American Academy of Actuaries

Issue Brief

Medicaid and Long-Term Care Insurance

FEBRUARY 2019

KEY POINTS

- The expected future increases in long-term care (LTC) service needs and costs will almost certainly stress LTC financing over the next several decades as Baby Boomers reach the oldest-old ages.
- Given that Medicaid funding already represents a substantial portion of federal and state budgets, its role, without modification/reform, as a long-term option for funding the LTC costs of the Baby Boomers and generations beyond raises many questions.
- The increasing awareness of the need to modify/reform Medicaid is but one indication—albeit a critical one—of the need for more comprehensive reviews of the existing LTC financing systems, with the ultimate goal of developing actuarially sound proposals for reform.

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Background

The potential for catastrophic LTC (long-term care) costs is a major financial risk especially facing older Americans. The purpose of this issue brief is to help clarify for the reader the nature of this risk and the options currently available for dealing with it. A more complete understanding of these two aspects can serve as a foundation for a fuller consideration of specific proposals to reform existing LTC financing options, including Medicaid and private LTC insurance (LTCI). Such specific proposals will be the subject of subsequent issue briefs.[1]

The Congressional Budget Office (CBO) has projected that the share of the U.S. population aged 75 or older will increase from 6.0 percent in 2010 to 11.2 percent in 2050.[2] The large increase in the number of the baby boom (i.e., those born during 1946–1964) expected to be covered by an LTC financing system or plan over the next several decades will create major financial challenges for those individuals and existing financing systems. The CBO has also projected that the share of gross domestic product (GDP) spent on LTC costs for the elderly will increase from 1.3 percent in 2010 to 1.9-3.3 percent in 2050 depending on the scenario used in its model.[3] In all three scenarios which the CBO modeled, the aggregate total costs for LTC will continue to rise and must be addressed.

An individual needing LTC could utilize one or more of the following support systems over time:

1. **Informal care**, which can come from family caregivers, friends, community volunteers, and others. The individual might not pay for this care, although it often places significant financial and emotional burdens on the caregivers, particularly the family.

1 Although combination products where LTC benefits are combined with life insurance policies or annuity contracts are growing in popularity, this issue brief treats them as a reform that is taking place, and they may be a component of subsequent issue briefs.

2 CBO, *Rising Demand for Long-Term Services and Supports for Elderly People*, Exhibit 1, p. 7, June 2013.

3 Ibid, Exhibit 23, p. 33.

2. **Formal care** from paid home and institutional services. Financing of this care can be from any of the following:
    a) Self-funding through privately owned accounts/assets;
    b) Prepaid private LTCI ; or
    c) Public funds, such as through Medicaid.

If informal care is not available or is not sufficient to meet the individual's LTC needs, then the expectation is that an individual will first "spend down" some or all of his or her own funds and available LTCI benefits before public funds will be available to cover the remaining lifetime LTC costs as part of a social "safety net."

It is important in an LTC reform discussion to understand the distribution of LTC funding today. The complexity of LTC financing can make it difficult to understand the existing funding shares and interactions between the primary funders of LTC—Medicaid, Medicare, private LTCI, and privately owned accounts/assets. However, the Office of the Assistant Secretary for Policy Evaluation (ASPE) at the U.S. Department of Health & Human Services has estimated the breakouts of the funding shares for LTC expenditures under the assumption that current governmental policies continue indefinitely into the future. Their breakouts are as follows:

- Private sources would cover 55% of the costs including 52% paid out-of-pocket from privately owned accounts/assets, and 3% paid by private LTCI.[4]
- Public sources would cover 45% of the costs including 34% paid by Medicaid, 10% paid by Medicare, and 1% paid by other government programs.[5]

Public financing of LTC is on a pay-as-you-go basis from current governmental revenues. As the share of GDP spent on LTC increases, additional revenues would be needed to maintain a public share at 45 percent if that was a desired public policy goal as estimated by ASPE. This differs from the funding mechanisms used to support private out-of-pocket LTC costs, as those funds are typically accumulated over time in privately owned accounts/assets. Private LTCI carriers accumulate needed funds over time in dedicated accounts maintained by the carriers to cover future LTC costs—not for single individuals, but for groups of individual LTCI policyholders who contribute to the pooled funding mechanism through premium payments.

This issue brief provides an actuarial perspective on the issues related to funding both informal and formal LTC services and supports with a focus on the complementary roles of Medicaid and LTCI within the existing LTC financing systems.

