



The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing

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Executive Summary

The benefits of private long-term care (LTC) insurance are many and varied. They reach beyond policyholders to include family caregivers. Public programs, specifically Medicaid, also benefit through reduced expenditures on LTC. Below, we summarize the value that LTC insurance provides to policyholders, caregivers, and Medicaid. These findings are based on analyses of empirical data collected over decades of research. Specifically, this study addresses the relationship between the amount of coverage individuals purchase and the cost of care; the connection between premiums and benefits; the impact of LTC insurance on the care received by seniors with impairments living in the community or in institutional care settings; the effects of policy ownership on the use of Medicaid; and factors influencing consumer purchasing choices.

The Value of LTC Insurance to Policyholders

- ▶ LTC insurance provides a more cost-effective way to pay for LTC services than relying on personal savings. To pay for the same amount of services covered by insurance costing \$188 a month, a 60-year-old person would have to put aside \$1,666 a month over 22 years.
- ▶ If an individual sets aside and invests the value of the average LTC insurance premium for 22 years, she would accumulate only enough to pay for six months of care. By putting the same amount into premiums, she could own a policy covering more than three years of care.
- ▶ Roughly 22 years of premium payments would be returned after only five months of receiving the average LTC insurance policy's full daily benefit.
- ▶ Compared to those without LTC insurance, insureds reduce their out-of-pocket LTC costs by between \$3,000 and \$5,000 a month (depending on the service setting).
- ▶ The great majority of LTC insurance claims are paid. In a study, only 4 percent of individuals filing a claim reported that it was declined and this decreases to 2.4 percent a year after the initial claim.

- ▶ Most claimants agree that LTC insurance enhances access and flexibility as they seek to obtain the services of their choice.
- ▶ Individuals with LTC insurance receive on average 35 percent more hours of care than those without, and their care is also somewhat more likely to address their needs than that received by the uninsured.
- ▶ The industry currently serves 7.4 million policyholders and is expected to pay out roughly \$700 billion in claims over the life of those policies.

The Value of LTC Insurance to Family Caregivers

- ▶ Individuals caring for family members with LTC insurance are nearly twice as likely to be able to work as when there is no insurance.
- ▶ Caregivers for LTC insurance claimants experience less stress in finding appropriate services for their loved one because of assistance from care coordinators provided by insurers.
- ▶ The services paid for by insurance enables family members to spend less time on hands-on care and more on social interaction and companionship with their relatives, improving the caregiving experience.

The Value of LTC Insurance to Medicaid

- ▶ Because LTC insurance covers a majority of LTC costs, insureds are not forced to rely on Medicaid, and Medicaid spend-down rates are reduced.
- ▶ Between 21 and 31 percent of insured nursing home residents would spend down to qualify for Medicaid if they did not have LTC insurance. Fewer than 5 percent of those with LTC policies spend down to Medicaid.
- ▶ The 7.4 million current policyholders are expected to save the Medicaid Program about \$50 billion over their lifetimes. Annualized Medicaid savings per in-force policy are about \$334.

Background

In September of 2002, LifePlans, Inc. authored a whitepaper on behalf of America's Health Insurance Plans (AHIP) that presented findings demonstrating the benefits of having a long-term care (LTC) insurance policy at that time. Various data sources were used to analyze the impact of having this insurance on the policyholders, their caregivers and public funding sources. Now, more than 10 years later, we are able to use more recent data to determine whether or not some of the original findings still hold true and to detail a number of additional benefits that LTC insurance offers policyholders.

Currently, more than 10,000 people a day are turning 65,¹ and they have little but their own resources to rely on to pay for future LTC costs. To qualify for public payments through the Medicaid program, individuals must first impoverish themselves by depleting their assets to pay for care. If they do so, they often cannot receive care in the setting of their choice because Medicaid restricts the providers it will cover and (despite recent efforts) still maintains its preference for nursing home settings. Moreover, roughly half of Medicaid expenditures are made by the states, and this is one of the fastest growing items in state budgets. A growing share of state resources used to pay for LTC diverts needed public investment and assistance from other populations.

LTC insurance has had—and will continue to have—a positive impact on hundreds of thousands of policyholders and their families, and it is already leading to reductions in public expenditures on LTC. A number of major studies conducted over the past decade provide new, important information about the role of this insurance and its effects. As a result, stakeholders are looking for ways to encourage the private sector to play a more meaningful role in paying for LTC.

In the sections that follow, we will update certain findings; provide new information based on more recent data and studies; and underscore why it is important to encourage growth in the LTC insurance market, from the point of view of seniors and their families as well as society as a whole.

Purpose

The purpose of this project is to review, summarize, analyze and update information from a number of studies that have examined the impact of private LTC insurance on seniors with functional or cognitive impairments and their families, and on the use of and expenditures on public LTC financing programs. These studies have been supported by both public and private entities including the U.S. Department of Health and Human Services, the SCAN Foundation, the Mature Market Institute, and America's Health Insurance Plans. More specifically, we seek to synthesize and analyze new information to answer the following primary questions:

1. What is the potential value of private LTC policies held by the public today?
2. What is the relationship between premiums and benefits, and how has this relationship changed over time?
3. What is the relationship between the amount of coverage people purchase and the cost of care, and how has this relationship changed over time?
4. What are the various impacts of private LTC insurance on the care received by seniors with impairments living in the community or in institutional settings?
5. How does having an LTC insurance policy affect the use of and expenditures by Medicaid, the primary public payer of LTC?
6. What impact does having a private LTC insurance policy have on consumer choice, level and type of caregiver involvement, and out-of-pocket costs of care?

Findings

Current Industry Parameters

In 2012 about 7.4 million people were privately insured for LTC.² (This does not represent the total number of people who have ever been insured for LTC, which is likely well over 10 million.) In that year, the total value of earned premiums was \$11.2 billion, and the average annual premium paid was \$1,531 (a little over \$125 a month). Companies established \$7.7 billion in claim reserves for individuals making claims on their policies, and given that about 72,000 policyholders filed new claims, this suggests that insurers were prepared to pay an average of \$106,000 in benefits for new claimants.³ A recent set of estimates by Webb and Zhivan indicate that, for a married couple turning 65, the expected out-of-pocket spending on LTC over the remaining years of life is \$63,000.⁴ Thus, the average reserve currently being set up by the industry would not only cover this amount, but would also provide significant protection against more catastrophic costs.

Through the end of 2012, about 262,000 individuals were receiving benefits under their LTC insurance policies. During the 20 years from 1992 through 2012, cumulative incurred claims totaled \$75.6 billion, of which 10 percent was incurred in the single year of 2012, demonstrating how quickly claims payments are growing. By 2000 claims payments represented only 34 percent of cumulative earned premiums, but by 2012 this figure had grown to 45 percent. While a decrease in sales over the period certainly contributed to this shift, the rapid growth in new claims was a major contributor. Table 1 summarizes a number of key industry parameters.

Private insurance financing of LTC is growing more quickly than public funding. While between 1991 and 2011 the share of expenditures of public sources grew by 14 percent, the share of private insurance grew by 300 percent.⁵ The insurance share is expected to continue increasing, but until even more rapid growth in the market is experienced, it will remain modest. (Currently, the insurance share is about 12 percent.)

