THE HENRY J. KAISER FAMILY FOUNDATION

Private Long-Term Care Insurance:

Who Should Buy It and What Should They Buy?

Prepared by

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Prepared for

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Summary

About 4 million Americans had private long-term care insurance (LTCI) in the year 2000. Most purchasers to date have been affluent elderly or near-elderly people, often interested in protecting their estates in the event of a long nursing-home stay or other catastrophic episode. The Bush Administration has proposed expanded tax incentives for the purchase of LTCI, and similar proposals have attracted considerable support in Congress. Supporters of these proposals argue that promoting the purchase of LTCI will both protect consumers against possible catastrophic losses and ultimately save the federal and state governments by reducing future Medicaid outlays. Opponents contend that much of any new tax expenditure might go to people who would have bought LTCI anyway, and that LTCI will remain a "niche" product, attractive chiefly to wealthier people at or near retirement age.

Perhaps the central question in this debate is whether private LTCI is—or could be made--a workable product for most middle-income individuals and families. Despite the growing interest in LTCI among policymakers, there has been little independent examination of just how much protection it really provides or of whether it is a worthwhile purchase for people of average means. This report provides data and analysis that may begin to shed light on these questions. Data are drawn chiefly from the 1998 Survey of Consumer Finances (SCF) and the 1996 Medical Expenditures Panel Survey (MEPS). Because people at or near retirement face different issues from those faced by younger potential purchasers, the two populations are considered separately.

LTCI for Working Age Adults

Which working age families can afford LTCI? Despite continuing growth in the LTCI market, the industry has had little success in reaching younger purchasers. It is conceivable that broader educational efforts might make more working-age adults aware of their future risk of long-term care expenses and the possible role of LTCI in meeting those costs. LTCI bought early in life is comparatively less expensive, and most working-age adults could afford it, in theory. However, they also face many other much more immediate financial risks than the very distant eventuality of needing long-term care. Most obviously, they need to save for retirement. Those with dependents are generally advised to have life insurance to replace lost earnings in the event of premature death. In addition, it is thought to be a good idea to have a private disability income plan, in case one is forced to retire early, because Social Security disability benefits replace only a fraction of earned income. And certainly there is broad consensus on providing everyone in the family with

health insurance. Arguably, for people in mid-life, every one of these needs ought to take precedence over LTCI.

As Table ES-1 shows, three out of four married couples could theoretically afford LTCI, using the affordability criteria adopted in a recent study by the American Council of Life Insurers.[1] Yet, only one in five is adequately protected in all the other areas, including retirement savings, life insurance, health insurance, and disability insurance. The data suggest that a great many families who could afford LTCI are not preparing for retirement, or are not protected against life contingencies that could arise before expected retirement age. Most couples, if they have discretionary funds available, would probably be better advised to put them into savings or other forms of insurance before buying LTCI.

Table ES-1. Percent of Married Couples Who Can Afford Long-Term Care Insurance and Meet Other Tests of Financial Security, 1998

Age of household head	Households (000s)	Can afford LTCI	AND has adequate savings, including home equity	AND has adequate life insurance	AND all family members have health insurance	AND principal earner has disability insurance
35-44	10,323	73%	57%	30%	29%	18%
45-54	10,605	80%	52%	39%	36%	21%
55-59	3,411	72%	43%	39%	37%	25%
Total	**24,340**	**76%**	**53%**	**35%**	**33%**	**20%**

Note: Excludes married couples in which either spouse is under 35
Source: 1998 Survey of Consumer Finances, using ACLI premiums and thresholds.

For those who can afford LTCI, is early purchase wise? About 20 percent of couples whose head of household was aged 35 to 59 in 1998—almost 5

[1] Affordability criteria include: 1) Could afford LTCI: The couple meets the ACLI standards, based on income and age of the family head, for the purchase of LTCI for both spouses; 2) Adequate retirement savings: The couple is saving enough, relative to earned income, to prepare for retirement, taking into account current age, education, and eligibility for a defined benefit pension plan. Savings include home equity; 3) Life insurance: If the couple has minor children or one spouse is employed less than full time, the couple has life insurance with a face value equal to at least four times the principal earner's annual earnings. (This is less than financial planners generally recommend.) Couples with both members employed full-time and no children are assumed not to need life insurance; 4) Health insurance: All family members have public or private health coverage; 5) Disability income insurance: The principal earner has some form of disability insurance in addition to Social Security.

million couples—could afford LTCI and were adequately protected against other financial risks. Would it make sense for these couples to buy LTCI now, or would they do better to wait until they were closer to retirement age?

There are two basic arguments for early purchase. First, LTCI premiums are based on the buyer's age at the time of purchase; someone who buys coverage at a younger age can in theory lock in a much lower rate than someone who waits. But this is partly because the insurer has the use of the buyer's money during the interval.

Strictly in investment terms, would a buyer do better to buy coverage at age 40 or to put the money somewhere else and use the resulting gains to buy higher-priced coverage later—for example, at age 60? The answer is generally no. This is not because insurers do better on their investments, but because of voluntary and involuntary lapses. While some 40 year-olds will buy coverage and continue paying premiums for 25 years, others will pay premiums for a while and then die or terminate their policies before reaching age 65. Their contributions remain available to fund care for those remaining in the pool; in effect, those who lapse cross-subsidize those who remain. One paradox of proposals to promote early purchase is that, if everyone who bought LTCI early in life retained the coverage until old age, the financial advantage of early purchase would largely disappear.

The second argument for early purchase is that individuals who delay buying LTCI run the risk of failing underwriting screens if they attempt to purchase a policy in later life. If younger applicants wait to buy coverage until later in life, there is a risk that their health will have deteriorated and that they will have trouble finding an insurer willing to sell them an LTCI policy. In 1996, 89 percent of all people ages 40 to 44 would pass LTCI underwriting criteria, compared to 79 percent of people ages 60 to 64 (Table ES-2). If disability rates remain constant in the future—which they may not do—one in nine people who passed at age 40 would fail by the time he or she reached 65. In addition, there is a real risk of actually needing long-term care before turning 65.

Table ES-2. Percent of Population Passing Specified Underwriting Screens, by Age and Sex, 1996

Age group	Men	Women	Total
40-44	93%	85%	89%
45-49	92%	81%	86%
50-54	89%	79%	84%
55-59	87%	73%	80%
60-64	84%	75%	79%
65-69	74%	71%	72%
70-74	69%	67%	68%
75-79	61%	63%	62%

Source: 1996 Medical Expenditures Panel Survey

Weighing against early purchase is the extraordinary length of time that is likely to elapse before the buyer will actually need long-term care services. Someone who buys LTCI at 40 might not need services until he or she is 75 or 80. Buyers face great uncertainty about their own circumstances and needs three or four decades into the future. Of course there is some irreducible degree of uncertainty in any attempts to prepare for old age, and any kind of insurance is by definition something of a gamble. But the problem is compounded, in the case of LTCI, because most policies are tailored to cover specific services in the current delivery and financing environment.

That environment could change in any number of ways, making a specific policy bought today obsolete. There are likely to be further efforts to develop prepaid systems that integrate acute and long-term care. There may be new forms of supportive housing arrangements. New technologies might reduce the need for hands-on care for some kinds of patients. Medicare benefits might be modified, to cover more or fewer long-term care services, or some new public financing program for long-term care might be adopted—potentially overlapping with coverage under private LTCI policies. Any of these changes could mean that a policy bought today could have less value in the future or could fail to provide access to newly emerging service options.

Stand-alone LTCI products are a sensible investment for only a small minority of active workers. People of working age might derive greater benefit from investment or insurance products that adapt to their evolving needs at different stages of their lives. One option is the scheme explored by the Academy of Actuaries, under which a worker would pay into a plan for many years and, when closer to retirement, decide whether to take the accumulated amount in the form of LTCI or some other benefit. Other possibilities include a

combined life insurance/LTCI product or a combined life annuity/LTCI product. This option would not just address the problem that a given benefit package might become obsolete over time; it might also appeal to people who are uncertain of what their personal circumstances will be in the distant future. These products may be difficult to market and may be inhibited by current tax policy. Still, if the future challenge of long-term care financing is to be met, it is important to examine more promising or attractive ways of harnessing individuals' resources.

LTCI for Older Purchasers

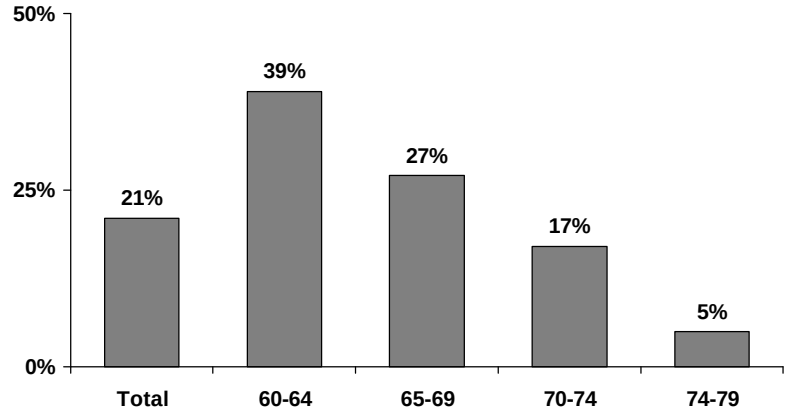
Which older adults can afford LTCI? At least for now, it is likely that the major market for LTCI will continue to consist of people at or near retirement age. They have a clearer picture than do younger people of what their resources and needs will be during their retirement years, and they are more likely to be conscious of their possible future need for long-term care. Underwriting aside, any estimate of the proportion of older people who could "afford" LTCI depends on fairly arbitrary concepts of what share of income people can spend, as well as on what kind of LTCI policy is thought to be minimally acceptable.