Informal Care

The SCAN Foundation reports that nearly 90 percent of Americans who need long-term care receive it in part from informal, or unpaid, caregivers such as family and friends.[6] In 2011 this represented about 1.3 billion hours of care per month for older Americans.[7] This care

4 Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Long-Term Services and Supports for Older Americans, Risks and Financing Research Brief*, Table 3A, p. 5, February 2016.
5 Ibid.
6 The SCAN Foundation, "Who Provides Long-Term Care in the U.S.? (Updated)," October 2012.
7 ASPE, *Informal Caregiving for Older Americans: An Analysis of the 2011 National Study of Caregiving*, April 2014.

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includes help with activities of daily living (ADLs) such as dressing, bathing, and toileting, as well as other support activities such as shopping, house cleaning, transport, and monitoring the general well-being of the care recipient, that enable a person in need of such supports to stay in a home setting. Often some informal care continues even when formal care is also provided.

Informal care for an individual is constrained by the availability of family and/or friends to assist the individual. The availability of potential caregivers is impacted by the caregivers' location, health, financial status, other responsibilities, willingness, and abilities. The availability of formal care can also play a role in the need for informal care.

Some common reasons that informal care is provided include: caregivers are more comfortable with providing the care themselves rather than having it provided by a stranger; caregivers feel it is their obligation; or an individual needs care but does not qualify for financed formal care. Cost can also be a factor in the decision to receive informal care. While family and friends are usually uncompensated, this is not always true (especially if a cash benefit LTCI plan is in effect), and while informal care seems to be the least costly option to the individual, it does have a cost to the caregiver and to society. In 2014 the RAND Corporation estimated the total opportunity cost nationwide of informal elder care as $522 billion annually.[8] To model the funding requirements for informal care, actuaries would consider expenses associated with both the care recipient and the caregiver.

The amount of support that informal caregivers can give is, of course, not infinite. And untrained informal caregivers are not always in a position to give the best care. To gain a better understanding of the viability of current provisions of LTC in the future, actuaries would need to model whether informal care can continue to provide the current share of the total caregiving load as the society ages and family dynamics change. This is difficult in the case of informal care, because the best estimates of current informal caregiving, such as those from the National Alliance for Caregiving or RAND, are based on surveys that may not offer an accurate basis for estimate assumptions.

If actuaries were to model the future financial sustainability of informal care as a program in America, it would be a huge undertaking, and well beyond the scope of this issue brief. Because informal caregivers generally provide their loved ones as much care as they can, as best they can, modeling this process would require expertise in demography, sociology, family structure/dynamics, behavioral economics, and perhaps other disciplines. Data collection would be difficult and likely involve the use of new or existing surveys. Still, certain important actuarial concepts apply when considering informal care as a part of how LTC is provided:

- Consideration of the morbidity and mortality of both the care recipient and the caregiver.
- Demographics of both the care recipients and the caregivers—the share of the older population that is unmarried and the average number of living children for older adults are significant assumptions when planning for the sustainability of informal care.
- Quality of care is a factor that can impact other assumptions. For example, a person living at home with informal care might not receive the support necessary to avoid a fall that could have been avoided if the person received formal care. This factor can also impact associated medical costs.
- Consideration of the expenses associated with providing care, including loss of income for the caregiver, must be measured and taken into account.

8 The RAND Corp., *The Opportunity Costs of Informal Elder-Care in the United States: New Estimates from the American Time Use Survey*, October 2014.

- Also, as a care recipient's needs change, there is a limit to the amount of care the informal caregiver is able or perhaps willing to provide. This limitation on informal care depends on many factors including: strength of familial or friendship bonds, geographic dispersion of families, other priorities of the caregivers, changes in financial expectations, changes in care expectations, changes in professional health care recommendations, and changes in technology and its cost.

In the absence of resources for increased informal care, there is a need for greater amounts of formal care—with additional costs beyond those expected when informal care is available. These additional costs can adversely impact the consideration of other funding sources discussed below.

Self-Funding

For those who need "formal" LTC but do not meet eligibility requirements for public financing, the primary sources of funding will be their own income and assets. Individuals can also use their assets to pre-fund through LTCI, which will be discussed later.

