Federal Reserve Bank *of* Atlanta

***ECONOMY MATTERS* PODCAST SERIES**

An Eye on the Future: A Discussion about the Long-term Care Insurance Market

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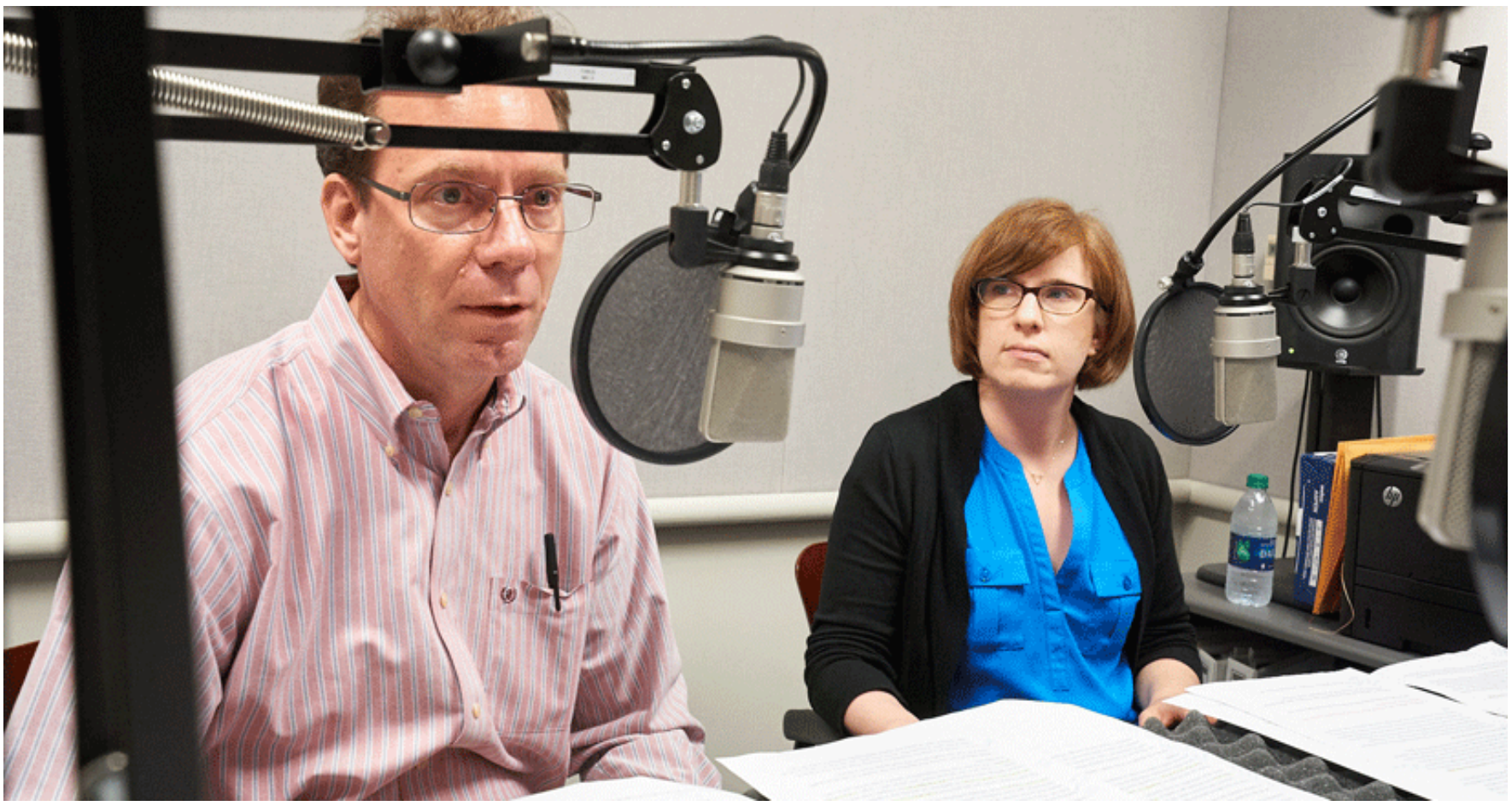
Charles Davidson: *Welcome to another Economy Matters podcast from the Federal Reserve Bank of Atlanta. I'm Charles Davidson, staff writer with Economy Matters, our digital magazine. I'm here today with Toni Braun and Karen Kopecky, research economists here at the Atlanta Fed. We're going to be talking about their research into long-term care insurance markets, as well as markets for individual health care insurance. So Toni, Karen: thanks for being with us today.*

Toni Braun: We're happy to be here.