The National Association of Insurance Commissioners (NAIC), in its model regulation for LTCI, suggests that consumers should be discouraged from buying a policy if the premiums account for more than 7 percent of income or if the purchaser does not have at least $35,000 in financial assets. This is only meant to be a rough upper limit, and it should be noted that that many elderly already devote a substantial share of their income to medical care and health insurance (usually a Medicare supplement). The Urban Institute has estimated that out-of-pocket spending by the average elderly Medicare beneficiary consumed 21.7 percent of income in 2000; adding another 7 percent to buy LTCI may not be sustainable. Even under the fairly liberal NAIC standard, only a minority of near-elderly people could afford a mid-range policy[2]. The percentage drops sharply for those ages 65 and over (Figure ES.1).

[2] Premiums used are the Federal Long-term Care Insurance Program (FLTCIP) rates for a policy providing a $125 daily benefit for 3 years, with a 90-day elimination period and a 5 percent compound inflation protection.

Figure ES.1

Percent of Households with Household Head Aged 60 to 79 that Could Afford Mid-Range LTCI Under NAIC Suitability Standard, 1998



Note: Premiums used are the Federal Long-Term Care Insurance Program (FLTCIP) rates for a policy providing a $125 daily benefit for 3 years, with a 90-day elimination period and a 5% compound inflation protection.
Source: Author's analysis of 1998 Survey of Consumer Finances.

What should older people buy? A larger number of elderly people might be able to buy at least *some* amount of LTCI coverage. How can middle-income seniors, who can afford some protection but cannot afford the most comprehensive plans, decide exactly what to get? Many private carriers offer hundreds of variants; for example, the MetLife plan offered through AARP in 2002 has 360 possible benefit combinations. Even if the consumer knows what he or she is able to pay for LTCI, the agent can arrive at an acceptable price by tinkering with any of numerous components of policy design, and there is no ready way for either the consumer or the agent to identify which policy features are more important.

Promotional materials for LTCI often emphasize the likelihood of a long stay late in life, and concern about this possibility is clearly reflected in the kinds of packages people are buying. However, packages that might be thought "affordable" for middle-income seniors are unlikely to be sufficient to prevent impoverishment in the event of a truly catastrophic nursing home episode. Table ES-3 shows six plans offered under the Federal employees' LTCI program that would meet the affordability test for a 65 year-old single woman with median income and assets. [3]

[3] The medians, derived from the 1998 Survey of Consumer Finances, are: income $20,900, home equity $35,000, and financial assets $52,600.

Table ES-3. Federal LTCI Program Options for a 65 Year-old with Premiums of about $120 per Month, 2002

Plan	Daily benefit	Benefit period	Waiting period	Inflation protection
A	$75	5 years	30 days	Compound 5%
B	$100	3 years	90 days	Compound 5%
C	$150	5 years	30 days	None
D	$175	3 years	30 days	None
E	$175	5 years	90 days	None
F	$200	3 years	90 days	None

These plans are not very different from those that current LTCI purchasers typically buy. If the purchaser's chief aim is to protect savings, including home equity, none of the policies can meet this goal if the purchaser has a long nursing home stay beginning late in life. Table ES-4 shows what happens if the 65 year-old LTCI policyholder enters a nursing home 20 years later—that is, at age 85. Under some of the plans, she would have to sell her house in order to pay for her care as early as the second year of her stay. None of the plans, even those nominally providing five years of coverage, would prevent her from spending down to Medicaid eligibility over the course of a five-year stay.

Table ES-4. Patient Responsibility and Depletion of Assets under LTCI Options, Nursing Home Stay Beginning at Age 85

Plan	Benefit term	Patient responsibility, first year	Sells house before end of year--	On Medicaid before end of year--
A	5 years	$ 78,703	3	5
B	3 years	$ 72,402	4	5
C	5 years	$ 95,118	2	3
D	3 years	$ 86,743	3	4
E	5 years	$ 97,243	2	4
F	3 years	$ 90,368	3	4

Estate protection, then, may not be a meaningful goal for middle-income purchasers. Seniors who are less concerned about leaving a bequest than about being able to remain at home as long as possible might do better to buy a policy very different from those available in the current market. While this paper does not propose an "ideal" package, it does consider a number of basic policy features that warrant reexamination:

- *Duration.* People who stay in a nursing home for a year or more have a very small likelihood of returning home. If asset protection is not a goal, buyers with limited resources might do better to choose the shortest available coverage period—perhaps one or two years—and beef up other components of their plans.

- *Elimination period.* Most policies sold now provide benefits only after the policyholder has received services for 90 days. People with modest savings who need services for only a short period can make a significant dent in their nest eggs before coverage begins. The most appropriate product for a modest-income senior might have no waiting period—an option available under some private plans—and a shorter benefit duration.

- *Daily benefit.* LTCI policies pay a fixed daily benefit. Even if this benefit is enough to cover most or all of the cost of an average day of care, actual charges for any particular patient may be much higher or lower than this average. For example, elderly residents who have a payment source other than Medicare and who have short nursing home stays incur higher daily charges than those with longer stays; an average benefit will be too low for a short stay and too high for a long one. Similar variation in needs and costs is likely to exist for home health care. Other major payers for long-term care services use payment methodologies that reflect cost variation. It is worth exploring whether private LTCI policies could be designed, like private health insurance policies, to vary payments by severity or intensity.

- *Benefit trigger.* Finally, the benefit trigger established by the Health Insurance Portability and Accountability Act (HIPAA) and now used under most policies sold—requiring assistance with 2 or more out of a list of 5 activities of daily living (ADLs), or requiring supervision because of severe cognitive impairment—may be too rigid. The need for paid care depends on availability of informal supports as well as on level of disability. HIPAA authorized the Secretary of the Treasury to define alternative triggers reflecting "similar" levels of disability, but this has not occurred.

Conclusion

About three out of four married couples with both spouses ages 35-59 and at least one active worker can theoretically afford to purchase a fairly comprehensive LTCI policy. However, many of these couples are not saving

enough for retirement or lack other key protections, such as life, disability, and health insurance. Once these needs are taken into account, about one in five couples can afford to purchase LTCI. Early purchase can give them more affordable premium rates and protect against the risk that they might not meet underwriting standards if they applied for coverage later in life. A potential disadvantage of obtaining coverage so long before the likely need for services is that buyers may be locked into a plan that does not meet their needs as long-term care delivery and financing evolve in the future. There is a need for innovative, more flexible coverage options.

Older people are much less likely to be able to afford comprehensive coverage. The pared-down products that may be financially within the reach of middle-income households can provide only limited asset protection and at the same time may be suited to meet other goals, such as maximizing the likelihood of being able to remain at home or in a community setting. More research is needed to identify the variety of risks that individuals face and to develop alternative products that can better suit individual purchasers' circumstances, needs, and objectives.

Introduction

About 4 million Americans had private long-term care insurance (LTCI) in the year 2000.[4] LTCI provides fixed daily payments toward the cost of care in a nursing home and, under most policies currently sold, home care and care in assisted living facilities.

Most purchasers to date have been affluent elderly or near-elderly people, often interested in protecting their estates in the event of a long nursing-home stay or other catastrophic episode. However, an increasing number of employers—now including the federal government--offer their workers an opportunity to purchase group LTCI coverage. Within the individual market, which continues to account for most LTCI sales, there has been a slight shift toward younger purchasers in recent years (HIAA 2000), and a majority of financial planners are now recommending LTCI as an important part of their clients' planning for retirement (ACLI 1999).

While the aggregate number of policies, both sold and in force, has been growing steadily, the rate of growth has slowed in recent years, as table 1 shows. This might suggest that the market is approaching saturation, at least among the elderly and near-elderly population who have been the major source of sales to date. The opening of the new Federal Long-Term Care Insurance Program (FLTCIP), which will be available to an estimated 20 million employees, annuitants, and their relatives, may bring a spike in new sales. But some analysts doubt that private insurance will ever play a major role in long-term care financing.

[4] The Health Insurance Association of America (HIAA 2002) reports cumulative sales of 6.8 million policies as of 1999. However, many early purchasers have died or allowed their coverage to lapse, and some new policies sold may have replaced existing LTCI coverage. The estimate of 4 million policies in force is from LIMRA International (2001), an insurance and financial services trade group.

Table 1. Cumulative Sales of Private Long-Term Care Insurance, 1987-1999

Year	Cumulative policies sold (000s)	Percent increase over previous year
1987	815	
1988	1,130	39%
1989	1,550	37%
1990	1,930	25%
1991	2,430	26%
1992	2,930	21%
1993	3,417	17%
1994	3,837	12%
1995	4,351	13%
1996	4,960	14%
1997	5,542	12%
1998	6,080	10%
1999	6,831	12%

Source: HIAA (2002)

While it is understandable that the elderly are most interested in this protection, LTCI is expensive for those who buy it at older ages. A typical policy with inflation protection cost $1,802 a year for a 65 year-old in 1999; for a 79 year-old, the average cost was $5,895.[5] Moreover, potential buyers are subject to medical underwriting, to screen out those likely to need long-term care in the near future. LTCI is much more affordable for those who buy it earlier in life, so that premium contributions can accumulate through the years before they are at much risk of needing services. The average premium for a 40 year-old for comparable coverage was only $649 in 1999. The amount may be even lower if coverage is purchased through an employer group plan. However, relatively few people of working age place a priority on providing for long-term care costs that may be very far in the future.

The Bush Administration has proposed expanded tax incentives for the purchase of LTCI, and similar proposals have attracted considerable support in Congress. Supporters of these proposals argue that promoting the purchase of LTCI earlier in life will both protect consumers against possible catastrophic losses and ultimately save the federal government money by reducing future Medicaid outlays. Opponents contend that much of any new tax expenditure might go to people who would have bought LTCI anyway, and that LTCI will

[5] Average premiums are "generally" for a $100 daily benefit, 4 years of coverage, and a 20-day elimination period, with 5 percent compound inflation protection (HIAA 2002).

remain a "niche" product, attractive chiefly to wealthier people at or near retirement age.