The top 5 percent of households in the U.S. earn an annual income of $237,034 or higher,[9] so those individuals will likely have resources to self-manage their LTC needs. Just over 20 percent of the U.S. population is eligible for public programs such as Medicaid and the Children's Health Insurance Program,[10] so those individuals will likely have Medicaid as their LTC funding source when needed. This leaves approximately 75 percent of the U.S. population—over 180 million people, primarily adults—who must decide whether to self-fund or rely on alternative funding sources as described in this paper. The following discussion explores a number of individual considerations for the decision to self-fund.

ASPE's aforementioned report estimated that the average lifetime cost of LTC for a person reaching age 65 in 2015–2019 would have been $138,000 (in constant 2015 dollars). Importantly, ASPE also estimated that only 52 percent of those reaching age 65 would have actually used paid LTC during their remaining lifetimes. While this might be good financial news for some—those who will not need LTC services and supports in their lifetimes—it means that the average lifetime cost of LTC borne by the 52 percent who will need LTC will be $266,000,[11] an amount that will far exceed the resources of the majority of retired Boomers. Moreover, given the difficulty for Boomers reaching age 65 to predict their future need for LTC, the uncertainties regarding the occurrences and sizes of future LTC costs make it especially difficult to plan for these contingencies.

Individuals must make a decision on whether they will self-fund or not. This decision requires consideration of the estimated amount of income or assets that should be set aside for the future risk of needing LTC. A reasonable way to estimate approximately the monthly amount to save is to use LTCI premiums or expected values as a starting point.

> Average price for a comprehensive LTCI policy (100% home care benefit + skilled care coverage), 90-Day Elimination Period with Compound Inflation Protection Option (benefit increases 5% compounded annually). Age 55 - Single Individual with $150 Maximum Daily Benefit x 3 Year Benefit Period.

The average of rates from selected leading insurers are as follows:

> Current Value of Benefits: $169,000; Value of Benefits at age 75: $305,000
>
> Cost: $1,480 per year (Low Cost: $1,325, High Cost: $2,550)

9 United States Census Bureau, "Income and Poverty in the United States: 2017," September 2018. (Table A-2 refers to 2017 experience.)
10 Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2017.
11 ASPE, *Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief*, Table 3B, p. 6, August 2015.

Because ASPE's aforementioned report estimated that only 52 percent of those reaching age 65 will actually pay for LTC during their remaining lifetimes, these annual costs need to be increased commensurately to reflect the average costs per user of paid LTC, yielding:

> Cost Per User: $2,846 per year (Low Cost Per User: $2,548, High Cost Per User: $4,904).

Because these costs are averages, an individual who chooses to self-fund will likely want to accumulate savings more than twice the average need in order to be able to fund potential LTC needs that exceed the average.

Even if an individual accumulates the targeted amounts, there are no guarantees that the funds will ever be needed or that the funds will be sufficient if needed. The potential outcomes for an individual are:

a) Individual never needs LTC services;
b) Assets earmarked for LTC purposes are adequate;
c) Actual LTC needs, and thus costs, exceed expectations due to varying health/wellness, incidence, intensity, duration, size of payments, location of care (depending on state, or facility; e.g., retirement home, assisted living, nursing home, or continuing care retirement community), or other factors; and
d) Actual asset accumulation, and thus source of funds for financing LTC services and supports, falls short due to unexpected changes in the economy, investment risks and yields, taxation, or other factors.

If needed funds fall short for any reason, individuals would need to use other financial resources, such as retirement savings, to fund the shortfalls, which would restrict their flexibility to manage their finances. The worst outcomes are where the available assets eventually become insufficient to cover continuing LTC costs; in these cases individuals become dependent on the public system to cover part or all of their LTC costs.

These stark potential outcomes of self-funding derive from the lack of pooling of risks and resources, as would be done in a pre-funded private system or a publicly financed system. Thus anyone who chooses self-funding should be fully aware of the risks and their likelihood of occurrence.

LTCI

LTCI as a currently available product as it now exists generally is not designed to cover every segment of the population. Policyholders generally are healthy enough and have enough financial resources to be insured. Applicants for LTCI typically face full medical underwriting in order to purchase a policy, and with average annual premiums on traditional LTCI policies around $2,500, those with lower levels of retirement resources might only be able to afford minimal LTC benefits. Furthermore, those who can afford insurance might need to supplement the insurance benefits with their own funds to pay for deductibles and copayments, or for LTC costs that exceed their policies' benefit caps.