Karen Kopecky: Thank you.



Toni Braun and Karen Kopecky, both of the Atlanta Fed's research department, during the recording of a podcast episode

Davidson: *All right, so first off—you guys have spent a lot of time researching dysfunction in long-term care insurance markets, which mostly involves insurance for older people. So first off, can we start by defining what we mean by long-term care and long-term care insurance?*

Braun: Sure, Charles. As we age, we all become frail, and some of us will require significant assistance with activities of daily living. Examples include taking a bath, or maybe making a meal. In some cases, these health issues become so severe that we need either assistance at home or, alternatively, in a nursing home. In terms of long-term care insurance, what that does, it provides coverage for those who need assistance at home and/or in a nursing home.

Davidson: *Karen, why is this work interesting to you guys? You have obviously put a lot of energy and brainpower into it. And further, why is it important to the macroeconomy, the larger economy?*

Kopecky: Part of the reason it's interesting is that Americans face a significant risk of having a protracted nursing home stay near the end of life, and those days are often associated with large, out-of-pocket medical expenses. What's surprising is that people are paying for this stuff out-of-pocket instead of buying long-term care insurance. So despite the fact that people face this large risk of incurring expensive nursing home stays, only a small fraction of people actually buy this insurance.

And that's just one of many fascinating puzzles in this long-term care insurance market. What's also interesting is that—if you look at the trends in the market—the population is aging. And you would think if anything that this market should be growing—people are living longer, they're more likely to be in these states where they need this type of care, and there's a larger fraction of people in the population who are going to need this care. Yet, despite that, if anything, the market is shrinking. Also, if you look at the policies that are offered in the market...

Davidson: *You're talking about the insurance policies themselves, right?*

Kopecky: Exactly. If you look at long-term care insurance policies that are offered to people who do buy insurance, they're far from comprehensive, so they don't provide very good coverage. They're also very expensive, yet despite that, insurers in the market have struggled to make profits—and if anything, you see insurers exiting the market.

One of the other interesting puzzles in the market is that you see very high rejection rates. So what happens is that there are some people who try to buy this insurance, and they go to the insurer and the insurer basically says, "Sorry, we're not going to cover you." It's just interesting to try to understand why there is no price that exists at which an insurer will offer them long-term care insurance.

Davidson: *Are those some of the major findings so far? The high rejection rates, the small number of people who actually own these policies—is that among the significant findings to this point?*

Braun: Actually, our findings are more to try to account for these puzzles that we see when we look at this market. So the puzzling features of this market that you're hitting on, that's exactly right. The ownership rates are low, many of those who apply find that they are denied coverage, and those who are offered coverage get incomplete coverage at a high price as compared to other insurance products. What we're trying to do, in terms of our model, is understand what are the principal factors responsible for these puzzling empirical results.

What we found is that there are really two distinct factors that are influencing this market. For those who are poor, there is social insurance provided by Medicaid. If your assets are low enough and your income is low enough, you can receive free coverage for nursing home stays that are covered by Medicaid. What's somewhat surprising is that the availability of Medicaid benefits also affects those who are in the middle class, because in some situations they may enter a nursing home as a private payer, but at some point they exhaust their own resources and can receive benefits, because they will then qualify for Medicaid benefits.

So Medicaid is certainly one of the important factors underlying what's going on in this market. A second factor, though, that is important for the middle class—as well as more affluent Americans—is private information and adverse selection.

Davidson: *Can you explain those please, Toni?*

Braun: Let me take on adverse selection—that's the more tricky one. A basic problem that the insurer faces is, they'll do medical underwriting and say, "Okay, you belong to a group that's average risk." But that underwriting process isn't perfect, and in many cases people have more information about their health risk as compared to the insurer. This poses a conundrum for him because if he offers coverage at a low price, then what he may find is that he gets a lot of these high-risk types entering. If the price is too high, it could go the opposite way. So the real puzzle for the insurer is, given a pool, he doesn't really know how risky that pool is and how should he price the product.

Davidson: *Why are they not a little bit better at gauging that risk? Is it a matter of, "I'm going to buy the insurance at age 50. I'm not going into the home until I'm 75 or 80," and so, things can change so much? Or there are other factors at work there that make it an—I don't know if it's an actuarial sort of puzzle, but what are the reasons why that's an issue?*

Kopecky: There's a lot of evidence that people have private information about their likelihood of entering a nursing home. For example, I may know that there's a history of some genetic disease in my family that the insurer doesn't know about. Or it could be things like, "I know that my children really want to take care of me if I were to need long-term care. The insurer doesn't know anything about my family situation or whether my children would be willing to care for me." It could be that I know that people in my family just tend to not die, you know, or they tend to hang on to very old age. My mom, and her mother, and her mother all lived late into their 90s—so I just think, given that we are a family of people who tend to live until very late in life, that there's a high probability that I'll be in these very old ages where I'm going to need nursing home care.