Perhaps the central question in this debate is whether private LTCI is—or could be made--a workable product for middle-income individuals and families. Despite the growing interest in LTCI among policymakers, there has been little independent examination of just how much protection it really provides or of whether it is a worthwhile purchase for people of average means.

The issues are different, depending on whether one focuses on younger potential purchasers or on the population at or near retirement:

- How many working-age families can afford LTCI? How does it fit into their overall financial planning? Is it a sensible investment for people who are decades away from requiring long-term care? How can LTCI policies can be made more flexible, to assure that they will keep pace with changes in long-term care delivery and financing?

- How affordable is LTCI for older people? For those who can afford it, what kind of coverage makes sense? Are there less costly products that might reach more buyers and could still provide some meaningful protection?

This report provides data and analysis that may begin to shed light on some of these questions. All of them involve subjective concepts, such as "affordability," and there is no single right answer to them. The aim is merely to lay the groundwork for a more realistic assessment of LTCI and its potential role in the nation's long-term care financing system.

Data used in this report are drawn from several national surveys:

- The 1998 Survey of Consumer Finances, conducted by the Federal Reserve Board.

- The 1996 Medical Expenditures Panel Survey, conducted by the Agency for Healthcare Research and Quality.

- The 1999 National Nursing Home Survey, conducted by the National Center for Health Statistics, Centers for Disease Control.

- The 2000 National Home and Hospice Care Survey, also conducted by the National Center for Health Statistics.

Most examples of LTCI premium rates and policy provisions are based on the terms of the new Federal Long-Term Care Insurance Program (FLTCIP). This program offered an early enrollment period beginning in March 2002, and the terms described here are those applicable during that period. There have been some changes in the program for the general open enrollment period beginning in July 2002.[6]

LTCI for Working Age Adults

Which working age families can afford LTCI?

Despite continuing growth in the LTCI market, the industry has had little success in reaching younger purchasers. In the individual market, virtually all purchasers in the year 2000 were 55 or older (LifePlans 2000). As growing numbers of employers offer access to group LTCI coverage, the number of younger purchasers may increase. However, penetration rates in group LTCI programs have been quite low, and participants have tended to be concentrated among older workers (LifePlans 2001).

A common explanation is that many people have little understanding of what long-term care services cost or how they are financed; many mistakenly suppose that Medicare, retiree health plans, or Medigap policies will meet their long-term care needs in old age (AARP 2001). It is conceivable that broader educational efforts might make more working-age adults aware of their future risk of long-term care expenses and the possible role of LTCI in meeting those costs.

However, younger workers might hesitate to invest in LTCI even if they understood that spending a small amount now could potentially prevent very large expenditures in the future. This is partly because the need for long-term care seems very distant, and partly because of what economists call "time preference" rates. For younger people, a dollar available for immediate consumption may be more valuable than a hundred dollars available ten years in the future, or a thousand dollars available in old age.

Some attempts to estimate the potential size of the LTCI market take account of this problem through simple linear formulas. For example, a recent study by the American Council of Life Insurers (Stucki and Mulvey, 2000) assumes that people aged 35-44 would be willing to spend 2 percent of income

[6] Some observers believe that, while FLTCIP is a group program, its rates may be higher than those for comparable individual coverage because of its less restrictive underwriting. However, FLTCIP is used for illustrations here because of its wide variety of easily comparable packages.

on LTCI, people aged 45-54 would be willing to spend 3 percent of income, and so on. This ascending scale may be taken as reflecting the fact that older people are more aware of long-term care and also more willing to forgo current consumption in order to save for long-term care. The particular income thresholds are derived from Wiener, Illston, and Hanley (1994); the authors meant them as extreme upper bounds of "affordability," rather than as estimates of what people would reasonably spend for LTCI.[7] They are adopted in the following discussion simply in order to build on ACLI's examples.

Table 2 shows ACLI's estimates of premiums for a reasonably comprehensive LTCI policy, the share of income working-age adults would be willing to spend, and the minimum income at which LTCI becomes "affordable."

Table 2. Premiums and Affordability Thresholds by Age, ACLI Model

Age	Premium for 3-year policy	Percent of income threshold	Minimum income to buy LTCI
35-39	$ 411	2%	$ 20,550
40-44	$ 541	2%	$ 27,050
45-49	$ 644	3%	$ 21,467
50-54	$ 693	3%	$ 23,100
55-59	$ 911	4%	$ 22,775

Note: Premium based on average price of four major insurers for a policy covering 3 years of care with a $100 daily benefit for both nursing home and home health care, a 90-day elimination period, and 5%compound inflation protection.
Source: Stucki and Mulvey (2000).

Tables 3 and 4 use ACLI's assumptions to calculate the proportion of households that could afford LTCI, based on household income reported in the 1998 Survey of Consumer Finances (SCF) conducted by the Federal Reserve Board.[8] Two out of three meet ACLI's affordability test.

[7] Personal communication, Joshua Wiener, July 2002.
[8] The estimates differ from ACLI's, partly because a different survey is used and partly because of some differences in methodology.

Table 3. Proportion of Households That Could Afford LTCI, by Age of Household Head, 1998

Age of household head	Households (000s)	Households that could afford LTCI (000s)	Percent that could afford LTCI
35-44	19,708	12,422	63%
45-54	19,260	13,692	71%
55-59	7,871	4,731	60%
Total	46,838	30,845	66%

Note: Assumes 10 percent discount for married couples and excludes couples in which either spouse is under 35. Percent-of-household-income thresholds for couples are the same as those used for single people. Columns may not sum due to rounding.
Source: 1998 Survey of Consumer Finances, using ACLI premiums and income thresholds.

Table 4. Proportion of Households That Could Afford LTCI, by Household Income, 1998

Household income	Households (000s)	Households that could afford LTCI (000s)	Percent that could afford LTCI
Under $25,000	11,916	953	8%
$25,000-$49,999	13,675	8,645	63%
$50,000-$99,999	15,485	15,485	100%
$100,000 and over	5,763	5,763	100%
Total	46,838	30,845	66%

Note: Assumes 10 percent discount for married couples and excludes couples in which either spouse is under 35. Percent-of-household-income thresholds for couples are the same as those used for single people. Columns may not sum due to rounding.
Source: 1998 Survey of Consumer Finances, using ACLI premiums and income thresholds.

Should all of these people be encouraged--through education, tax incentives, or other means—to buy LTCI?

While the risk of needing long-term care in old age is significant, working-age adults face many other much more immediate financial risks. Most obviously, they need to save for retirement. Those with dependents ought to have life insurance, to replace lost earnings in the event of premature death. Because Social Security disability benefits replace only a fraction of earned income, it is a good idea to have a private disability income plan, in case one is forced to retire early. And certainly everyone in the family ought to be covered

by health insurance. Arguably, for people in mid-life, every one of these needs ought to take precedence over insuring against the much more distant eventuality of needing long-term care. (This doesn't even consider other financial priorities a couple might have, such as providing for their children's education.)

How well are people doing? Table 5, again using the 1998 SCF, examines the financial health of married couples whose head was aged 35 to 59 and in which either the household head or the spouse was still actively employed.[9] It shows the percent of households meeting each of the following criteria:

- **Could afford LTCI.** The couple's income meets the ACLI standard for the purchase of LTCI for both spouses.
- **Adequate retirement savings.** The couple is saving enough, relative to earned income, to prepare for retirement, taking into account current age, education, and eligibility for a defined benefit pension plan.[10] Savings are measured with and without including home equity.
- **Life insurance.** If the couple has minor children or one spouse is employed less than full time, the couple has life insurance with a face value equal to at least four times the principal earner's annual earnings. (This is less than financial planners generally recommend.) Couples with both members employed full-time and no children are assumed not to need life insurance.
- **Health insurance.** All family members have public or private health coverage.
- **Disability income insurance.** The principal earner has some form of disability insurance in addition to Social Security.

[9] In contrast, tables 3 and 4 include single people and do not consider employment status.
[10] The thresholds adopted here are those developed by Engen, Gale, and Uccello (1999). They yield more optimistic estimates than some other measures of the proportion of families with adequate savings.

Table 5. Percent of Married Couples Meeting Each Specified Criterion of Financial Health, 1998

Age of household head	Households (000s)	Could afford LTCI	Adequate savings		Adequate life insurance	All family members have health insurance	Principal earner has disability insurance
			Including home	Excluding home			
35-44	10,323	73%	69%	55%	49%	81%	52%
45-54	10,605	80%	61%	44%	71%	85%	53%
55-59	3,411	72%	55%	29%	85%	86%	53%
Total	24,340	76%	64%	47%	64%	84%	53%

Note: Excludes married couples in which either spouse is under 35
Source: 1998 Survey of Consumer Finances, using ACLI premiums and thresholds.

When these tests are applied one by one, most couples pass each of them—although fewer than half have adequate savings if home equity is excluded, and a great many families lack disability income coverage.[11] What if the tests are applied in combination? That is, how many couples who could afford LTCI also have adequate savings? Of these, how many have life insurance, and so on?

As table 6 shows, while three out of four couples could in theory afford LTCI, only one in five is adequately protected in all the other areas. Obviously different measures could be used: financial planners have widely varying ideas about how much people need to save, how much life insurance is enough, and so on. The point is simply that a great many families who could in theory afford LTCI are not preparing for retirement, or are not protected against life contingencies that could arise before expected retirement age. Most couples, if they have discretionary funds available, would probably be better advised to put them into savings or other forms of insurance before buying LTCI.

[11] Obviously families' financial condition has changed since 1998. Home equity has risen, although there is growing speculation that some of the gains may have been temporary. Financial assets may not have changed very much; major stock indices are, at this writing, at or below 1998 levels.