By purchasing insurance when healthy, individuals could think of the insurance as pre-funding future needs. Yet if they die or lapse their policy prior to needing benefits, they will forfeit any personal value from having owned the policy (unless they also purchased a nonforfeiture benefit). Such individuals are essentially helping to fund others who will need benefits in the future. Because of this risk-sharing feature, these other policyholders will often receive substantially more in benefits than they paid in premiums.

When individuals purchase long-term care insurance policies, they are typically purchasing a policy that is intended to have a level premium

for life. There is generally one important exception. While the policies are guaranteed to be renewed each year (they cannot be canceled by the insurance company), the premiums could increase when (1) the experience for the policyholder's entire class of policies is projected to be substantially worse than originally projected, (2) the policyholder's insurance company decides to increase the premium rates, and (3) the policyholder's state accepts the increase. Substantially worse experience can be caused by any or all of, but is not limited to, actual experience to assumptions variations in investment income, the number of lapses, the number of deaths, the number and size of the claims (benefits), medical underwriting approaches, and items that are otherwise common to insurers including capital levels and corporate taxes.

The potential for substantial adverse experience to develop can depend on the insurance company the individual chooses. Hypothetically, if individuals purchasing LTC insurance were to apply for coverage from more than one insurance company, they could be asked to provide different information, and they might find their particular health status treated differently by each company. The underwriting decisions are not always transparent to the applicants. Yet there might be insurance agents available who might be familiar with which company would treat various health circumstances with a better premium rate class or with offering coverage at all. In that way, some insurance companies may find that adverse or beneficial experience develops differently. Policyholders might not understand why their insurer asks for a premium rate increase when others do not. For example, if an insurer accepts certain less severe forms of diabetes when its competitors do not, the insurer that accepts them is likely to acquire disproportionate numbers of people with diabetes who might not initially experience severe symptoms but are more likely to require care in the future. Such an insurer could be more likely to ask its policyholders for premium rate increases.

Numerous other considerations can create volatility in the insurance carrier's experience, such as how individuals interpret policy language, how courts rule on various policy provisions, changes in policyholder priorities, changes in cultural attitudes toward the use of specific types of LTC services and wellness programs, advances in technology, changes in investment yields, inflation, and expectations of individuals and regulators. These can precipitate the need for premium rate increase requests should such changes prove to represent materially greater future benefit payments than anticipated in the original pricing projections. Overall, the significant pre-funding, long-term nature, and multiple moving parts associated with LTCI can be disconcerting to policyholders when they face a premium rate increase. Policyholders have apparently recognized the value of owning long-term care insurance coverage, as evidenced by the high percentage who accept premium rate increases when they face them rather than letting their policies lapse.

Medicaid

Medicaid is intended to be an LTC safety net: It provides care to supplement or replace informal supports and other LTC financing when they are either insufficient or unavailable. Within the Medicaid beneficiary community, the phrase "long-term care" has been replaced with the more inclusive terminology of "long-term services and supports" (LTSS).

Before an individual is eligible for LTSS from Medicaid, most personal savings must be exhausted. This generally means the individual must have "spent down," or paid for LTSS out of pocket, until what remains is limited (in most states) to $2,000 in countable assets. In addition to the $2,000, Medicaid allows the beneficiary to retain a primary residence, car, and a small amount of life insurance and other personal property.[12] In addition, if an LTSS recipient has monthly income, such as from a pension or Social Security, the state will generally garnish any income in excess of that needed for support.

12 Congressional Research Service, *Medicaid Financial Eligibility for Long-Term Services and Supports*—General Asset Rules, March 7, 2017.

Those who receive Medicaid LTSS in their homes are allowed to retain income sufficient to pay for rent, food, and utilities, while those in nursing homes are allowed to retain a small monthly personal needs allowance.

If an LTSS recipient is married, with most assets held jointly, states have protections against spousal impoverishment. The LTSS recipient's spouse can continue to live in the couple's house, and keep half the couple's income and assets, within certain limits. During 2017, spouses of Medicaid LTSS beneficiaries could continue to receive between $2,030 and $3,023 of the couple's joint monthly income, and could retain assets of between $24,180 and $120,900.[13]

Spend-down requirements support the concept that Medicaid is a safety-net payer of last resort, making individuals responsible for their own care for as long as they are able. Individuals can transfer assets to others rather than use them to pay for first-dollar coverage of LTSS, accelerating the need for public support; however, there is a five-year lookback rule that allows Medicaid to recoup asset transfers that occurred in the five years prior to Medicaid LTSS eligibility.