Table 1: Key LTC Insurance Market Parameters, 2012

Parameters	Values
Policies in force	7.4 million
Earned premiums	\$11.2 billion
Cumulative earned premiums 1992-2012	\$168.0 billion
New claim reserves	\$7.7 billion
Number filing new claims	72,000
Average claim reserve per claimant	\$106,000
Cumulative claims paid 1992-2012	\$75.6 billion
Number of in-force claimants	262,000

Source: National Association of Insurance Commissioners (NAIC), NAIC Long-Term Care Insurance Experience Exhibit Report for 2012, 2014.

I. The Impact of LTC Insurance on Policyholders

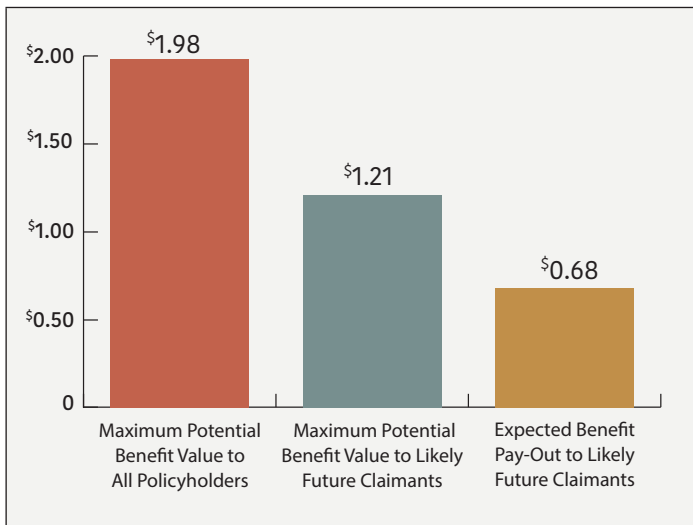
The potential value of LTC insurance benefits is significant.

The total value of potential insurance payments to current policyholders is substantial. We have conducted an analysis of policies sold over the past two decades, and it shows that in 2014 the average daily benefit amount for in-force policies is \$138 and the average duration of coverage is 5.3 years. (This takes into account the change in policy parameters over the last 20 years, and for policies with inflation protection it adjusts benefits up to 2014 levels.) We can apply these policy parameters to the 7.4 million policyholders to produce three figures that reflect the value of LTC benefits (in 2014 dollars), as shown in Figure 1:

- ▶ The total “face value” of the policies (the aggregate of all benefits payable) is \$1.98 trillion.
- ▶ Roughly 70 percent will need LTC at some point in their lives, but the other 30 percent will not.⁶ As well, a small number of individuals (.75%) will lapse their policies each year over the period. So a more realistic valuation figure is the total amount potentially payable to those who still have their policies and are likely to become future claimants. This is \$1.21 trillion.
- ▶ Moreover, of the policyholders who will receive benefits, fewer than 15 percent will receive all of the benefits payable by their policy. (While the average duration of coverage is 5.3 years, the average time spent on claim is only about three years.⁷) Thus, while likely future claimants have \$1.21 trillion available to them, they are expected to receive only about \$679 billion in benefits.

To put these figures in perspective, in 2010 total spending for LTC was \$208 billion.⁸

Figure 1: Benefit Value of Current LTC Policies (2014 Dollars, Trillions)



Note: Based on analysis of policy design information and policyholder purchasing patterns between 1990 and 2010.

LTC insurance policies provide high value in benefits relative to premiums paid.

With regard to the value of LTC insurance benefits, it should be noted that many policyholders receive benefits. This is an important point because many consumers question the value of LTC insurance on the grounds that they could pay premiums for years and never receive a benefit payment (a complaint that, curiously, is rarely voiced about coverages that only infrequently pay claims). And even when monetary benefits are not paid, the policyholder enjoys a psychological benefit—the peace of mind that comes from knowing that, if care is needed, benefits will be available.

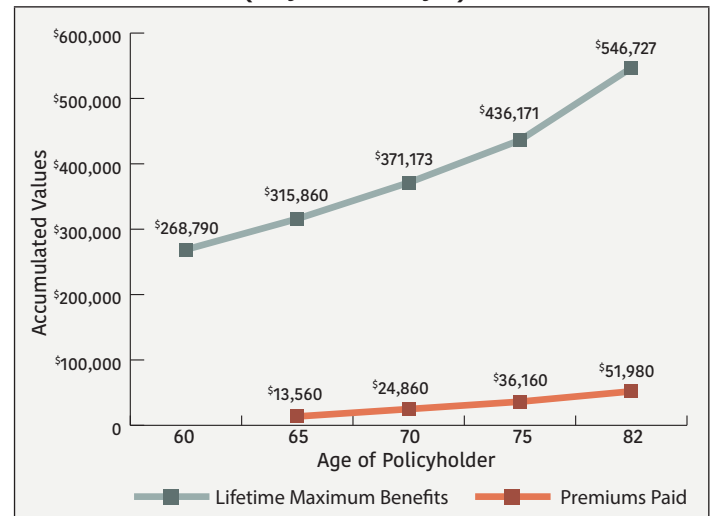
Looking beyond incidence of claim payment, one way to judge the value of LTC insurance is by comparing the premiums that a policyholder could expect to pay with the maximum benefits she would receive if care were needed. To make this comparison, we drew on policy design data from individuals who purchased in 2010 (the most recent year for which detailed buyer data is available). The key policy parameters for this group (which are representative of recent buyers) include:⁹

- ▶ Policy premium..... \$2,261
- ▶ Daily benefit amount..... \$153
- ▶ Percent choosing inflation protection..... 82%¹⁰
- ▶ Duration of coverage..... 4.8 years

Based on these parameters, we calculated the total amount of premiums that a person who bought a policy at age 60 would pay before becoming a claimant at age 82 (the average age when an individual would make a claim¹¹). We then compared this to the maximum amount of benefits to which that person would be entitled. Figure 2 shows that a person buying a policy at 60 will have paid approximately \$52,000 in premiums by the time she is 82,¹² at which time she would be entitled to a maximum monthly benefit of \$9,492 for 4.8 years, or roughly \$547,000 of total benefits.¹³ This premium/benefit relationship could also be expressed in these terms: Roughly 22 years of premium payments (\$52,000) would be returned in the form of benefits after only about five months of the full daily benefit.

Another way to look at this issue is to ask how much money one would have to save in order to self-fund the amount available from a policy at claim time. To accumulate the average lifetime benefit amount of \$547,000 by the age of 82 (starting at age 60), one would have to set aside a little over \$1,666 each month for the 22-year period (assuming 2 percent interest compounded annually). Compare this to the average monthly insurance premium of \$188 for a similar level of benefit. For most Americans, setting aside \$1,666 a month is not an affordable option, but paying a premium of less than \$200 is affordable to more people.

Figure 2: Total Premiums Paid and Policy Benefit Value over Time (60-year-old Buyer)



Note: Benefit value increases over time because most policies have inflation protection.
 Source: LifePlans analysis of data from: America’s Health Insurance Plans (AHIP), Who Buys Long-Term Care Insurance in 2010-2011? A Twenty-Year Study of Buyers and Non-Buyers (In the Individual Market, 2012), 2012.

What if a person's premium is increased after she buys a policy? Would the policy still offer a good value? We calculated two premium increases, one of 30 percent and the other 50 percent, both occurring seven years after policy purchase at age 60. For the 30 percent increase, if the policyholder receives the full daily benefit, it will take her 6.6 months to recoup the premiums she has paid; for the 50 percent hike, it takes 7.3 months. This is of course longer than for the average premium (about five months), but still a very favorable return.