Table 6. Percent of Married Couples Meeting All Specified Criteria of Financial Health, 1998

Age of household head	Households (000s)	Can afford LTCI	AND has adequate savings, including home equity	AND has adequate life insurance	AND all family members have health insurance	AND principal earner has disability insurance
35-44	10,323	73%	57%	30%	29%	18%
45-54	10,605	80%	52%	39%	36%	21%
55-59	3,411	72%	43%	39%	37%	25%
Total	24,340	76%	53%	35%	33%	20%

Note: Excludes married couples in which either spouse is under 35
Source: 1998 Survey of Consumer Finances, using ACLI premiums and thresholds.

For those who can afford LTCI, is early purchase wise?

About 20 percent of couples whose head was aged 35 to 59 in 1998—almost 5 million couples—could afford LTCI and were adequately protected against other financial risks, using the measures described above. Would it make sense for these couples to buy LTCI now, or would they do better to wait until they were closer to retirement age?

There are two basic arguments for early purchase. First, LTCI premiums are based on the buyer's age at the time of purchase; someone who buys coverage early in life can in theory lock in a much lower rate than someone who waits. (There remains a risk that the insurer will impose a general rate increase; this issue is considered later in this section.) Second, younger applicants are more likely to meet insurers' underwriting tests. If they wait to buy coverage until later in life, there is a risk that their health will have deteriorated and that they will have trouble finding an insurer willing to sell an LTCI policy.

Weighing against early purchase is the extraordinary length of time that is likely to elapse before the buyer will need long-term care services. Someone who buys LTCI at 40 might not need services until he or she is 75 or 80. Buyers face great uncertainty about their own circumstances and needs three or four decades into the future. Nor can they predict what the world will look like. Will medical advances reduce the likelihood that they will need long-term care? Will the way long-term care is delivered change, so that coverage sold today might not meet

future needs? Could future changes in public policy affect the role of private financing for long-term care?

The remainder of this section will explore each of these considerations—cost, underwriting, and uncertainty—in greater detail.

Premiums and issue age

Table 7 shows annual premiums under the FLTCIP for a policy providing a $100 daily benefit for three years, with a 30-day elimination period. The policy is available with and without a 5% compound inflation option, which increases the daily benefit each year.[12] For the policy without inflation protection, the rate at age 60 is more than 3 times the rate at age 40. For a policy with inflation protection the ratio is somewhat lower, a little more than 2 to 1. This is because the compound value of the protection is greater for purchasers with a longer interval between purchase and claim.

Table 7. Annual Premium Rates for Comparable Benefits by Age and Inflation Protection, FLTCIP, 2002

	At age 40	At age 60	Difference
Compound inflation protection:			
No	$ 168	$ 562	234%
Yes	$ 593	$ 1,282	116%

Source: OPM (2002)

Harry, aged 40, could buy the policy without inflation protection now for $168 or could wait until age 60 and pay $562, or $394 more per year. (This price, for the fixed $100 daily benefit, would not be expected to go up over the intervening 20 years unless the insurer made some change in its basic rating assumptions.) Strictly in investment terms—leaving aside underwriting or other considerations--would he do better to buy the coverage now or to put the money somewhere else?

For example, Harry might put $168 a year into a Roth IRA. If this account earned 5 percent interest a year, Harry would have accumulated $5,833 by age

[12] Policies without the compound inflation feature have a future purchase option: the buyer will be offered an opportunity every two years to increase the daily benefit amount by paying an additional premium. The added premium amount is based on the buyer's age at the time he or she accepts the benefit increase.

60. At this point he could take the proceeds in the form of a life annuity paying $445 a year, more than enough to pay the extra premium resulting from the delayed purchase.

Table 8. Early Purchase of LTCI Compared to Investment of Premium Amounts over Twenty Years

	No compound inflation	Compound inflation
Cost of LTCI at age 40	$ 168	$ 593
Cost of same protection at age 60	$ 562	$ 3,400[a]
Difference	$ 394	$ 2,807
Invest age-40 premium for 20 years, with 5% interest		
Accumulation by age 60	$ 5,833	$ 20,582
Annuity value[b]	$ 445	$ 1,993

[a]Premium for a $265 daily benefit with compound inflation protection.
[b]The payout calculation is based on the Society of Actuaries' mortality table RP-2000 for healthy male annuitants and again assumes a 5 percent return.

This assumes that Harry will only want a $100 daily benefit twenty years from now. Given future inflation, this is unlikely to buy very much care. If he were to buy the policy with inflation protection now, at a cost of $593 a year, the policy's daily benefit amount would have reached $265 by the time Harry was 60, and would increase thereafter. If he waited until he was 60 and wanted a policy providing the same protection—a $265 starting daily benefit and future inflation increases—he would have to pay $3,400, or $2,807 more than if he bought the policy now.

Could Harry make up this difference, as in the previous example, by investing $593 a year over twenty years? Not quite. If his savings earn 5 percent a year, he will have only $1,993 a year available at age 60—about $800 less than he needs to pay the higher premium resulting from delayed purchase. He would break even if he could realize 8 percent a year on his investments, but this is very optimistic, especially over a twenty-year period.

How does an insurance company—which is basically taking Harry's premium payments and investing them--do so much better? Insurers are required by regulators to invest fairly conservatively; most project interest on

reserves in the 5 to 7 percent range. Moreover, they must use some of this return to cover administrative costs and produce a desired profit level.[13]

The insurer is able to charge so much less to a 40 year-old because, while some 40 year-olds will buy coverage and go on paying premiums for 25 years, there are others who will pay premiums for a while and then die or voluntarily terminate their policies before reaching age 65. Considering just voluntary lapse: the insurer might assume that 10 percent of purchasers would drop coverage after the first year, 7 percent after the second, and 2 percent in each subsequent year. At the end of 20 years, only 59 out of every 100 original buyers are still in the pool. But the amounts the other 41 buyers paid before lapsing remain in the pot, earning interest and ultimately available to pay claims for the remaining policyholders. In effect, those who lapse cross-subsidize those who remain.

Some people refer to LTCI as a "lapse-driven" product, because its pricing is so heavily dependent on the assumption that many purchasers will drop out before incurring claims. If everyone who bought LTCI early in life retained the coverage until old age, the financial advantage of early purchase would largely disappear.[14] The advantage has in fact been diminishing: based on recent experience, conservative insurers are now assuming voluntary terminations at a rate of 2 percent a year, rather than the 4 percent that was thought to be conservative just a few years ago. In addition, lapse rates appear to be smaller when coverage is bought through group plans.

One proposal in the 107th Congress to expand tax preferences for LTCI (H.R. 831/S. 627) included incentives to retain coverage. For people under age 55 who were buying LTCI for the first time, 60 percent of the premium would have been deductible. Once the buyer had been continuously covered for 4 years, 100 percent of the premium would have been deductible.

At least for the present, Harry would benefit financially from buying early *if he is reasonably certain that he will go on paying premiums*—that he'll be one of the 59 winners and not one of the 41 losers. Of course no one can be entirely certain; even people who have done careful financial planning can be at risk of

[13] The funds required for these purposes amount to a higher percentage of a low premium than of a high premium. This is why Harry could actually beat the insurer in the $168/$562 example, but not in the $593/$3,400 example, even though both are affected by lapse.

[14] It would not disappear entirely, because rates for older purchasers are also likely to reflect the fact that they may be in a better position to assess the likelihood that they will need LTC, resulting in adverse selection.

unexpected shocks, like loss of a job or a decline in the value of investments, that may make paying for LTCI more difficult.[15]

Moreover, there is always the possibility that rates will increase. The NAIC has adopted new model regulations intended to reduce the likelihood that insurers will set artificially low initial premiums and raise rates later on. However, insurers' experience with LTCI is still so limited that large rate increases remain a real possibility even in the few states that have adopted the new rules. (For a review of the model rules and the loopholes that may remain, see Lewis, Wilkin, and Merlis 2003)

Under many plans, Harry can hedge his bets by adding a nonforfeiture feature. A nonforfeiture benefit allows a purchaser who stops paying premiums to retain some coverage. However, a nonforfeiture benefit typically raises the price of a policy by about 30 percent, precisely because it deprives the insurer of some of the financial gain resulting from a lapse. In effect, buying the benefit neutralizes most of the advantage of early purchase.

Underwriting

Someone who delays buying LTCI runs the risk of failing underwriting screens if he or she tries to buy a policy later in life. This may be especially true if someone declines employer-based group LTCI, which tends to have lenient underwriting standards, and later seeks LTCI in the individual market.

How great is this risk? Table 9 shows, by age group, the share of the noninstitutionalized population that would pass a set of screens roughly comparable to the "short form" criteria used for active federal workers applying for coverage under the new FLTCIP. (Annuitants and other eligible groups face more stringent "long form" underwriting.) The illustration is based on the household and nursing home components of the 1996 Medical Expenditures Panel Survey (MEPS). Individuals fail if they meet any one or more of the following criteria:

- Required assistance with any activity of daily living (ADL) during 1996.
- Received any paid home health care during 1996.
- Received treatment in 1996 for any of a list of specified medical conditions.[16]

[15] It is perhaps ironic that Enron employees were able to buy group LTCI; now that their retirement savings are gone, those who bought LTCI may wish they had put their money somewhere else.

- Was a nursing home resident on January 1, 1996.

Table 9. Percent of Population Passing Specified Underwriting Screens, by Age and Sex, 1996

Age group	Men	Women	Total
40-44	93%	85%	89%
45-49	92%	81%	86%
50-54	89%	79%	84%
55-59	87%	73%	80%
60-64	84%	75%	79%
65-69	74%	71%	72%
70-74	69%	67%	68%
75-79	61%	63%	62%

Source: 1996 Medical Expenditures Panel Survey

As the table shows, 89 percent of all people aged 40 to 44 would pass, compared to 79 percent of people aged 60 to 64.[17] If disability rates remain constant in the future—which they may not do—one in nine people who passed at 40 would fail by the time he or she reached 65. It should be noted that actual decline rates by LTCI carriers may be somewhat lower, perhaps 10 to 20 percent of applicants (American Academy of Actuaries 1999). However, this figure may not include people who are deterred from applying when they learn about underwriting tests.