And these are things...it's just very difficult for the insurer to learn about individuals. And the other thing that we see is that—in particular for individuals the insurers observes as high risk because they're already very frail, or in poor health—in those risk pools the insurer is even more uncertain about who are the people who are already very sick and about to die, or who are people who are very sick and know that, "Oh, in a very short period of time I'm going to need to go to a nursing home," and that's why they're interested in buying the insurance.

And because he faces a lot of uncertainty about who are the sick people who are going into a nursing home versus the sick people who are maybe going to die or not go into a nursing home, he struggles to come up with a way to price insurance for that pool such that he can make profit, and that's what the adverse selection problem is.

Davidson: *Okay. Can we talk about a few basic numbers for just a second? For example, typically, how much does it cost to stay in a nursing home for a year? So that's $80,000, roughly?*

Kopecky: It's $80,000 for a shared room, and if you want a private room, or other fancier, nicer amenities, it would be more than that. So I'd say $80,000 is the lower end of the costs.

Davidson: *Right.*

Braun: And it varies a lot across regions. The costs in Long Island are obviously going to be a lot higher than the costs in rural Indiana.

Davidson: *Sure, sure. What about these policies? They're expensive. Is there a way to get a read on what's the average premium? What do people typically pay for long-term care insurance?*

Kopecky: The average annual premium is between $3,000 and $5,000 a year.

Davidson: *Okay, so it's a chunk of money, then. And you're going to be paying it for a long time, one would assume.*

Braun: It's about 20 years between the time people purchase, on average, and when they receive benefits.

Davidson: *Right. Toni, what about the market for long-term care itself? How do we see that taking shape in the coming years? For example, there's been a trend toward aging at home rather than people going to nursing homes. Is that likely to continue?*

Braun: Yes. As America grays, we're going to see a much higher fraction of Americans that are old. One response of governments—as well as insurers—to this is to try to keep people at home. Nursing homes are very expensive, and if you can keep people home longer, then that reduces the cost either to the insurer or to the government. And so I expect that we're going to see more effort associated with trying to keep people home longer. And there'll probably also be market solutions as well—services with more retirees, there will be more services that come in and help out with the laundry or a whole range of other market products, such as the types of bath tubs that we see that you can open up and you don't have to climb into. So the market for retirees is likely to be a growing market in the future.

Davidson: *Right. Well, that naturally leads to a question about the market for long-term care insurance. How do we see that evolving, Karen? Will there be more products out there aimed at people who are going to be at home, but maybe they want to cover their expenses of home care?*

Kopecky: Yes. I expect we're going to continue to see this market evolve. This has been an evolving market since long-term care insurance products really became popular in the late '80s, early '90s. And I expect that what we're going to see going forward is that—as Toni was saying—as we see a shift towards trying to keep people out of nursing homes and getting care at home, I think there's going to be more active management of insurers in the care that individuals are receiving.

So insurers also have a lot of skin in the game when the care management plan for an individual is decided upon. Not only, obviously, does the individual probably care a lot about, "Am I going to be in a nursing home or at my own home, and who's going to be caring for me?" The family cares about that, but the insurer cares because that will impact the payout that they have to give in terms of claims to the individual that they're insuring.

And I think the problem that you have when you get more and more into home health care as opposed to nursing home care is that with home health care there's a higher risk of a moral hazard problem. This is because for nursing home care, the view is generally that people don't want to be in a nursing home—that they would only go there if they really need to be there—but for home health care, there's some evidence that there are some older people who like the idea of having somebody come to their house to...

Davidson: *A companion, someone to talk to.*

Kopecky: Yes, a companion, someone to talk to, someone to help them run some errands or do some housework—even though they may not really need that person due to their health conditions. So there is going to be more of a concern by the insurer that individuals may buy this insurance with the intention of using it just to pay for a companion that they don't really need. And so that's why I said there'll be more effort in trying to screen individuals, to make sure that they really need the insurance claims that they're requesting, and perhaps actively managing their care and coming up with better solutions—putting some resources in trying to figure out what's the best way to provide them with the care or the help that they need.

Davidson: *I wonder if at some point you could hire a companion. Maybe someone rents you a dog, for example—or a person—to hang out for a while. I'm being somewhat flippant, but not really. It seems like something that could be out there at some point.*

Braun: Well, communities are also involved in this issue. We're seeing an increasing number of communities starting to provide daycare services for adults—so you can go to a community center and spend time with other adults of your age. These are arrangements that, historically, were handled exclusively by families and the community, and both will continue to play an important role in this.