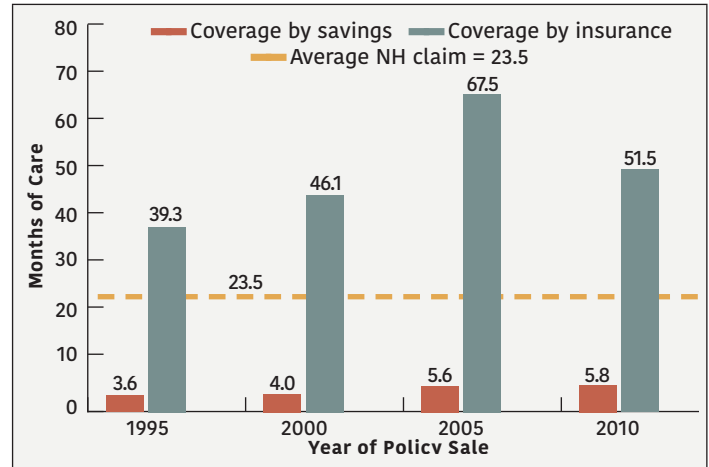
Financing LTC costs through insurance is more cost-efficient than personal savings.

An alternative method of judging the value of LTC insurance is to compare two ways of deploying the same amount of money to pay for LTC: using it to pay LTC insurance premiums or saving and investing it to cover LTC expenses. Which approach would pay for more care?

As shown in Figures 3, 4, and 5, for each of the three main LTC settings, insurance would pay for much more care than savings. For the insurance approach, we examined policies sold in 1995, 2000, 2005, and 2010 and calculated the average total benefit amount payable at age 82. For the savings approach, we assumed that, starting at age 60, the individual places the money she would have spent on the LTC premium in an investment that earns 3 percent interest annually, and we calculated the amount accumulated by age 82. We then projected care costs for each setting and calculated the amount of care covered by the insurance benefits and by the savings.

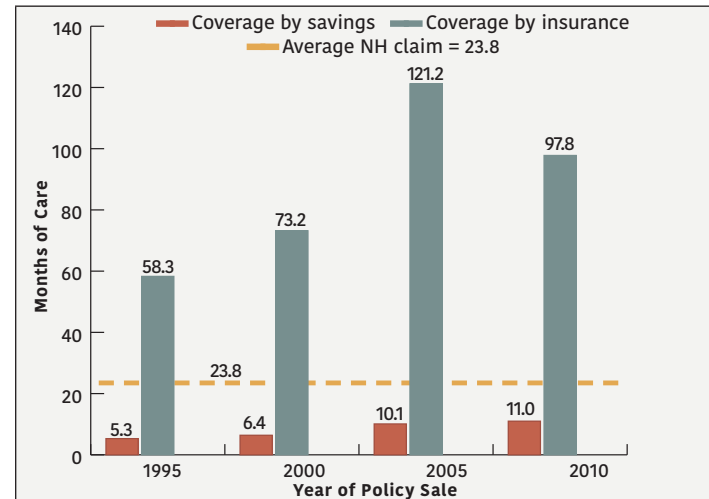
In Figures 3 through 5, we also indicate the average length of time each type of care is needed (based on the average insurance claim). This demonstrates that those saving an amount equal to the insurance premium do not accumulate enough to pay average LTC costs—in fact, their savings fall far short, as much as 20 months short or more. Insurance benefits, on the other hand, far exceed average costs, in most cases by a few years or more. In other words, while savings do not cover even average costs, insurance covers catastrophic situations, when much more than the average duration of care is needed.

Figure 3: Months of Nursing Home Care Covered by Savings vs. LTC Insurance



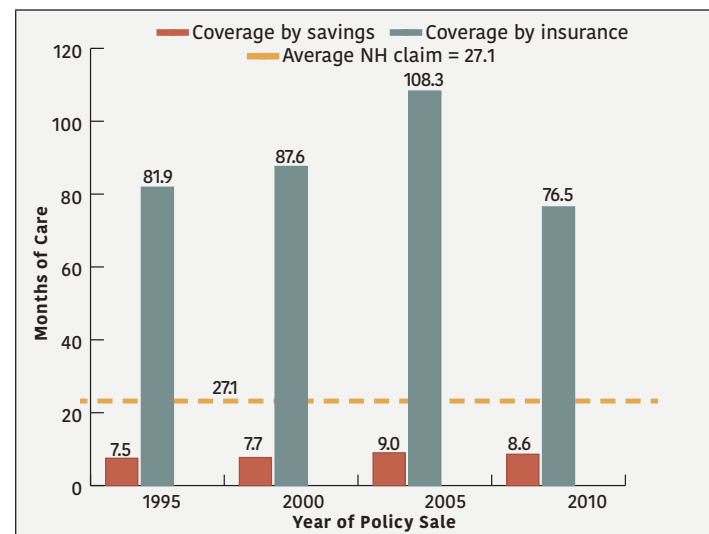
Note: Average length of nursing home claim (closed claims, 2011) from LifePlans, Inc. analysis of LTC insurance industry claimant data, 2011.

Figure 4: Months of Home Health Care Covered by Savings vs. LTC Insurance



Note: Average length of home health claim (closed claims, 2011) from LifePlans, Inc. analysis of LTC insurance industry claimant data, 2011.

Figure 5: Months of Assisted Living Covered by Savings vs. LTC Insurance



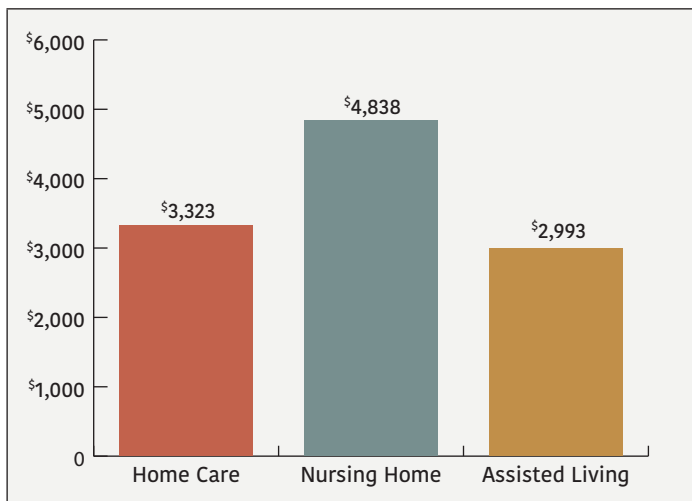
Note: Average length of assisted living claim (closed claims, 2011) from LifePlans, Inc. analysis of LTC insurance industry claimant data, 2011.

Table 2 (next page) summarizes the data in a different way—it shows the percentage of accumulated savings and of insurance benefits needed to pay for two years of care in each of the settings. This analysis too demonstrates that saving for potential LTC expenses is an inefficient way to prepare for the risk, given the alternative of insurance, and that saving the same amount as one pays in premiums will result in insufficient funds to cover even average costs.

LTC insurance reduces out-of-pocket expenses for claimants.

Yet another way of expressing the value of LTC insurance is to say that, since policyholders receive benefits to cover care costs, they pay much less out of their own pockets than those without insurance. Figure 6 shows the average amount of money an insured person would receive in benefits and therefore avoid spending from her own resources. Depending on the care setting, this amount ranges from \$3,000 to \$5,000 a month.

Figure 6: Reduction in Monthly Out-of-Pocket LTC Expenditures by Individuals with LTC Insurance (2014 dollars)



Sources: U.S. Department of Health and Human Services (DHHS), Decisions, Choices, and Care Management among an Admissions Cohort of Privately Insured Disabled Elders, 2006; and MetLife Mature Market Institute, Market Survey of Long-Term Care Costs, 2012.