In addition, there is a real risk of actually needing long-term care before turning 65. Table 10 shows, not surprisingly, that the share of the population that is in a nursing home or that is in the community and receiving care with at least one ADL rises with age. However, this does not reflect the risk faced by a typical LTCI purchaser, because many people receiving long-term care before old age would be screened out in the underwriting process. Actual experience of long-term care insurers during the period 1984-1993 was that only 5 out of 10,000 policyholders under the age of 60, and about 1 out of every 1,000 policyholders aged 60-64, filed a claim in any given year.

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[16] The MEPS diagnostic classes used to approximate the FLTCIP excluded conditions are: acute and unspecified renal failure, acute cerebrovascular disease, chronic renal failure, diabetes mellitus with complications, mental retardation, multiple sclerosis, other bone disease and musculoskeletal disease, other psychoses, paralysis, Parkinson's disease, schizophrenia and related disorders, senility and organic mental disorders, transient cerebral ischemia.

[17] Women are less likely to pass at each age level, largely because they have a much higher reported incidence than men for every one of the medical conditions used in screening. Because conditions are self-reported, this may or may not reflect real differences in prevalence.

Table 10. Population Receiving Long-Term Care Services by Age, 1996

Age group	Population (000s)	In nursing home or in community and receiving ADL assistance	
		Number (000s)	Percent
40-44	21,857	312	1.4%
45-49	18,559	214	1.2%
50-54	14,842	290	2.0%
55-59	10,931	272	2.5%
60-64	9,893	412	4.2%

Source: 1996 Medical Expenditures Panel Survey

Dealing with uncertainty

Someone who buys long-term care insurance at age 40 is unlikely to need services for 35 years or more. A 40-year-old cannot know what his or her finances, health, or functional status will be, and cannot easily predict other changes in personal circumstances that might affect the need for long-term care. For example, will her children remain nearby, able to furnish informal care, or will they live thousands of miles away? Will she herself remain in the same place, or will she move to someplace where long-term care costs much less or much more?[18]

Of course there is some irreducible degree of uncertainty in any attempts to prepare for old age, and any kind of insurance is by definition something of a gamble. But the problem is compounded, in the case of LTCI, because most policies are tailored to cover specific services in the current delivery and financing environment. That environment could change in any number of ways that could make a specific policy bought today obsolete.

To illustrate the scope of possible changes over 35 years, one might consider long-term care delivery and financing as it existed in 1967. Formal home health care delivery was rare, accounting for 7 percent of total long-term care spending, compared to a projected 28 percent in 2002 (CMS, Heffler et al.).

[18] One recent survey suggests that nursing home costs are three times as high in the New York City area as in Louisiana (GE Capital 2002).

Some service modalities, such as assisted living facilities and continuing care retirement communities, did not exist. The Medicare program had just begun operations, offering very limited long-term care benefits; in particular, home health care was available only after a hospital stay. Some states had not even implemented their Medicaid programs, and Medicaid coverage for intermediate care in nursing homes was not yet permitted.

This report will not offer any guesses about what the world will look like in 2037. There are likely to be further efforts to develop prepaid systems that integrate acute and long-term care. There may be new forms of supportive housing arrangements. New technologies might reduce the need for hands-on care for some kinds of patients. Medicare benefits might be modified, to cover more or fewer long-term care services, or some new public financing program for long-term care might be adopted—potentially overlapping with coverage under private LTCI policies. Any of these changes could mean that a policy bought today could have less value in the future or could fail to provide access to newly emerging service options.

The problem of LTCI policy obsolescence has already arisen. The earliest policies, sold in the 1970s, covered nursing home care only; even this coverage was often subject to a prior hospitalization requirement. States have occasionally intervened to compel insurers to modify benefits; for example, some states require insurers to cover care in assisted living facilities even if this benefit was not included in the policy at the time it was issued. More commonly, however, policyholders who want to update their coverage must pay to do so.

The policyholder can terminate existing coverage and buy a new policy with the desired additional features. The disadvantage is that the new policy will be priced according to the buyer's attained age. So a buyer who bought coverage at age 40 and seeks to replace that coverage at age 60 will pay more—or, if he no longer meets underwriting standards, may not be able to buy new coverage at all. Some insurers will allow policyholders to upgrade their coverage without underwriting, but the price of the upgrade is always based on attained age.

Relying on replacement as the way of assuring that policies keep pace with system change has the further disadvantage that it is subject to abuse. Because agents and brokers may receive higher commissions for new business than for renewals, they can have an incentive to churn policyholders into new policies even when the new policy is not materially better than the one it replaced. States have responded by requiring consumer disclosures and reporting of replacement sales to state regulators. Regulators believe that inappropriate replacement is less of a problem than it was some years ago

(Lewis, Wilkin, and Merlis). Still, given the price disadvantages of replacement, it would be preferable if there were some other way of keeping policies current.

At least one insurer, Prudential, offers an "emerging trends benefit," under which benefits may be provided for services not specifically covered under the policy. What to cover, and how much to pay, remains at the sole discretion of Prudential. In effect, the provision merely formalizes what other insurers may be doing informally, making ad hoc coverage decisions on an individual basis—presumably when authorizing an extra uncovered service can prevent the use of a more costly covered service.

Consumers can make their own decisions if they buy a policy that provides a fixed cash benefit, instead of services, when the policyholder meets specified disability criteria, such as requiring assistance with two or more ADLs.[19] This kind of policy is less likely to become obsolete, because the benefits could be used for whatever new kinds of services become available. However, these "indemnity" policies tend to be more costly than service-specific policies furnishing comparable benefit values. This is because every policyholder who meets the disability criteria is likely to file a claim, while not every disabled person holding a service policy will actually receive covered services.

It is possible to conceive of a product that would allow buyers to begin paying into the pool fairly early in life but delay the choice of actual policy features until some later date. For example, Harry might start paying premiums at 40 and then, at age 60, be presented with a menu of LTCI policies that he could buy at the same annual premium. This system might require some form of outside referee—whether a state regulator or a private arbitrator—to assure that the policies ultimately offered fairly reflected what Harry had been paying in. But delayed decision-making might be a way of preserving the advantages of early purchase and fund accumulation, while at the same time allowing selection of a product at a time closer to actual use of services.

A study by the American Academy of Actuaries (1999) considered a further extension of the same principle, under which people would pay into a (public or private) program during their working lives and, when reaching retirement age, decide whether to take the proceeds in the form of LTCI or in the form of a retirement annuity. This option would not just address the problem that a given benefit package might become obsolete over time; it might also appeal to people who are uncertain of what their personal circumstances will be in the distant future.

[19] These policies were first marketed by UnumProvident.

The major potential problem with allowing this kind of deferred decision-making is adverse selection at the time the decision is finally made. A 40-year-old may have no idea of the likelihood that he or she will need long-term care; a 60-year-old, while still uncertain, may be in a better position to guess. Healthy people might choose the retirement income and sicker ones the LTCI. Similar selection problems might occur if the choice were between different LTCI policies. People who thought they would need care soon might opt for a higher immediate benefit, while those not expecting to need services until later might choose a lower benefit with inflation protection.

One solution is to require some time to elapse between the decision date and the actual effective date of LTCI coverage. For example, the buyer might choose between LTCI and retirement income at age 60, but would not actually receive either benefit until age 65. The Academy of Actuaries study suggests that this five-year interval would probably be sufficient to overcome most of the selection problem.

Another option would be to develop products that automatically convert from one kind of insurance to another at a given point in life. For example, a policy might function as a life insurance plan only until retirement age, because the main function of life insurance is to replace lost potential earnings of an active worker. After age 65, the accumulated premiums might then be treated as having been paid into an LTCI policy.[20] Yet another alternative is a product bought at retirement age that provides both a life annuity and long-term care coverage (Warshawsky, Spillman, and Murtaugh 2000).

There may be other ways of designing investment or insurance products that can evolve to meet people's changing needs over the course of their lives. One barrier to these products may be that consumers find them difficult to understand, while agents and brokers find them complicated to sell (LIMRA International 2002). In addition, they may present complex tax policy issues, to the extent that they may combine products that are currently tax-favored (such as LTCI) with products that are not (such as life or disability insurance). Still, it is clear that stand-alone LTCI is a product that is likely to appeal only to a relatively small number of active workers. Innovation in this area is urgently needed.

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[20] There exist life insurance policies with long-term care riders that essentially provide an accelerated death benefit for a policyholder needing long-term care. However, few companies are still marketing these products (HIAA 2002). Moreover, because these policies pay out whether or not the policyholder receives long-term care before death, a given level of long-term care protection is more costly than under a policy that converts from one kind of coverage to another at a given age.

LTCI for Older Purchasers

Which older adults can afford LTCI?

At least for now, it is likely that the major market for LTCI will continue to consist of people at or near retirement age. They have a clearer picture than do younger people of what their resources and needs will be during their retirement years. They are more likely to be conscious of their possible future need for long-term care (though even younger elderly people may still be in denial on this point). And they may prudently drop other kinds of insurance whose purpose is to replace employment earnings, such as life and disability coverage, and shift the spending to LTCI. Unfortunately, by the time people reach the age at which they might think seriously about LTCI, a majority are likely to find that the premiums for very comprehensive policies are unaffordable. Moreover, as was suggested by table 9, a substantial number of people who could afford coverage might, if they have waited until reaching 60 or 65, fail underwriting screens.