Davidson: *Right. Well, Toni, you have deep experience researching—as well as living in—Japan, and the economics there. The aging process there is farther along than we are here. Demographically we're similar, but they're in a more drastic position, as I understand it—the population is actually shrinking in Japan. Are there lessons learned there that may come into play here?*

Braun: Well, one important difference between Japan and the United States is that the nature of the social insurance for long-term care is quite different. In the United States, we have Medicaid, and as we discussed previously, Medicaid is means-tested. A second feature of Medicaid is that it's a secondary payer, so if you have private long-term care insurance, that's the primary payer—Medicaid is a secondary payer.

In Japan, there is social insurance as well. It's a more recent phenomenon. They started up the program around 2000, and it's a universal program that all retirees are provided with some base level of benefits. And there is a needs assessment that's not financial needs, it's more medical needs—the number of ADLs [assisted daily living] that you have. So the first tier is universal coverage, and it's up to some cap. And then you pay out of pocket, but there's also an annual cap in your out-of-pocket payments.

And the other difference I would say between Japan and the United States is that when they talk about the role for society in providing social insurance, they use the term preventative—that they're interested in keeping individuals out of institutions and at home as long as possible.

Davidson: *Right. Well, it sounds like we're moving a little more toward that model, I guess?*

Braun: Medicaid is now experimenting in some states with offering home services as well, but it's a relatively recent phenomenon. It's a phenomenon, though, that I expect we'll see more of in the future.

Davidson: *Interesting. I understand that you guys are starting to turn your attention toward the market for individual health insurance. So, Karen—can you briefly talk a little bit about this next phase of the research?*

Kopecky: One thing that we have observed is that the individual market for working age people in the U.S....

Davidson: *Now, we're talking about people who don't get insurance through their employer, right, basically?*

Kopecky: Exactly. This would be the market for people who are under 65—so they're not eligible for Medicare—but they do not have access to employer insurance, either directly or through their spouse. They're looking to purchase insurance on their own by going into the individual market. If you think about this market pre-ACA [Affordable Care Act], it's a market that shares a lot of similar properties with the long-term care insurance market. And the two big similarities, I would say, are one, that it's a market where you had high rejection rates of individuals. So if you recall, many people could not purchase insurance on that market due to having preexisting conditions, just like we have people who try to purchase long-term care insurance and are rejected by the insurer due to their health status.

And the other one is that it's a market where the type of insurance you can buy in that market is far from comprehensive and very expensive. So recall again that people who had policies off the individual market had much less—the amount of coverage they had was much worse than people who had it

on the employer market, and they paid a much higher price for that coverage—similar, too, in the long-term care insurance market, that we see that the policies are far from comprehensive and very expensive.

It's our view that the reasons that you see these similarities is that there are similar mechanisms at work accounting for the state of the market, because in the individual market, you also have the problem that you have a means-tested option—Medicaid is available to some of these individuals. And so just like Medicaid crowds out demand for long-term care insurance, individuals who can get Medicaid to cover their medical expenses when they're working age potentially also don't have demand for this individual health insurance.

And then the other thing is that you have a private information or adverse selection problem in this market, right? So it's just like what we were talking about with the long-term care insurance market, that—pre-ACA—if you wanted to buy individual health insurance, you had to go through a medical underwriting process. What the insurer is trying to do there is, they're trying to collect information about your medical needs so that they can accurately forecast your medical expenses.

Individuals know more about their medical expenses for a variety of reasons. I may know I'm planning to have a baby next year. I don't have to tell the insurer that when I go and try to buy insurance. Or I may know that everybody in my family had a heart attack or a stroke when they were in their 60s, and now I'm 60 and I'm thinking, "I better get this health insurance because I face a high risk of having a heart attack as well in the next couple of years," or something like that.

So just like the long-term insurance market, you have an adverse selection problem in the market. And so what we are trying to do now is think about a similar framework—except modified to be applicable to the individual market—and then try to understand how important these frictions are, potentially, in accounting for what we see in that market. And then think about the ACA reforms and how they modified the market——what the impact of that reform should look like, and how it compares to what we're seeing.

I think what we're seeing right now in the market is that the market's still in the transition state—the ACA was never fully implemented, and there's been a lot of political uncertainty about what that market will look like going forward. But we think it will be very interesting, given that there's a lot of uncertainty about the future of the market, to try to understand what the ACA, in the long run—what kind of effect it would have had on the market, and then also possibly to analyze some of the other reforms that have been put forth that Congress is now considering and what the implications of those reforms will be for the market going forward.