Note: Data were adjusted to 2014 costs with assumptions of 1%, 3.5%, and 4% increases in the costs of home care, nursing home, and assisted living care (respectively).

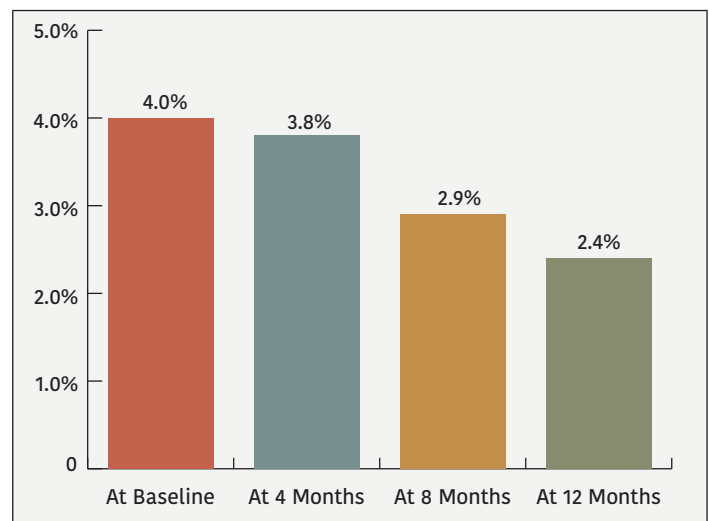
We can also look at lifetime reductions in out-of-pocket costs:

- ▶ Home care (average duration of two years)—almost \$80,000
- ▶ Assisted living (2.3 years)—almost \$83,000
- ▶ Nursing home (two years)—about \$116,000

The great majority of LTC insurance claims are paid.

As part of a broader longitudinal study funded by the U.S. Department of Health and Human Services, roughly 1,400 LTC claimants were asked a series of questions.¹⁴ Those who reported in a baseline interview that they had filed a claim or intended to do so were interviewed at four-month intervals over one year. Almost all of those who filed a claim at baseline were either approved (89 percent) or awaiting a final decision (7 percent); only 4 percent had been denied. When claims were denied, it was usually (as was to be expected) because the claimant did not meet policy benefit eligibility criteria. Because individuals were interviewed repeatedly, it could be learned whether those who were initially denied benefits ultimately received them over the course of the year. Figure 7 shows that the claims denial rate declines to 2.4 percent after one year.

Figure 7: Denial Rates for LTC Insurance Claimants over One Year



Source: U.S. Department of Health and Human Services (DHHS), Following an Admissions Cohort: Care Management, Claim Experience, and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Twenty-Eight Month Period, Final Report, 2008.

Table 2: Percentage of LTC Costs Covered by Savings versus Insurance Nursing Home, Assisted Living, and Home Health Care

Savings Approach	YEAR PURCHASED POLICY OR BEGAN SAVING			
	1995	2000	2005	2010
Money saved annually	\$1,405	\$1,596	\$1,903	\$2,280
Savings accumulated by age 82	\$24,665	\$33,051	\$63,497	\$76,069
Average monthly cost at age 82				
Nursing home	\$6,862	\$8,194	\$11,342	\$13,148
Assisted living	\$3,292	\$4,312	\$7,071	\$8,854
Home care	\$4,624	\$5,161	\$6,316	\$6,921
Percentage of 2 years of care covered				
Nursing home	15%	17%	23%	24%
Assisted living	31%	32%	37%	36%
Home care	22%	27%	42%	46%
Insurance Approach	1995	2000	2005	2010
Premium paid annually	\$1,405	\$1,596	\$1,903	\$2,280
Benefits payable by age 82	\$269,517	\$377,711	\$765,526	\$676,968
Average monthly cost at age 82				
Nursing home	\$6,862	\$8,194	\$11,342	\$13,148
Assisted living	\$3,292	\$4,312	\$7,071	\$8,854
Home care	\$4,624	\$5,161	\$6,316	\$6,921
Percentage of 2 years of care covered				
Nursing home	164%	192%	281%	215%
Assisted living	341%	365%	451%	319%
Home care	243%	305%	505%	408%

Note: Increases in care costs are based on LifePlans' cost of care survey data from 2004 to 2012. Age calculations are based on average age of purchase for each cohort. Savings calculations assume a 3 percent annual interest rate.

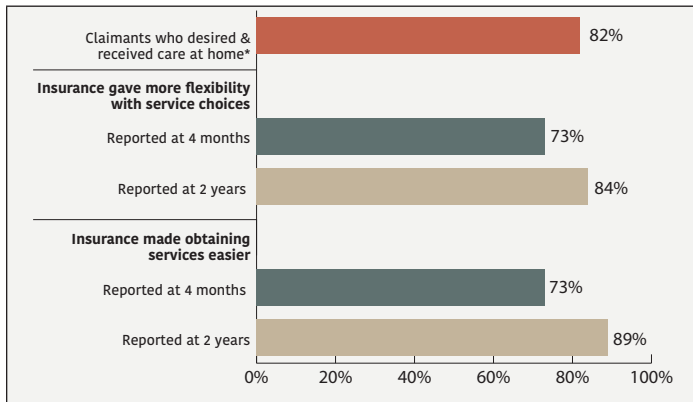
It should also be noted that, in the great majority of cases, claims are settled to the satisfaction of claimants—policyholders do not feel that they have to “fight for” benefits, and they report that disagreements are resolved fairly. Among interviewees who were approved and denied, 94 percent reported that they had no disagreements with their insurance company or that their disagreements were resolved satisfactorily.

The responses of the interviewees indicate that when people need to rely on their insurance, the vast majority are able to do so. Claim denial rates are low, the reasons for denials are in line with policy requirements, and most disagreements are dealt with constructively by the company. Of course, this does not mean that process errors and incorrect decisions never occur, but based on the evidence of this study, they tend to be the exception rather than the rule.

LTC insurance provides non-financial benefits.

LTC insurance also offers benefits that are not strictly monetary. Insureds may be better able to obtain care in the setting of their choice, including their own homes. In the study of LTC claimants cited in the preceding section, interviewees were asked if they wanted to receive care at home, and if so, if they were able to do so. They were also asked if their insurance had made it easier for them to obtain the services they wanted and given them more flexibility in doing so. As shown in Figure 8, a high percentage were able to receive home care, and large majorities agreed that LTC insurance enhanced service access and flexibility, with even more feeling this way after two years. (Perhaps their longer experience with LTC made them more aware of people who have to change care settings for financial reasons.)

Figure 8: Non-Financial Benefits of LTC Insurance Reported at Four Months and at Two Years after Initial Service Use

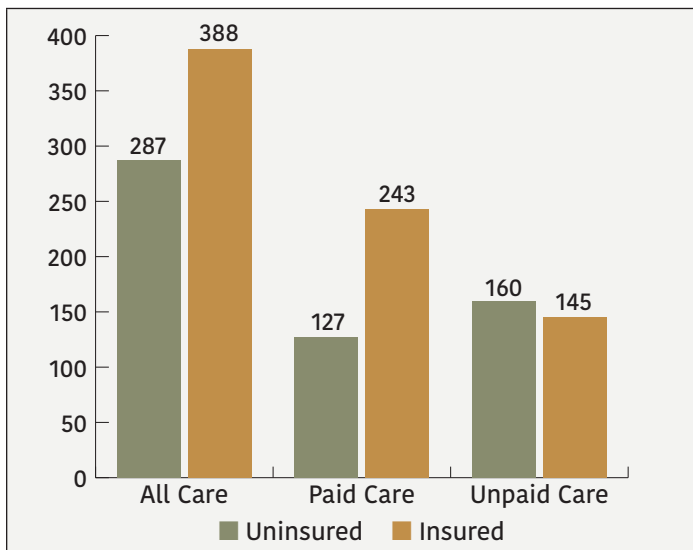


*This question was asked only at baseline.
Source: DHHS 2008.