Underwriting aside, any estimate of the proportion of older people who could "afford" LTCI depends on fairly arbitrary concepts of what share of income people can spend, as well as on what kind of LTCI policy is thought to be minimally acceptable. The National Association of Insurance Commissioners (NAIC), in its model regulation for LTCI, suggests that consumers should be discouraged from buying a policy if the premiums will take more than 7 percent of income or if the consumer does not have at least $35,000 in financial assets. Other organizations have suggested standards ranging from 5 percent to 10 percent of income.

The higher the share of income one imagines consumers can devote to LTCI, the higher one's estimate of how many people could afford coverage. While a 7-percent standard and a 10-percent standard do not seem very far apart, the difference actually has a sizeable effect. Table 11 compares three sets of standards: the NAIC guideline, the same guideline without an asset test, and a 10-percent standard without an asset test. Premiums used are the FLTCIP rates for a policy providing a $125 daily benefit for 3 years, with a 90-day elimination period and 5 percent compound inflation protection.[21]

[21] The $125 daily benefit is higher than that used in the earlier discussion of affordability for younger purchasers, because that discussion was meant to build on ACLI figures that used a $100 benefit. Given current nursing home costs, $125 is a more reasonable daily amount. Note that the tables in this section use a 10 percent discount for married couples, to reflect common practice in the individual market. FLTCIP does not actually offer this discount.

Table 11. Percent of Households with Household Head Aged 60-79 That Could Afford Mid-Range LTCI under Different Suitability Measures, 1998

Age of household head	Premium less than 7% of income and at least $35,000 in assets	Premium less than 7% of income, no asset test	Premium less than 10% of income, no asset test
60-64	39%	46%	64%
65-69	27%	30%	48%
70-74	17%	19%	28%
75-79	5%	5%	12%
Total	21%	24%	37%

Source: 1998 Survey of Consumer Finances

Obviously, more people can buy LTCI if they are willing to settle for less comprehensive benefits. Table 12 uses the NAIC and 10-percent standards to estimate how many people could afford any of three packages:

A. the least costly federal package—a $50 daily benefit for 3 years, with a 90-day elimination period and no compound inflation protection;

B. a $125 daily benefit for 3 years, with a 90-day elimination period and 5 percent compound inflation protection; and

C. the most costly federal package—a $300 daily benefit for 5 years, with a 30-day elimination period and 5 percent compound inflation protection.

Table 12. Percent of Households with Household Head Aged 60-79 That Could Afford Various LTCI Plans under Different Suitability Measures, 1998

Age of household head	Lowest-cost plan		Mid-range plan		Highest-cost plan	
	NAIC	10 percent	NAIC	10 percent	NAIC	10 percent
60-64	52%	98%	39%	64%	9%	17%
65-69	55%	97%	27%	48%	4%	8%
70-74	62%	88%	17%	28%	2%	3%
75-79	39%	63%	5%	12%	0%	1%
Total	52%	86%	21%	37%	3%	6%

Source: 1998 Survey of Consumer Finances

Under the 10 percent standard, the vast majority of households—even those with a head aged 75 to 79—could afford the least costly policy. But a $50

daily benefit without inflation protection doesn't provide much security, especially for younger buyers. At the other extreme, practically no one can afford the most comprehensive plan, even under the 10 percent standard.

The examples to this point have assumed that married couples seek coverage for both spouses. It is certainly an option to purchase coverage only for one spouse, usually the wife. This practice has grown less common over time. In 2000, 17 percent of married buyers bought a policy only for one spouse, down from 37 percent in 1995. Couples that make this choice might assume that the husband is likely to become disabled before the wife—meaning that she can provide informal care for him but will need formal care if she becomes disabled later on. Or it might be that one spouse can pass underwriting tests and the other cannot. Table 13, using the middle coverage option (Plan B) and the NAIC standard, shows that many more couples could afford to cover one member than could afford to cover both.

Table 13. Percent of Married Couples with Household Head Aged 60-79 That Could Afford Mid-Range LTCI for Both Spouses or for the Wife Only, 1998

Age of household head	Households (000s)	Percent that could afford coverage for--	
		Husband and wife	Wife only
60-64	1,505	46%	59%
65-69	2,606	33%	54%
70-74	2,638	24%	43%
75-79	1,958	5%	22%
Total	8,707	26%	44%

Source: 1998 Survey of Consumer Finances

Finally, in considering what elderly people might be able to spend, it should be noted that they must already devote a substantial share of their income to medical care and health insurance (usually a Medicare supplement). The Urban Institute has estimated that out-of-pocket spending by the average elderly Medicare beneficiary consumed 21.7 percent of income in 2000 (Maxwell, Moon, and Segal 2001). This share is likely to increase in the future—for example, if drug prices continue to rise and a Medicare drug benefit is not enacted, or if retiree health coverage continues to erode.[22] Even given current spending levels, the NAIC 7-percent standard suggests that elderly families

[22] Only 34 %of large firms offered retiree health benefits in 2001, down from 66% in 1988, and some may not offer coverage to new hires or current workers. (Kaiser / HRET 2001.)

could spend close to a third of their income on health and long-term care costs. This is unlikely to be sustainable for modest-income individuals and couples.

What should elderly people buy?

Most elderly people, especially the younger elderly, can afford at least some amount of LTCI coverage. Very few can afford the most comprehensive plans; among those who can, many may be in a financial position to meet their long-term care needs without insurance.[23] How do middle-income seniors, who can afford some protection but cannot afford the richest plan, decide exactly what to get?

Interviews with consumer advocates and insurance agents suggest that agents often start out by showing the customer the most comprehensive available plan, and then begin trimming features until the premium is reduced to something the prospective buyer is willing to pay. If LTCI policies varied on only one dimension—say, the daily benefit amount—this process would be fairly straightforward. But even the relatively simple federal LTCI program offers eleven different daily benefit amounts, two benefit durations (three-year and five-year), and two elimination periods (sixty and ninety days), with optional compound inflation protection—for a total of 88 different possible policies. Many private carriers offer hundreds of variants; for example, the MetLife plan offered through AARP has 360 possible policy designs.[24] Even if the consumer knows what he or she is able to pay for LTCI, the agent can arrive at an acceptable price by tinkering with any of numerous components of policy design, and there is no ready way for either the consumer or the agent to identify which policy features are more important.

Suppose that Hester is a 65 year-old woman living alone and eligible to participate under the new federal LTCI program. She has the median financial resources of unmarried women in their sixties as of 1998:

Income:	$20,900
Home equity:	$35,000
Financial assets:	$52,600

Hester figures, using the NAIC 7-percent-of-income guideline, that she can afford to spend about $120 per month for LTCI. This is more than most

[23] A more meaningful estimate of the potential LTCI market might use suitability ceilings as well as floors.

[24] See http://www.metlife2000.org/Aarpltc/, accessed May 2002.

women in Hester's circumstances are likely to want to spend, but Hester is especially worried about long-term care. The $120 limit narrows her choices considerably: there are six plans she could get for about this amount, as shown in table 14. (The labels A through F are used for discussion here; they are not used in the federal program.) Two plans offer 5 percent compound inflation protection. The others offer a "future purchase option," under which the policyholder can increase the daily benefit at some future date by paying a higher premium.

Table 14. Federal LTCI Program Options for a 65 Year-old with Premiums of about $120 per Month, 2002

Plan	Daily benefit	Benefit period	Waiting period	Inflation protection	Monthly premium
A	$ 75	5 years	30 days	Compound	$ 123.90
B	$ 100	3 years	90 days	Compound	$ 118.40
C	$ 150	5 years	30 days	Future purchase	$ 120.30
D	$ 175	3 years	30 days	Future purchase	$ 119.00
E	$ 175	5 years	90 days	Future purchase	$ 122.15
F	$ 200	3 years	90 days	Future purchase	$ 117.60

Source: OPM 2002

That the plans have similar premiums means that their actuarial value—the amount of protection they provide for a "typical" purchaser—is about the same. But no one is typical, and the relative value of the plans depends on when, if ever, the policyholder needs services and what services she needs. Table 15 shows the percentage of total charges each plan would pay under four scenarios: nursing home stays of three years and five years, beginning at age 70 (five years after purchase) or at age 85 (twenty years after purchase). The examples assume that a day of nursing home care costs $150 at the time of purchase and increases at a compound annual rate of 5 percent. This means that a day of care will cost $191 by the time Hester is 70 and $398 by the time she is 85.

Table 15. Percent of Total Charges Paid by LTCI Options for 3-year or 5-year Stay Beginning at Age 70 or Age 85

Plan	I	II	III	IV
	Three-year stay beginning at age:		Five-year stay beginning at age:	
	70	85	70	85
A	49%	49%	49%	49%
B	61%	61%	39%	39%
C	73%	35%	70%	34%
D	85%	41%	50%	24%
E	80%	38%	79%	38%
F	91%	44%	57%	27%

Plan F, with a high initial benefit but no inflation protection, provides the most protection for scenario I, a three-year stay beginning in the near future, but the least protection for scenario IV, a long stay beginning later in life. Plan A offers the least protection under scenario I and the most under scenario IV. Again, the fact that the plans have very similar premiums means that the plans' actuaries have concluded that, over the pool of all purchasers, ultimate payout is going to be about the same under each plan design.[25] Unless Hester has some way of foretelling which scenario is most likely for her, why should she choose one plan over another?

Table 16, which looks at the same comparison in a different way, may begin to suggest an answer. Here the plans are compared in terms of the total amount Hester would have to contribute toward the cost of a stay, over and above the benefits paid by the plan. Her potential exposure for a stay beginning at age 70 varies dramatically under the different plans. Under plan F, she could meet the cost from her income or—assuming she had some other ongoing expenses even while in the nursing home (home maintenance, Medigap premiums, and so on)--by drawing modestly on her savings. Under plan A she would almost certainly exhaust her savings and might even have to sell her house, again depending on what other expenses she had.