Davidson: *Would this model allow you to basically conduct "what if" scenarios? Say, if policy "X" is implemented, here's the likely result?*

Braun: Yes. The word "model" is very important here. We use models to answer these questions, and models are helpful in two different ways. First, there's a whole range of probably 20 different potential explanations that have been offered for what you referred to as the dysfunctions in the long-term care insurance market or the dysfunctions in the individual health insurance market. What we can use a model to do is to formalize some of these potential explanations and ask what's big and what's small? What are the key mechanisms that can account, both at a qualitative level and a quantitative level, for what we see in the data?

Having done that, though, the second thing that a model is wonderful for is asking "what if" questions. So we can use it as a laboratory for running experiments where we conduct different types of reforms and consider their impact on things like coverage levels and pricing of insurance.

Davidson: *I guess on some level—we don't want to veer into politics here, clearly—but the Congressional Budget Office, when they score a proposal, essentially that's a bit of what they're doing, right? They're running the proposal through their model and saying, "Okay, there's a range of outcomes, and here's what we think it is."*

Braun: Yes, and the difference between them and us is that they usually have to come up with an answer over a horizon of three months, maybe. *[laughter]*

Davidson: *Or even faster, in some cases?*

Kopecky: Yes. Often the models they use are simpler.

Davidson: *But by necessity, I guess, because they have to do it more quickly.*

Kopecky: Yes, because they have a short deadline, and they need to usually run a large number of scenarios in a short period of time.

Davidson: *Right, a lot of work going into this, clearly—I know you guys have spent the better part of two years working on this so far, and probably working on similar problems previous to that. So ultimately, what is the aim of this research agenda? What are we trying to get at here, or get to?*

Kopecky: I would say the ultimate aim is to understand what are good policies for these markets. We've identified that there's frictions—for example, in the long-term care insurance market—that impede the market from providing coverage to a large amount of people and at a reasonable price. The next question is really, "Well, what can we do about that? What should the government do to improve the insurance options of individuals?"

For example, it could be that, should the government be putting restrictions on insurers or on the markets to improve their functioning? Or, for example, maybe the government should be providing a public alternative to the private market. Maybe Medicaid should be expanded so that it's not just a means-tested program, but it's more like Medicare—it's an entitlement program, and everybody can get nursing home care covered by the government.

Braun: I guess I'm going to toot our own horn, but one of the contributions of our research is that we have a theory that can account for the fact that we see insurers screening—not so much through offering different types of contracts. I mean, they do that in our set-up as well, but the new screening device, and the most significant screening device, that our model can account for is the fact that insurers reject clients. These rejections and denials —we've talked about two specific markets, but denials occur in a whole range of insurance markets, and so we have a setup where we can actually talk about that in a sensible way.

Davidson: *Other insurance markets—say, for automobiles, homeowners insurance, appliance warranties, things like that—I trust those are much simpler in most ways than the kind of stuff we're talking about here. But those markets, I guess in general, seem to function reasonably well. Are there things to be learned from those markets, or is it just a matter that they're so different and so much simpler that there's really no real comparison there?*

Kopecky: I would say that they're quite a bit different. The adverse selection problems are less severe in those markets. So both of the key frictions that we have identified I think are less important, so I think there's less of an adverse selection issue, and there's not really an alternative public option that potentially is crowding out demand or reducing the ability to make profits in those markets.

Braun: Yes. Take the automobile insurance market, for instance. That's a market where in virtually all states there's a mandate.

Davidson: *Yes. You have to have auto insurance.*

Braun: Right, and there's no mandate right now that says you have to have health care insurance. There are some costs if you don't, but you're not required to purchase health care insurance.

Kopecky: Yes, and there's definitely no mandate for long-term care insurance.

Braun: So that's one important difference, and certainly that's being discussed right now—the role of mandates in this market or in these markets.

Davidson: *All right. Well, guys, there's an awful lot to chew on here, and I trust you guys will be hard at work on this for some time to come. Thanks so much for your time today.*

Kopecky: It was great to be here. Thank you.

Braun: Thanks so much.

Davidson: *All right. Join us next month, please, as the* Economy Matters *podcast will look at the results from a recent Atlanta Fed survey of business optimism. So how bright does the future look to firms in this time of transition? Well, be here next month to find out. And as always, go to our website, frbtlanta.org, for more economic research. There, you can find Karen and Toni's papers as well as lots of other interesting and important economic research and other materials. Thanks for your time today.*

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