LTC insurance enables individuals to receive more hours of care.

With LTC insurance benefits, policyholders can afford more care; those without insurance may be forced to rely more on family caregivers or simply make do with less care than they really need. We set out to ascertain whether those with insurance in fact receive more hours of care than those without. We looked at data from a population of people with insurance who had an impairment (an inability to perform at least two activities of daily living (ADLs) or a cognitive condition¹⁵) who were receiving home care. For data on non-insured persons with similar levels of impairment, we relied on information from the National Health and Aging Trends Study (NHATS).^{16,17} Figure 9 compares the total hours of paid and unpaid care received by insured and uninsured individuals.

Figure 9: Monthly Hours of Care for Impaired Home Care Recipients, by Insurance Status

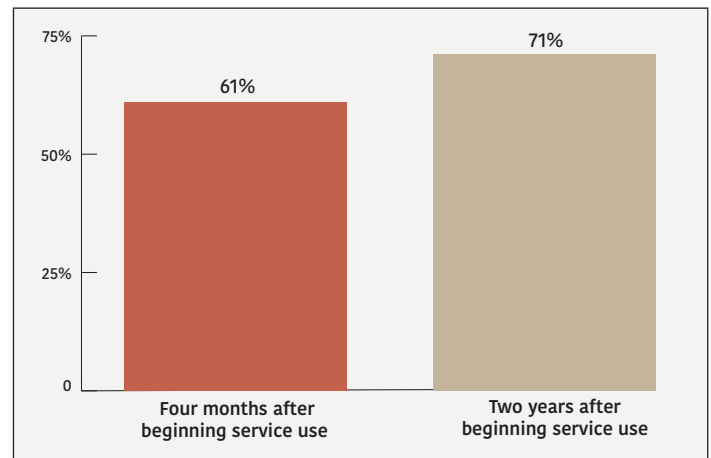


Sources: U.S. Department of Health and Human Services (DHHS), Service Use and Transitions: Decisions, Choices, and Care Management among an Admissions Cohort of Privately Insured Disabled Elders, 2006; and National Institute on Aging, National Health and Aging Trends Study (NHATS), 2011.

Insured individuals receive substantially more hours of care (35 percent more) than the uninsured. The insured receive almost twice as much paid care, but (perhaps surprisingly) only 10 percent less unpaid care. It would seem that when paid services are available, family members do not spend much less time caring for their loved one, although perhaps they devote fewer hours to helping with ADLs and more to providing companionship.

Another indication that people with LTC insurance are less likely to have to go without needed care comes from the survey of claimants cited earlier.¹⁸ A majority of interviewees reported that if they did not have insurance they would have to decrease the amount of care they were receiving, and the percentage saying so increased over time (see Figure 10 below).

Figure 10: Claimants Reporting They Would Receive Less Care Without LTC Insurance



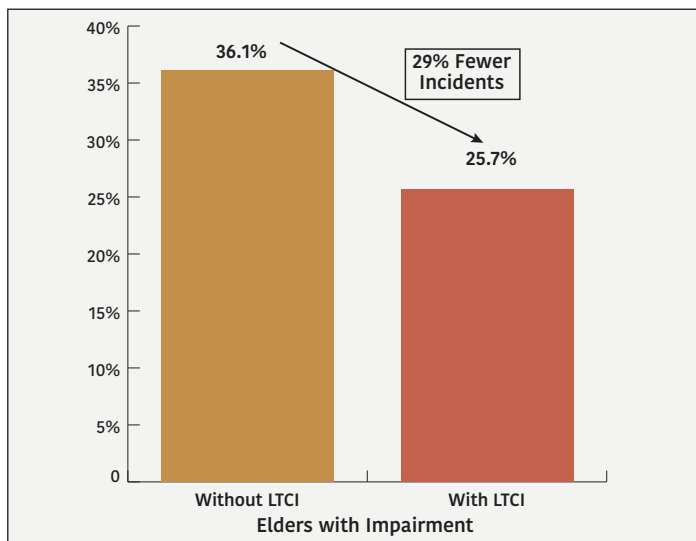
Source: U.S. Department of Health and Human Services (DHHS), Following an Admissions Cohort: Care Management, Claim Experience, and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Twenty-Eight Month Period, Final Report, 2008.

LTC insurance helps prevent a lack of LTC services caused by a lack of funds, and it can also reduce problems with the delivery of LTC services.

An issue closely related to the number of hours of care received is LTC needs that are not met or not adequately met. Those with LTC insurance are less likely to report unmet or under-met needs. The NHATS survey asked community residents if during the last month they had experienced certain incidents (such as wetting their clothes, going without bathing or eating, having to stay in bed or indoors, etc.) because a task was too difficult to do or because no one was available to help them. If they reported any of the listed incidents they were classified as having an unmet/under-met need. As shown in Figure 11, the insured reported a 29 percent lower level of unmet or under-met need than the uninsured.

While data from the study of claimants cited above suggest that insurance may enable people to obtain greater levels of care, deficiencies in the delivery and quality of services still remain for a meaningful minority of individuals with impairments.¹⁹ Often, these people had multiple caregivers and there was a mismatch between their preferences and service schedules, especially for those without insurance.^{20,21}

Figure 11: Deficiencies in Care Received, by Insurance Status



Source: National Institute on Aging (NHATS), 2011.

Of course, it must be kept in mind that a reported unmet or under-met need does not necessarily indicate a lack of funds to pay for services. There are many causes, such as individuals' lack of comfort performing a particular ADL, their unwillingness to use available care, or provider problems (availability, scheduling, quality, etc.). But LTC insurance largely eliminates the financial barrier to receiving care, so if insureds have an unmet/undermet need, it is most often caused by provider issues.²² Moreover, insurance benefits can enhance insureds' ability to shop around for caregivers who perform well and meet their needs.

II. The Impact of LTC Insurance on Family Caregiving

Family caregivers continue to play an integral role in the care of the elderly, with an estimated 26.8 percent of Americans (61.8 million people) providing unpaid care to an adult within the previous year.²³ The majority of care (reported by 58 percent of caregivers) is help with ADLs, to which family members devoted an average of 19 hours per week. They also spend significant time in companionship activities and help with instrumental activities of daily living (IADLs) like shopping, doing laundry, and the like.

The National Alliance for Caregiving has documented research showing that caregiving takes an emotional toll on caregivers, as a result of reduced social activities, greater stress, multiple workforce accommodations, the financial burden associated with care, and an increase in illness leading to declines in overall health status.²⁴ Additional assistance would likely have a positive impact on caregivers.

LTC insurance helps caregivers remain in the workforce and better maintain a social life.

By providing funds for paid services, LTC insurance alleviates the burden of informal caregivers. This makes it easier for caregivers to work (and to avoid disruption in work) and keep up social interactions. Research shows that individuals caring for elders with private LTC insurance are nearly twice as likely to be able to work as those whose elders do not have insurance. This research also indicates that a working caregiver of someone with LTC insurance is less likely to experience severe social stress than a caregiver of a non-insured person.^{25,26}

LTC insurance improves the caregiving experience.