[25] More precisely, the net present value of the ultimate payout is about the same for all the plans.

Table 16. Patient Liability under LTCI Options for 3-year or 5-year Stay Beginning at Age 70 or Age 85

(thousands of dollars)

Plan	I	II	III	IV
	Three-year stay beginning at age:		Five-year stay beginning at age:	
	70	85	70	85
A	$ 113	$ 235	$ 196	$ 407
B	$ 85	$ 177	$ 237	$ 494
C	$ 61	$ 298	$ 117	$ 533
D	$ 34	$ 272	$ 194	$ 611
E	$ 44	$ 282	$ 82	$ 499
F	$ 19	$ 257	$ 167	$ 584

On the other hand, if Hester doesn't enter a nursing home until age 85, all of the plans leave her exposed to very high costs. The benefit value of the plans without inflation protection has eroded, so that even the $200 daily benefit covers just half of her daily charges. The benefit value of plans A and B has risen with inflation, but *the costs not covered by the plan inflate as rapidly as the costs covered by the plan*. Suppose Hester buys plan B—with a $100 daily benefit and compound inflation protection--figuring that she can afford to pay $50 a day toward her care? She is protected only if she can be sure that she will be able to pay $133 a day twenty years from now. If Hester is like most people retiring today, she cannot be sure that her retirement income will keep pace even with general inflation, much less the higher rate of inflation likely for nursing home charges.[26]

Still, let us suppose, optimistically, that Hester's income and assets have grown by 3 percent a year in the twenty years since she bought the policy. When she enters the home at age 85, she has income of $37,748 and a net worth, including the home, of $158,215. As table 17 shows, every plan leaves her with a patient responsibility in the first year that is twice her income or more. Even if she has no other ongoing expenses, she will have to begin drawing on her liquid assets. As the years go on, she will exhaust those assets and will have to sell her house and use the proceeds for her care. When her savings are reduced to $2,000, she will qualify for Medicaid.

[26] The problem here is, to some extent, a reflection of the general failure of retirees to insure for longevity risk; this issue is considered further below.

Table 17. Patient Responsibility and Depletion of Assets under LTCI Options, Stay Beginning at Age 85

Plan	Benefit term	Patient responsibility, first year	Sells house before end of year--	On Medicaid before end of year--
A	5 years	$ 78,703	3	5
B	3 years	$ 72,402	4	5
C	5 years	$ 95,118	2	3
D	3 years	$ 86,743	3	4
E	5 years	$ 97,243	2	4
F	3 years	$ 90,368	3	4

Under every plan but B, if Hester has a three-year stay, she will have used up all her liquid assets and will have had to sell her house before the end of the stay. Under all six plans—even those covering five years of care—Hester spends down to Medicaid before the end of a five-year stay. Under plan C, she spends down during the third year of her stay. Once she has spent down, the plan continues to pay benefits for the next two years, but the effect is simply to reduce the amount the Medicaid program must contribute. Hester receives no benefit at all.

Given Hester's budget of $120 a month, no available plan offers meaningful protection against the costs of a long stay late in life. Of course, she could spend more of her income on LTCI and buy greater protection. But the plans available to Hester are not very different from what actual buyers of LTCI are purchasing. The average plan sold in the individual market in 2000 had the features shown in table 18 and lacked compound inflation protection. This plan probably leaves buyers potentially exposed to costs at least as high as those faced by Hester.

Table 18. Average LTCI Plan Purchased in 2000

Duration of nursing home coverage	5.5 years
Daily nursing home benefit	$109
Daily home care benefit	$106
Nursing home elimination period	65 days

Source: LifePlans (2000).

The big difference between Hester and actual purchasers of LTCI is that real buyers tend to have more financial resources to begin with. The median income of buyers in 2000 was $42,500—more than twice Hester's income—and

five out of seven buyers had liquid assets of $100,000 or more (LifePlans 2000). This means that they can afford to contribute more to the cost of their care, and are less likely to find that gaps in their LTCI coverage expose them to impoverishment.

Rethinking LTCI benefit packages

That none of the plans available to Hester adequately protects her under certain scenarios does not, of course, mean that the coverage is worthless. There are many other scenarios—perhaps more likely than any of the ones shown--under which each plan offers considerable protection. But the peculiar outcomes of some plan designs—such as the not implausible scenario under which plan C effectively paid money to the state government instead of to Hester for two years--suggest that the basic structure of LTCI benefit packages might warrant some reexamination.

As was suggested earlier, people picking an LTCI plan often start with an "ideal" plan—lifetime coverage with a high daily benefit—and then start pruning to meet a budget. What might happen if, instead, Hester began by identifying the reasons she is seeking coverage and then began to build a plan that might best meet her needs?

Let us suppose that Hester is *not* buying LTCI for the purpose of estate protection. (As the examples suggested, her chances of leaving an estate after any fairly long episode of care are not very good under any policy.) Hester's main reason for buying LTCI is that, in the event of disability, she wants to be able to remain at home as long as possible. This suggests two basic criteria for a policy:

- The policy pays enough for home care that she can receive the help she needs and have enough income left to meet her other routine expenses.

- If she should require a nursing home stay, at the end of which she has recovered enough to return to the community, she will not have had to sell her house in the interim or depleted her resources to the point at which independent living is no longer feasible.

Given Hester's particular circumstances—age, finances, and so on—there is theoretically some optimum insurance package at any given premium level: some policy that is likely to go the farthest toward meeting her particular goals within her budget limit. For someone else, with different circumstances and different goals, some completely different package might be best.

This paper will not attempt to develop an optimum policy for Hester, but can at least show how certain policy features do and do not work to advance Hester's interests. The following discussion continues to focus chiefly on the nursing home component, simply because it is easier to see how different benefit features work out in practice.

Duration of coverage. Promotional materials for LTCI commonly emphasize the likelihood of a very long stay, and concern about this possibility is clearly reflected in the kinds of packages people are buying. As table 18 showed, average duration of coverage under policies sold in 2000 was 5.5 years, and 30 percent of buyers chose lifetime coverage.

Table 19 shows a recent estimate, based on the 1993 National Mortality Followback Survey, of probable lifetime nursing home use for people who were 65 years old and living in the community in 2000. Almost half of 65-year-olds can expect to have at least one nursing home stay. For those who do, the average stay will be about two and one-half years, and about one in five patients will have a stay of five years or more.

Table 19. Projected Future Nursing Home Use, Community Residents Aged 65 in 2000

Risk of nursing home use	44%
Expected years to admission	18.4
Mean use by users	2.4 years
Percent using--	
Less than 3 months	27%
3 months to 1 year	20%
1 year to 5 years	34%
5 years or longer	19%

Source: Spillman and Lubitz (2002)

If Hester were interested in leaving an estate, it might make sense for her to buy a policy with as long a coverage period as she could afford. But Hester is buying nursing home coverage chiefly to avoid impoverishing herself if she enters a nursing home and can later return to the community. This happens more often than is commonly supposed. Of 2.2 million elderly people discharged in 1999, over 700,000—nearly one-third—were recovered or

stabilized. As one might expect, however, nearly all these patients had very brief stays.

Table 20 shows the distribution of stays for elderly people whose discharge status was "recovered" or "stabilized"—those who might go home. Two-thirds of these patients were still using their Medicare skilled nursing facility benefit at the time of discharge. Among those whose primary payment source at the time of discharge was not Medicare, 88 percent had stayed less than three months, and only 2 percent had stayed for a year or more. The average length of stay was just over two months. These figures understate actual lengths of stay, because of problems with estimates based on the National Nursing Home Survey.[27] Still, it seems clear that people who stay in a nursing home for more than a few months are less and less likely to return to the community.

[27] The National Nursing Home Survey tracks only the patient's current nursing home stay; if a patient was in one nursing home, transferred to a second home, and was then discharged, only the length of stay in the second facility, not the total length of stay, would be recorded. The same would be true if a patient were in a nursing home, left for an inpatient hospital, and then returned to the same or a different nursing home. This means that the lengths of stay may be understated. However, it appears that the problem is less likely to affect estimates for the total patient population than for the subset discharged as recovered or stabilized. For example, while 8.3 percent of all elderly residents discharged had been transferred from another nursing home, only 3.5 percent of those who were recovered or stabilized had been transferred.

Table 20. Length of Stay for Nursing Home Residents Aged 65 or Older at Admission and Discharged as "Recovered" or "Stabilized," by Primary Payment Source at Discharge, 1999

	Medicare	Other	Total
Length of stay:			
Under 30 days	75%	69%	73%
30-59 days	16%	14%	15%
3-6 months	5%	5%	5%
6 to 12 months	3%	10%	5%
12 to 24 months	0%	1%	1%
2 years and over	0%	1%	1%
Total	100%	100%	100%
Average days	35	67	46
Discharges	481,378	232,381	713,759

Source: 1999 National Nursing Home Survey, NCHS

If Hester stays in a nursing home for more than a year, her chances of ever going home become very small. And, if she isn't going home, why should she care how rapidly she exhausts her resources and becomes eligible for Medicaid? She might care somewhat—if, for example, she's concerned that the quality of care she receives will decline after she has spent down. Still, if her budget is limited, it might make sense for her to choose the shortest available coverage period—perhaps one or two years—and beef up other components of her plan.

Does the same hold true for home health care? Table 21, based on the 2000 National Home and Hospice Care Survey, shows total duration of home care for elderly people receiving assistance with two or more ADLs.[28] This appears to show that home care episodes are also of short duration. However, the numbers are somewhat deceptive, for a variety of reasons. First, a patient can have multiple discharges during a year—for example, when home care is interrupted by a hospitalization and then resumes. Second, the table shows only the length of time people actually received care, not how long they might have gone on using services if they could have financed them. Finally, the survey is

[28] The six-ADL list for HIPAA tax-qualified LTCI policies is used.

confined to services provided by licensed home health agencies and does not reflect other kinds of paid personal care or attendant services.

