank. Long-term Care Financing in the United States: Sources and Institutions. Applied Economic Perspectives and Policy (2012) volume 34, number 2, pp. 333–345. Doi:10.1093/aepp/pps016.

[20] Kunreuther, H., R. Meyer, R. Zeckhauser, et al. 2002. High Stakes Decision-Making: Normative, Descriptive and Prescriptive Considerations. Marketing Letters 13(3): 259–268.

An illustration produce by the Life Insurance Marketing Association International and the Society of Actuaries (Figure 7) illustrates the experience that purchasers of lower priced LTCI policies[21].

Figure 7. Voluntary Lapse Rates by Lifetime Maximum Benefit and Policy Year (Maximum Defined as Dollar Amount)[22]



The cumulative effect over a few years is easy to compute by reading the percentages off the graph: if 23% of under $100k policy holders lapse in the first year, 77% did not lapse. In the second year, 78% did not lapse, in the third, 89% did not lapse and in the fourth year 92% did not lapse. Multiplying these percentages (as decimals) together gives us 49% who are still insured at the end of the fourth year with an under $100,000 policy. Everyone else who held that policy has lapsed the coverage.

This effect, of higher lapse rates for lower cost LTCI policies and aftershocks to a relationship such as death of a spouse, divorce, or a serious illness is echoed by Lown and Palmer[23]:

> The main problem facing LTCI purchasers is whether they will be able to continue to afford rising premium payments for the decades between initial purchase and potential use. The problem is particularly acute for persons who make the purchase when they are in their prime earning years and enjoy employee health and retirement benefits. A premium that is affordable during earning years with steady and predictable income may become unaffordable once retired, particularly for a woman after the death of her husband. A lapse in policy coverage because of failure to pay premiums negates the advantage of having purchased the insurance

Finally, marital status at time of issue appears to affect the rate of lapse: single, divorced and widowed customers have the highest lapse rates in later policy years.

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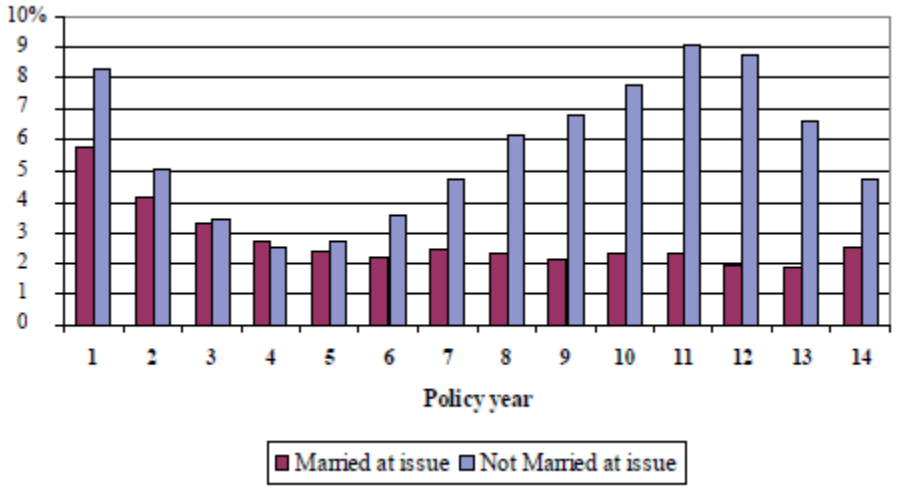
[21] http://www.soa.org/Research/Experience-Study/Group-Health/hlth-long-term-care-insurance-persistency-experience.aspx.

[22] LIMRA/SOA Persistency Report Figure 12.

[23] Jean M. Lown and Lance Plamer. Long Term Care Insurance Purchase: An Alternative Approach. .Journal of Financial Counseling and Planning, Vol. 15, Nov. 2, 2004. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2255137##

Figure 8. Voluntary Lapse Rates by Marital Status at Issue[24]



This effect is unexpected, as we would think the group without partners would be most committed to retaining their LTCI coverage to assure themselves of adequate care should they grow frail..

3.3.4. Buying LTCI

The process of purchasing LTCI is not simply one-sided. The potential buyer must: (1) have some sense of the risk of needing LTSS in the future; (2) have enough money to purchase an insurance policy; (3) have faith in the insurance provider that no major changes in coverage or cost of coverage will occur in the predictable future; and (4) expect that the benefits of the policy will have a positive effect on their quality of life. A Congressional Budget Office study of the demand for LTSS sets out some of the complications to this picture[25];

> Many, if not most, people do not make private financial preparations for their future LTSS needs. They may not have the personal financial resources necessary to purchase private LTC insurance, their health history may preclude the possibility of obtaining such insurance, or they may have concerns about the value of private coverage, including uncertainty about the stability of premiums in the future and the ability of insurance carriers to pay for care that might not be needed for several more decades. Other people may prefer to spend their money on activities while they are still healthy, expecting that their quality of life if they are severely impaired would not be much better even if they had more money to spend on assistive services[26].