Other research on LTC insurance suggests additional potential benefits to caregivers.

- ▶ Most policies provide free-of-charge the help of a care coordinator. It is not easy for an insured and her family to find the services best suited to their needs, and a care coordinator can work with them to locate and arrange for such services. This significantly reduces caregiver stress, and a survey of claimants showed that it is highly valued by them and their families.²⁷
- ▶ When a person is insured, the number of family caregiving hours is about 10 percent less than for the uninsured (see Figure 9). Family members must spend less time on hands-on caregiving, with its challenges and burdens.
- ▶ Satisfactory paid services enable family caregivers to focus on companionship and social interaction with their loved one, rather than hands-on care. This, helps restore a greater sense of normality to the relations between adult children and their parents, or between spouses. Insured claimants are generally satisfied with the services they receive because insurance makes it easier to receive care in the setting of their choice.²⁸

III. The Impact of LTC Insurance on Medicaid

Medicaid is the largest source of public funding for LTC services, and its share has grown over the last 20 years; it now pays two of every three dollars of LTC costs.²⁹ Medicaid covers the LTC of those who do not have the resources to pay for it themselves. Some people qualify immediately for Medicaid; others must spend most of their assets on care before becoming eligible. This process is referred to as “spending down” and typically occurs while the individual is in a nursing home, where most Medicaid dollars are spent.

LTC insurance reduces the number of people who spend down to qualify for Medicaid.

A key purported benefit of LTC insurance is that policyholders will be able to avoid having to spend down their assets and relying on Medicaid if they require institutional care. There is a presumption that middle-income policyholders would in the absence of their LTC insurance spend most if not all of their savings on costly institutional care (in contrast to more affluent policyholders, who have sufficient resources to cover LTC costs without impoverishing themselves and going on Medicaid). Public policy support for the private insurance market is built on the belief that as more people become insured, fewer will require public financing for their LTC needs. The argument is that growth in the private insurance market will help ensure that scarce public dollars are targeted only to those who do not have available private alternatives to fund care, and consequently, market growth will strengthen the social safety net.

However, recent data collected by AHIP show that over the past decade, the share of LTC insurance buyers who are in the middle-income range has declined.³⁰ In 1995, 41 percent of buyers were considered middle-income, but by 2010 that number had declined to 36 percent.³¹ This suggests that, everything else held constant, the pool of policyholders who, in the absence of insurance, would spend down to Medicaid has declined. This raises the question of whether the potential impact of LTC insurance on Medicaid spend-down rates might be minimal. And this might be the case if Medicaid rules had remained constant. But eligibility rules and the amount of assets that states allow families to keep and still qualify for Medicaid have changed. Currently, the community spouse in many states is allowed to keep \$117,240 in liquid assets even as Medicaid pays for a spouse in the nursing home.^{32,33} (Other states have different limits). Another factor is that while LTC costs have increased by an average of 4 percent annually, income has grown more slowly. Thus, although new policyholders

are now financially better off than buyers were a decade ago, liberalization of Medicaid’s resource allowances for married couples and rising care costs may still result in many policyholders accessing Medicaid in the absence of their policies.

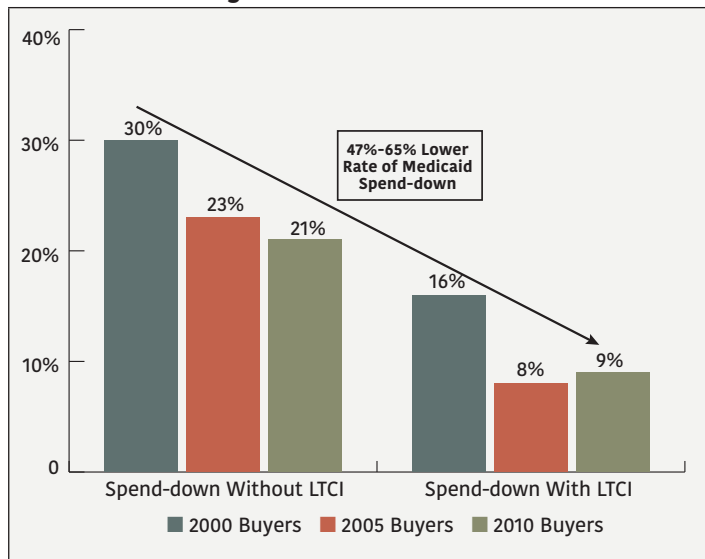
To simulate the extent to which policyholders would spend down to Medicaid eligibility in the absence of their LTC insurance, we began by analyzing the socio-demographic profile (income, assets, age, and marital status) of LTC insurance buyers in 2000, 2005, and 2010. We then linked state-specific Medicaid eligibility rules and cost-of-care data to a policyholder dataset (including more than 4,300 policyholders) and used historic trends in asset, income, and cost-of-care growth to project forward. The specific policy designs chosen by individuals were used to determine the impact on Medicaid spend-down rates in the presence of insurance. Finally, we used insured claims experience to estimate the amount of time individuals could be expected to spend in a nursing home. This allowed us to estimate the number of people who would deplete their income and assets and qualify for Medicaid. We did not take into account assets deliberately transferred to qualify for Medicaid, as evidence for this is controversial. These spend-down estimates are only a function of the relationship between the costs of care and income and assets.

We developed our simulation and modeling approach to answer the “spend-down” question in two ways: (1) a cross-sectional snapshot of how many current policyholders would spend down to Medicaid if they went into a nursing home in 2014 and (2) a longitudinal look at how many current policyholders who became claimants would spend down to Medicaid if they entered a nursing home at age 82 (the average age of nursing home entry in the insured population).³⁴ The first method minimizes the need to make multiple assumptions relating to changes in income, assets, and costs throughout the aging process because current policyholder financial data is available. The second provides an estimate for what is likely to happen to individuals who require nursing home care in the future.³⁵ For both methods, we tracked differences by purchaser cohort (2000, 2005, and 2010) and also determined the impact of their insurance policy on spend-down rates. Based on industry data, roughly 30 percent of claimants use nursing home care.³⁶

The results of this analysis are shown in Figures 12 and 13. Depending on the purchaser cohort and the analysis method, between 21 and 31 percent of nursing home claimants would spend down to Medicaid in the absence of their LTC insurance policy. This theoretical claimant spend-down rate is lower than among the general population,³⁷ which is not surprising given that LTC insurance purchasers are generally better off financially. However, when we take into account the amount of LTC insurance benefits available to these claimants (that is, in the presence of LTC insurance), the spend-down rates decline significantly to between 8 and 16 percent.³⁸ Thus, LTC insurance reduces Medicaid spend-down rates by between 47 and 65 percent for those policyholders entering nursing homes.

To look at policyholders rather than claimants: Roughly 70% of those maintaining their policies will become claimants, and of these, 30 percent will use nursing home care. Therefore, the theoretical spend-down rate among policyholders in the absence of their policy would be between 5 and 7 percent; in the presence of insurance only between 1.8 and 3.2 percent would spend down.