Table 21. Average Duration of Paid Home Health Care, Elderly People Receiving Assistance with Two or More ADLs, 2000

Duration of service	Discharges (thousands)	Percent
Under 3 months	1,419	80%
3 to 6 months	211	12%
6 to 12 months	77	4%
Over 12 months	78	4%
Total	1,784	100%

Source: 1999 National Home and Hospice Care Survey, NCHS

Even if the distribution were reliable, it does not follow that Hester should buy only a year of home care. Very limited nursing home coverage may make sense because, if Hester is going to be in a nursing home permanently, it doesn't matter very much at what point she spends down to Medicaid. Spending down to Medicaid while using home care is quite a different matter, as it would entail a drastic change in Hester's standard of living.

Hester might, then, want to cover home care for a longer period than nursing home care. Some policies already do this, or do so implicitly, by establishing a pool of money. For example, under the FLTCIP, if Hester chooses three years of coverage at $100 a day, she has available a pool of $100 x 365 x 3, or $109,500. She can use this for home care instead of nursing home care, but can only draw $75 a day; if she uses only home care, the pool will last for four years instead of three. Hester might well wish to take this concept further—perhaps buying just one year of nursing home care and four or five years of home health care. However, no one is actually selling this kind of policy.

Elimination period. Of LTCI policies sold in 2000, 52 percent had 90-day elimination periods (LifePlans 2000). As table 20 showed, 88 percent of non-Medicare patients discharged from nursing homes because they have recovered or been stabilized have stays shorter than 90 days. Thus the most commonly sold LTCI policies would provide no benefit for a typical short admission.

Purchasers with some amount of savings may choose to accept the risk of paying for a short stay, because the length of the elimination period can have a major effect on price. Under the FLTCIP, for example, premiums for a 65 year-old choosing a 30-day period tend to be about 15 percent higher than premiums

for comparable coverage with a 90-day waiting period. At the same premium level, the policy with the longer waiting period provides a higher daily benefit once the period is over. So, for example, a policy with a 30-day waiting period and a $125 daily benefit for three years costs about the same as a plan with a 90-day waiting period and a $150 daily benefit for three years.

If a typical short stay lasted 67 days and the cost per day were the current nursing home average of about $150, a person choosing the 30-day waiting period would pay $150 for 30 days and $25 for 37 days, for a total out-of-pocket cost of $5,425. A person choosing a 90-day waiting period would, of course, pay $150 for all 67 days, for a total cost of $10,050. The difference in out-of-pocket costs under the two policies would diminish for longer stays. Costs would be equal for a 13-month stay, and the plan with the longer waiting period would be more valuable for any stay of greater duration. As was suggested earlier, however, a patient is unlikely to return home after a 13-month stay. The most appropriate product for a modest-income senior might have no waiting period—an option available under some private plans—and a shorter benefit duration.

Daily benefit. The preceding discussion has assumed that all days of nursing home care cost the same amount. Of course they do not. Besides geographic variation in costs, charges vary according to an individual resident's needs. As table 22 shows, elderly residents who had a payment source other than Medicare and who had short stays had higher daily charges than those with longer stays. Those who recovered or were stabilized had higher charges than those who died or were transferred to another facility.[29] So someone with a short stay could be exposed to very large costs even if an LTCI policy began payment on the first day of care. Someone with a longer stay might find that the daily benefit amount was actually too high.

Table 22. Average Daily Charges by Discharge Status and Length of Stay, Elderly Residents with Non-Medicare Primary Payment Source at Time of Discharge, 1999

	Recovered or stabilized	All other statuses	All discharges
Under 90 days	$ 382	$ 252	$ 287
90-179 days	$ 119	$ 136	$ 134
180 days and over	$ 120	$ 133	$ 132
All lengths	$ 351	$ 194	$ 221

Source: 1999 National Nursing Home Survey, NCHS

[29] Elderly non-Medicare residents in the "current resident" sample of the 1999 NNHS, as opposed to the discharge sample, had daily charges averaging $112.

Similar variation in needs and costs is likely to exist for home health care. One recent survey of LTCI policyholders who had used home health care services found that most had a daily benefit that was larger than the amount they were actually paying for services. On the other hand, about a third of claimants reported that their daily benefit was insufficient (Cohen et al., 1999).

Other major payers for long-term care services have long recognized that costs vary. Medicare, for example, uses "resource utilization groups" (RUGs) to categorize different kinds of patients using skilled nursing facility services. Base reimbursement for patients with the greatest needs can be three times as much as that for less severely disabled patients. Many states have adopted similar systems for Medicaid reimbursement. Similarly, national Medicare rates for episodes of home health care vary by a ratio of about 5 to 1, depending on the intensity of care required by each beneficiary.

In theory, there is no clear reason a private LTCI policy could not be designed to vary payments by severity or intensity. For example, a plan with a fixed daily benefit amount of $100 could pay $75 for a low-intensity day of care and $125 for a high-intensity day, using RUGs or some similar index. A plan with a daily benefit of $150 would pay $112.50 and $187.50 for the same two days. While this would be more complex to administer than current policies, the major barrier is probably that insurers have insufficient information to price a variable-payment plan. Insurers are uncertain about the validity of their current premium rates, which require projections of gross utilization of days of care. Adding in case mix would compound this uncertainty.

A more primitive adjustment that would still target assistance better than a flat-rate policy would simply pay more in the early days of a stay than later on. A policy of this kind would be much more easily priced and administered.

Benefit trigger. Finally, the benefit trigger established by the Health Insurance Portability and Accountability Act (HIPAA) and now used under most policies sold—requiring assistance with 2 or more out of a list of 5 ADLs, or requiring supervision because of severe cognitive impairment—may be too rigid. For example, Kassner and Jackson (1998) found that people who required assistance with no ADL or only one ADL, but with five or more IADLs, needed as many hours of care as people requiring assistance with two ADLs. HIPAA authorized the Secretary of the Treasury to define alternative triggers reflecting "similar" levels of disability, but this has not occurred.

It is possible that a single set of triggers, however refined or expanded, would not be appropriate for all purchasers. The need for paid care depends on

availability of informal supports as well as on level of disability. Someone who is highly disabled but living with family members might require services only intermittently, while someone living alone might need help even with less severe disability. People with fewer supports could buy more extensive coverage: some insurers still sell non-tax-qualified policies with a one-ADL coverage threshold or with a "medical necessity" trigger. However, these policies are more costly, and there is a necessary trade-off between the trigger and the scope of benefits.

The combined package. In sum, modest-income elderly people might be better served by policies that are quite different from those commonly sold today. A more workable policy might have the following features:

- a shorter benefit period, particularly for nursing home care,
- a shorter elimination period,
- higher payment during the early part of a nursing home stay,
- a more flexible benefit trigger.

The last three provisions raise cost, so maintaining an affordable policy would mean an offsetting reduction in the benefit period. Again, if estate protection is not the prime objective of the coverage, a shorter benefit period for nursing home care might be appropriate for most buyers.

Of course estate protection does matter to many current purchasers of LTCI. Among buyers in 2000, 79 percent cited leaving an estate as an "important" or "very important" reason for buying coverage, and 31 percent said it was the most important reason—more than cited any other goal (LifePlans 2000). Realistically, however, it may not be possible for middle-income people to buy coverage that would preserve assets in the face of a truly catastrophic long-term care episode. People do have other reasons for buying coverage, such as avoiding dependence and assuring that they can choose the services they prefer. It may make sense to start tailoring packages around these more attainable goals.

From a federal policy perspective, the hypothetical benefit package has one key drawback. It doesn't save Medicaid very much money, because it is designed to prevent asset depletion during very short stays and provides less protection for long custodial stays. Promotion of this kind of policy might mean that any new tax expenditure for LTCI would not, as some studies have

suggested, be offset by Medicaid spending reductions.[30] Estimates of this offset effect may have been exaggerated in any event.

Conclusions

The coming decades are likely to mean exploding demand for long-term care services. Even if advances in medical care and other factors lead to reduced incidence of disability, the sheer number of people reaching very old ages will still mean that many more people will need care and that payment for this care will consume a larger share of national health spending (Spillman and Lubitz 2002). This may mean mounting strains on public financing programs, greater burdens for individuals and families, and reduced quality or access.

A greater role for private financing might conceivably reduce some of these pressures. But the private long-term care insurance products that have emerged in response to the demands of a small, relatively affluent market are not affordable for most people and may not even be very well-designed to meet the real needs of many people who can afford modest coverage.

Stand-alone LTCI products are a feasible investment for only a small minority of active workers. People of working age might derive greater benefit from investment or insurance products that adapt to their evolving needs at different stages of their lives. One option is the scheme explored by the Academy of Actuaries, under which a worker would pay into a plan for many years and, when closer to retirement, decide whether to take the accumulated amount in the form of LTCI or some other benefit. Other possibilities include a combined life insurance/long-term care insurance product or a combined life annuity/LTCI product. These products may be difficult to market and may be inhibited by current tax policy. Still, if the future challenge of long-term care financing is to be met, it is important to examine more promising ways of harnessing individuals' resources.

Few retirees are able to afford comprehensive long-term care protection. The pared-down products that may be financially within their reach can provide only limited asset protection and at the same time may be poorly designed to meet other goals, such as maximizing the likelihood of being able to remain at home or in a community setting. More research is needed to identify the variety

[30] One prominent study (Cohen and Weinrobe 2000) finds that Medicaid savings for people newly induced to buy coverage by an above-the-line tax deduction would offset the tax expenditure *for those people*. However, the study appears to make no allowance for the fact that the deduction would also be available to people already buying coverage.

of risks that individuals face and to develop limited-coverage products that can better take account of individual purchasers' circumstances, needs, and objectives.

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