Despite stringent eligibility requirements and required monthly cost sharing when beneficiary income is available, more than half of LTSS spending is publicly funded under Medicaid.[14] Medicaid LTSS expenditures were $167 billion during FY 2016,[15] representing approximately one-third of Medicaid expenditures and 5 percent of total U.S. health expenditures.[16] There is concern that Medicaid could be asked to shoulder an increasing share of the cost of LTSS across the nation due to demographic pressures, trends in longevity and morbidity, and younger Boomers lacking the levels of pension income of older Boomers. Because Medicaid is financed by federal and state government funds on a pay-as-you-go basis, it also faces fiscal uncertainty due to policy constraints and tensions at both the federal and state levels.

Medicaid is trying to control increases in LTSS costs in two primary ways (among others):

- *Changing where LTSS is delivered*—Over the past 20 years, Medicaid has transitioned from providing over 80 percent of LTSS in institutions (such as nursing homes) to approximately 43 percent in FY 2016.[17] Institutional care has been replaced with a variety of supports delivered in the beneficiary's home or community, such as attendant care, personal care, assisted living, and adult day care.
- *Using managed care in the LTSS program*—Managed LTSS has grown to 23 percent of Medicaid LTSS expenditures as of FY 2016.[18] Proponents suggest private companies can be more motivated and more effective at providing efficient and high-quality LTSS, but experience is still limited.

Even with such cost-mitigating approaches in place, funding of Medicaid LTSS is expected to put strains on federal and state budgets over the next several decades as the Baby Boomers reach the oldest-old ages with greatest LTSS needs.

Conclusions

The need for LTC services will continue to increase as the U.S. population on balance ages. LTC services can be provided through informal care and/or formal care. Informal care is usually provided free of cost by the caregiver, but there is still a material cost associated with earnings forgone by the caregiver, and potentially unnecessary system costs created through low-

13 CMS, 2017 SSI and Spousal Impoverishment Standards, 2017.
14 Kaiser Family Foundation, *Medicaid and Long-Term Services and Supports: A Primer*, December 2015.
15 Medicaid Innovation Accelerator Program, Medicaid long-term services and supports expenditures in FY 2016, 2016.
16 Irene Papanicolas, PhD, Liana R. Woskie, MSc, Ashish K. Jha, MD, MPH, "Health Care Spending in the United States and Other High-Income Countries," *Journal of the American Medical Association*, March 13, 2018.
17 Medicaid Innovation Accelerator Program, *Medicaid Expenditures for Long-Term Services and Supports in FY 2016*, May 2018.
18 Ibid.

quality care. Formal care can be funded by one of the following methods:

- Self-Funding—Accumulating assets that ultimately pay for the costs of LTC services when needed.
- LTCI—Pre-funding future LTC services through insurance premiums.
- Medicaid—A public safety net for providing LTC services for individuals who have no other sources of funding.

Individuals should plan for the risk of needing LTC services and consider which of these options are available to them based on their individual circumstances. Over the course of the time that individuals need LTC services, they could utilize more than one of these options; due to the unpredictability of LTC needs, however, there is a high degree of uncertainty for individuals to ensure they have planned appropriately.

The expected future increases in LTC service needs and costs will almost certainly stress LTC financing over the next several decades as the Baby Boomers reach the oldest-old ages. Changing demographics and the fact that family members do not live in as close proximity with one another as in the past will likely decrease the availability of informal care and increase the need for formal care, which is already in short supply in many instances.

LTCI offers individuals an option to pre-fund their future LTC care, but this type of insurance is severely underutilized as the vast majority of individuals choose instead to self-fund or to rely on Medicaid to provide for their future LTC needs. Often times, they will use both by spending down their income/assets to reach Medicaid eligibility. Given that Medicaid funding already represents a substantial portion of federal and state budgets, its role, without modification/reform, as a long-term option for funding the LTC costs of the Baby Boomers and generations beyond raises many questions. The potential drivers to modify/reform Medicaid is but one indication—albeit a critical one—of the need for more comprehensive reviews of the existing LTC financing systems, with the ultimate goal of developing actuarially sound proposals for reform.[19] These will be topics for future, planned-for issue briefs.

19 American Academy of Actuaries, *Essential Criteria for Long-Term Care Financing Reform Proposals*, November 2016.