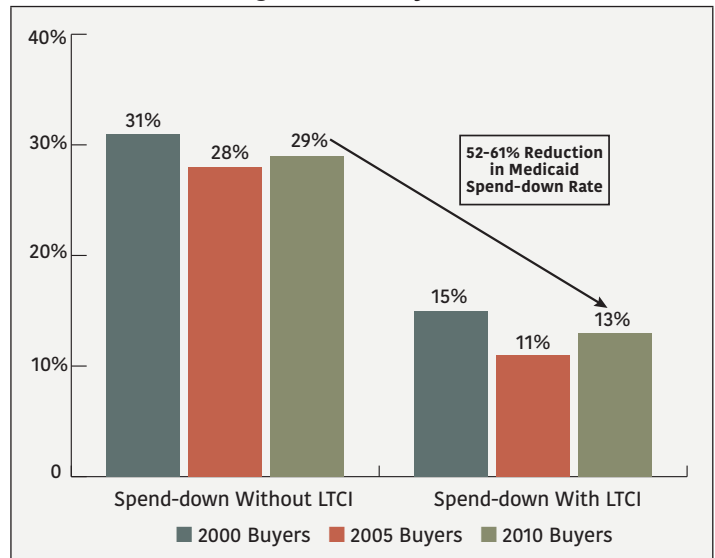
Figure 12: Impact of LTC Insurance on Medicaid Spend-down Rates Among Nursing Home Claimants, by Purchaser Cohort: Current Policyholders Accessing Care in 2014



Note: LifePlans analysis. Key assumptions used: 2014 Medicaid resource allowances for community spouses are at each state's maximum; the average length of stay in the nursing home is 1.9 years; and about 30% of claimants will use a nursing home.

In addition to modeling spend-down rates for those in a nursing home, we also looked at assisted living and home health care. Many people eligible for Medicaid immediately on entering a nursing home have "spent down" to Medicaid by spending resources on these other types of LTC, or they have become impoverished for other reasons unrelated to the use of

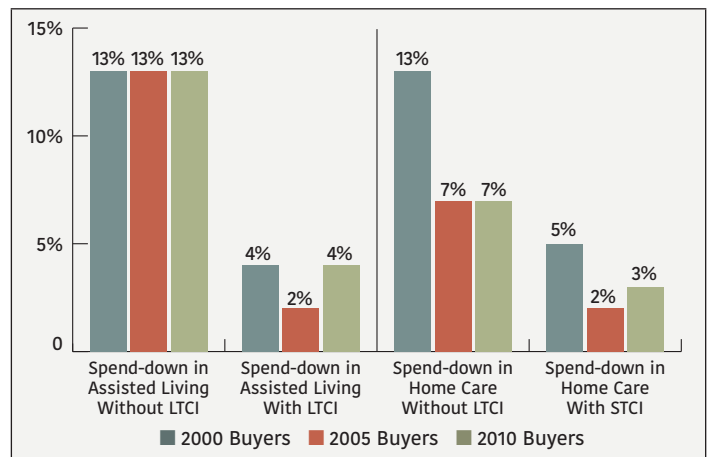
Figure 13: Impact of LTC Insurance on Medicaid Spend-down Rates Among Nursing Home Claimants, by Purchaser Cohort: Longitudinal Analysis of Service Use



Note: LifePlans analysis. Key assumptions used: 2014 Medicaid resource allowances for community spouses are at each state's maximum; income is increased at 3% per year to age 65 and at 2% per year from 65 to 82; assets are increased at 5% per year to age 65 and remain constant after 65; daily nursing home costs increase at 3.5% per year; the 2014 Medicaid eligibility income and asset limits remain the same for single buyers and increase by 1% per year for married couples; the average length of stay in the nursing home is 1.9 years; and about 30% of claimants will use a nursing home.

LTC services. Figure 14 shows the probabilities of spending down resources to Medicaid eligibility levels in the home care and assisted living settings in the presence and absence of insurance (using projections based on the longitudinal analysis of the data—that is, showing what would happen when people begin using care at age 82). In these settings, spending down is much less likely than in a nursing home, and for those with LTC insurance it is virtually eliminated.

Figure 14: Impact of LTC Insurance on Medicaid Spend-down Rates in Assisted Living and Home Care, by Purchaser Cohort

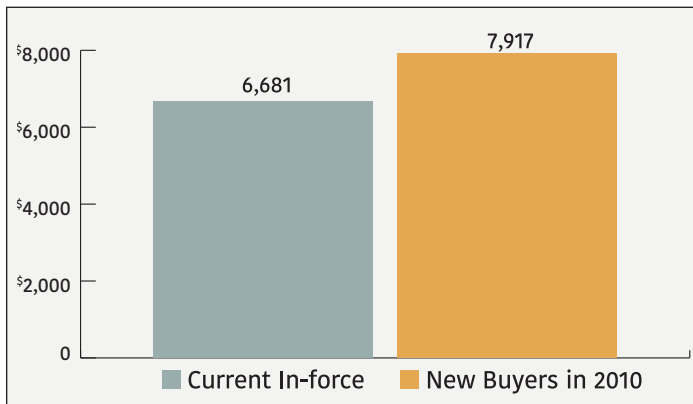


Note: LifePlans analysis, based on longitudinal claimant data. Key assumptions used: 2014 Medicaid resource allowances for community spouses are at each state's maximum; income is increased at 3% per year to age 65 and at 2% per year from 65 to 82; assets are increased at 5% a year to age 65 and remain constant after age 65; daily assisted living costs increase at 4.6% per year, and home care costs increase by 1.85% a year; the 2014 Medicaid eligibility income and asset limits remain the same for single buyers, and increase by 1% per year for married couples; the average length of stay in assisted living is 2.3 years and in home care is 1.98 years.

LTC insurance reduces Medicaid expenditures.

A key question facing policymakers is the extent to which encouraging the purchase of LTC insurance leads to reductions in Medicaid spending. In Figure 15 we estimate the expected lifetime Medicaid savings derived from the current in-force policyholder given their socio-demographic and policy design profile, as well as projected savings for new buyers (2010). Again, we account for the fact that a small percentage (.75%) will drop their policies each year. We focus exclusively on savings attributable to nursing home care, which likely underestimates to some extent the total savings attributable to growth in the LTC insurance market.

Figure 15: Projected Lifetime Medicaid Nursing Home Savings per In-force Policyholder and per New Buyer in 2010



Note: LifePlans analysis. Key assumptions used: 2014 Medicaid resource allowances for community spouses are at each state’s maximum; income is increased at 3% per year to age 65 and at 2% per year from 65 to 82; assets are increased at 5% a year to age 65 and remain constant after age 65; nursing home costs increase by 3.5% per year starting from a base of \$234 in 2014; the 2014 Medicaid eligibility income and asset limits remain the same for single buyers and increase by 1% per year for married couples; the average length of stay in the nursing home is 1.98 years; nursing home care is accessed at an average age of 82.

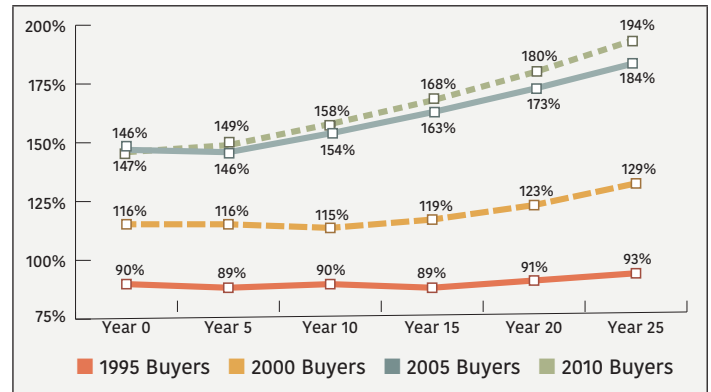
Currently there are roughly 7.4 million LTC insurance policyholders. A savings of \$6,681 per policyholder translates to Medicaid savings of \$49.4 billion over the lifetime of this cohort of policyholders. Given the average age of these policyholders, we assume that they will hold their policies for roughly 20 years, so the annualized Medicaid savings per in-force policy would be about \$334.