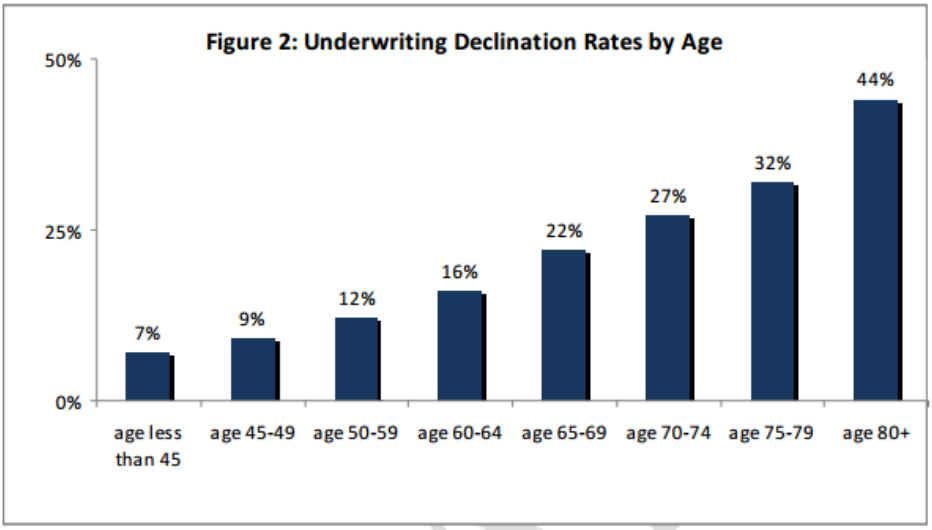
[24] LIMRA. LTCI Persistency Report (ibid.) Figure 18.
[25] http://www.cbo.gov/sites/default/files/44363-LTC.pdf
[26] This latter remark is attributed to Jeffrey R. Brown and Amy Finkelstein, "Insuring Long-Term Care in the United States," Journal of Economic Perspectives, vol. 25, no. 4 (Fall 2011), pp. 119–142, http://tinyurl.com/l997ekg.

Isn't it just a matter of planning?

The Federal Reserve found in 2014 that nearly a third of American households experienced significant income swings. The volatility is hardest, of course, on the poor, who don't just earn less than the better-off, but also earn their lower incomes more choppily, the money coming in irregular bursts, surging in some weeks, vanishing in others, always making a mockery of plans.

The supply side of this picture so far is missing. The people most interested in LTCI are in part those who believe they will more likely need assistance. This disposition leads to what insurers call "anti-selection." The insurer cannot remain solvent if the risk mixture of the policy applicants differs markedly from the risk mixture on which it had estimated cost of insurance. Insurers therefore *underwrite* the applicants. That is, the insurers require a medical exam, a review of health records, or in some cases of group insurance, simply the assurance that the applicant is working and in generally good health. If the applicant does not pass the screening tests, the insurer will not write a contract for LTCI. A Life Plans study for the Department of Health and Human Services illustrates the way in which the proportion of LTCI applications declined varies by age[27].

Figure 9. Percentage of Applicants Declined for LTCI by Age



Source: Results of the Long-Term Care Underwriting Survey for the Individual Market in 2009. LifePlans, Inc. Waltham, MA. November, 2010.
Note: Data weighted to represent market share of participating companies.

Insurers decline to cover people for a variety of reasons. Most of the diagnoses are seen as predictors of frailty and ADL failure as the client grows older. It is important to note that no insurer can offer voluntary insurance for LTCI without some degree of underwriting. The simplest underwriting test is based on employment: if you are working, you are in pretty good health. There will be some folks with

[27] Life Plans, Inc A Profile of Declined Long-Term Care Insurance Applicants: A View of Selected Socio-Demographic Characteristics. http://aspe.hhs.gov/daltcp/reports/2011/class/appJa.pdf, Figure 2, p. 9.

greater disabilities in the pool of workers, but they will in fact be working, and the pool will generally be healthy. As a matter of principle, insurers must always examine the applicants for any kind of coverage to determine their likely risk.

The outcome of this rationality – on the part of applicants to try to obtain coverage if they believe they are especially at risk and on the part of insurers to try to exclude those who are most likely to need LTSS – is that voluntary LTCI programs cannot cover the community sufficiently, because as people age, their health becomes more fragile and the chances of obtaining insurance drop. In effect, those with more fragile finances, those with more fragile health, and those who are single face serious problems in obtaining and continuing LTCI coverage as they grow older. This opens the question as to how a society can insure against events that: (a) impact many people, (b) differ in risk of occurring across the age spectrum, and (c) have an impact on all the families in the community. Therefore we are left without a reasonable prospect that private LTCI can cover the largest segment of our aging population.

The next note in this series will set out the application of social insurance to long-term services and supports.