LTC insurance is effective in reducing Medicaid spend-down because it covers most of an insured’s LTC costs.

One of the reasons LTC insurance is effective in reducing spend-down rates is that it covers a majority of policyholders’ LTC costs. Figures 16 through 18 show the percentage of daily LTC costs covered by policies, based on each purchaser cohort for each of the three major service categories. We model the percentage of costs covered for

up to 25 years after policy purchase. The policy designs of roughly 8,000 people are modeled, along with the projected inflation rate in each of the service settings. The projection is based on historical cost data over the last decade.

Figure 16: Percentage of Daily Home Care Cost Covered by LTC Insurance



Note: LifePlans analysis. It is assumed that an individual uses roughly five hours of care a day, and the projected increase in costs is 1.85%, based on historical cost of care data. Inflation protection features in policies are accounted for.

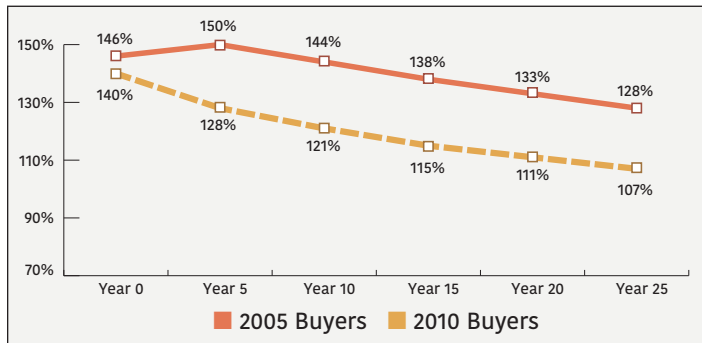
With regard to home care, LTC insurance is projected to cover at least 100 percent of daily costs, except for 1995 buyers. In 1995 a number of policies on sale still paid only 50 percent of the nursing home benefit for home care. Also, these earlier buyers are less likely to have compound inflation protection. After 1995 most individuals had home care daily benefit amounts that would cover all of the expected costs.

The average daily costs of assisted living are also covered fully by LTC insurance, as shown in Figure 17. Note that the percentage of costs covered declines over time—this is because the costs of assisted living, which include room and board, are expected to increase more rapidly than benefits chosen by purchasers. Moreover, not all individuals chose inflation protection, and of those who did, not all opted for compound inflation protection. We exclude from the analysis purchasers in 1995 and 2000, since assisted living facilities were not common then and many of the policies that were sold at that time did not explicitly cover them.

In the nursing home setting, somewhere between 50 and 80 percent of daily costs are covered, depending on the purchase cohort. Given their average age at policy purchase, 1995 and 2000 buyers typically enter the nursing home about 15 years after purchase, and at this point, policies show a decline in the average percentage of daily nursing home costs covered. This is due in large part to the fact that a smaller proportion of purchasers prior to 2000 were buying policies with inflation protection, and the costs of care increased while daily benefit amounts for these earlier policies stayed relatively constant.

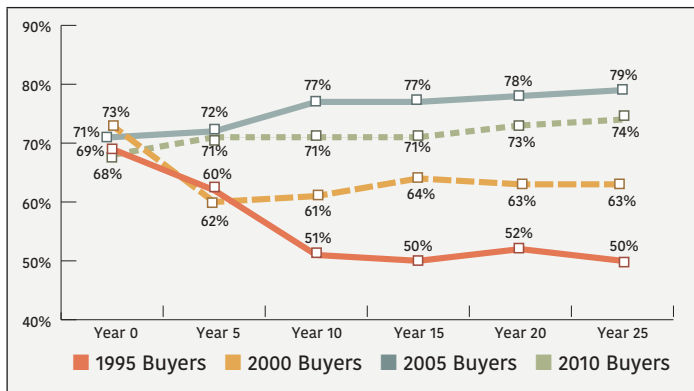
Taken together, these findings suggest that in the service settings most highly desired by individuals with impairments—home care and assisted living—insurance should cover almost all of the daily costs of care for a typical policyholder. Among buyers since 2005, policies cover

Figure 17: Percentage of Daily Assisted Living Cost Covered by LTC Insurance



Note: LifePlans analysis. A projected increase in costs of 4.6%, based on historical cost of care data, is assumed. Inflation protection features in policies are accounted for.

Figure 18: Percentage of Daily Nursing Home Cost Covered by LTC Insurance

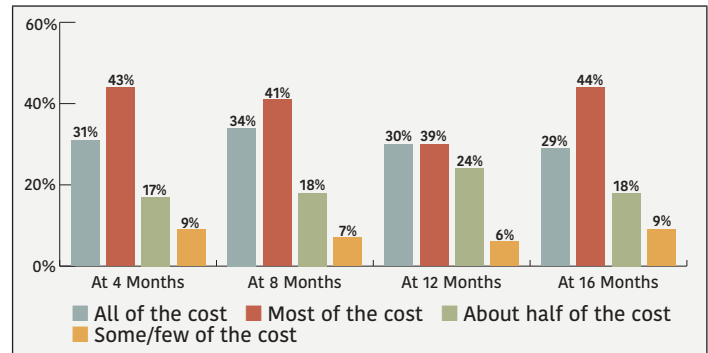


Note: LifePlans analysis. A projected increase in costs of 3.8%, based on historical cost of care data, was assumed.

75 to 80 percent of nursing home costs. It is important to note that this is not out of line with cost-sharing required by health insurance plans and is also consistent with expectations of individual buyers, who indicate that they expect their policies to pay for most but not necessarily all of the costs of care.³⁹ They choose to accept this cost-sharing in part to keep premiums down.

A view of current claimants, which is heavily weighted toward individuals who purchased policies in the 1990s, supports the finding that most or all of the costs of care are being covered by insurance. We analyzed results over a 16-month period among individuals who had just begun using services. Figure 19 shows that the policies of between 69 and 75 percent of claimants were paying for most or all care at any given time during this period.

Figure 19: LTC Costs Paid by LTC Insurance Over 16-Month Period, All Service Settings



Source: U.S. Department of Health and Human Services (DHHS), Following an Admissions Cohort: Care Management, Claim Experience, and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a Sixteen-Month Period, 2007

Conclusions and Implications

A review of basic industry parameters, information provided by individuals currently benefitting from the insurance, and a careful evaluation of the impacts of the insurance on Medicaid expenditures demonstrate that there is great current and future value in private LTC insurance policies. Growth in the market can both benefit new policyholders and caregivers and improve overall financing of LTC. But for LTC insurance to play a larger role in meeting the nation’s LTC needs, more middle-income individuals would have to obtain LTC coverage. This remains an ongoing challenge.

Growth in middle-income purchasers of LTC insurance is likely to lead to meaningful reductions in lifetime Medicaid costs. Such reductions could, in part, be used to cost-justify targeted tax-related subsidies designed to encourage middle-income consumers to buy. Finally, as the demographic balance shifts over the coming decades toward greater number of seniors living longer lives, there will be tremendous demands placed on the LTC service system. A robust private insurance market will help support the growth and development of a high-quality service infrastructure to meet growing demands. For all of these reasons, LTC insurers and policymakers must work together to ensure that the benefits of this insurance are more widely accessible to a much greater share of the middle income population.

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