ACLI
Financial Security...for Life.

WHO WILL PAY FOR OUR LONG-TERM CARE?

October 2014

Who Will Pay for Our Long-Term Care?

American Council of Life Insurers
101 Constitution Avenue, NW
Suite 700
Washington, DC 20001–2133
www.acli.com

OCTOBER 2014

Prepared by:
Andrew Melnyk, Ph.D
and Harsh Sharma

ACLI
Financial Security...for Life.

OVERVIEW

Between 1946 and 1964 about 76 million children were born in the United States. This generation, the baby boomers, grew up during one of the longest periods of sustained economic growth in U.S. history and enjoyed a considerably higher standard of living than any previous generation. The boomers represent a disproportionately large segment of the population (roughly 28 percent) and have started swelling the ranks of the elderly.

By 2030, when the youngest boomers will have reached retirement age, the elderly population will be nearly double what it is today.[1] By 2050, when the youngest surviving boomers will be 85, the '85 and over' population will have tripled. Currently, about 37 percent of those 85 and older use paid long-term care.[2] As the elderly population grows, demand for long-term care will increase. By 2050, up to 14.7 million seniors will require some form of long-term care.[3]

The possibility of a baby boomer needing long-term care during his or her elderly years is very real and much more likely than most people realize. Many seniors may never need formal long-term care, but 70 percent of those who are currently 65 will. A sizable percentage will require long-term care services for an extended period of time, with women being at more risk than men. On average, elderly individuals will use long-term care for 3 years, and one in five for more than 5 years. Among those who enter a nursing home, the most costly and intensive form of care, 12 percent of men and 22 percent of women will be residents for over 3 years, while one in eight elderly women can expect to live in a nursing home for over 5 years.[4]

The cost of long-term care is high and increasing, and is expected to continue its upward trend. Today, a one year stay in a nursing home costs $87,600 for a private room or $77,380 for a semi-private room; non-certified home health aides typically charge $20 per hour; the average base rate for the services of an assisted living facility is $42,000; and, one year of adult daycare services is $16,900.[5] Since 2005, the price of both nursing home care and assisted living increased at an average annual rate of 4.5 percent – compared to a 2.5 percent overall inflation rate.[6]

The current system, where 33 percent of long-term care expenditures for the elderly are paid by Medicaid, 34 percent by Medicare, and 20 percent out of pocket—is not sustainable.[7] Total annual expenditure on long-term care for the elderly is estimated to be $231 billion, which accounts for over 7.5 percent of total spending on health care for individuals of *all* ages. This is roughly 1.3 percent of the U.S. GDP.[8] Because baby boomers are aging and the cost of care is increasing, total spending on long-term care is expected to increase 64 percent by 2030 and 153 percent by 2050.[9] Under the current system, these increases will place a heavy burden on Medicaid and ultimately on taxpayers, most of whom are working age adults. Currently there are about 3 employed adults per senior, but by 2030 there will only be 2—a 33 percent decline. This decline will occur while both the need and cost of long-term care are increasing.

Those who do not plan for long-term care may face poor choices. Given the strong possibility that the typical senior will require long-term care, and given it's high and escalating cost, whether seniors enjoy a comfortable retirement or suffer economic hardship may depend largely on their ability to afford long-term care. Most Americans have not planned for this and face the prospect of paying large sums 'out-of-pocket' or relying on Medicaid, which in its current form requires 'spending down' virtually all assets and retirement income. Neither option is very appealing and may leave seniors and their spouses impoverished, with few choices.

Private long-term care insurance offers a solution. Private long-term care insurance

currently pays for only 7 percent of total nursing home expenditures. By comparison, private medical insurance pays for 34 percent of overall health expenditures. There is clearly a large gap in the market which long-term care insurance can fill.

While long-term care insurance has existed for several decades, few people who can afford to purchase a policy have actually done so. If one in four working age adults were to purchase and maintain a policy throughout their senior years, then by 2050 the savings in Medicaid nursing home expenses would total $48 billion annually, and the savings in annual out-of-pocket expenses would total $69 billion.[10]

A Looming Crisis

Over the coming decades the demand for formal long-term care is expected to accelerate because:

- Baby boomers have started entering their elderly years.
- Life expectancy is increasing.
- Home-based care provided by family members is becoming a less-viable alternative for a growing number of elderly.

Baby boomers account for about 28 percent of the U.S. population and over the next several decades will be reaching retirement age. More specifically, the oldest boomers will soon reach 70 and the youngest will have reached 65 by 2030. By 2050 the youngest surviving boomers will be 85 years of age, roughly the age at which long-term care is most needed.[11] Between today and 2050 the size of this age group, those 85 and older, will have increased more than three-fold and the overall elderly population will have grown by 89 percent (see Figure 1).

Both advances in medical care and greater prosperity have resulted in increased life expectancy among the elderly. Today, a typical 65 year old can expect to reach 84.1 years of age, whereas in 1950 he or she could only expect to live to 78.9.[12] Life expectancy will continue to climb: by 2030, the average 65-year-old can expect to reach 86 – and 88 by 2050.[13] Improved life expectancy increases the need for long-term care. As the elderly population is growing, the demand for formal, paid long-term care rises.

Because longevity may be increasing at a faster pace than improvements in the quality of health, the typical senior may live longer in the future, but may also need long-term care for a longer period of time. An increase in life expectancy does not necessarily mean better health in old age and does not preclude the need for long-term care. Even though there has been an improvement in overall disability, the specific disabilities that have declined are not those that imply better health and lower costs, but instead simply reflect changes in the external environment and improvements in assistive devices.[14] Also, as life expectancy increases so does the incidence of degenerative diseases which require constant care and monitoring in their advanced stages.[15] Alzheimer's disease is of particular concern because 43 percent of all seniors 85 and over have this condition.[16]

The combination of greater longevity and declining health suggests that the demand for long-term care may increase even more than expected. If this becomes a trend, both utilization rates and the length of time spent receiving care may further increase, placing an even greater financial burden on seniors, families, and state and federal government.

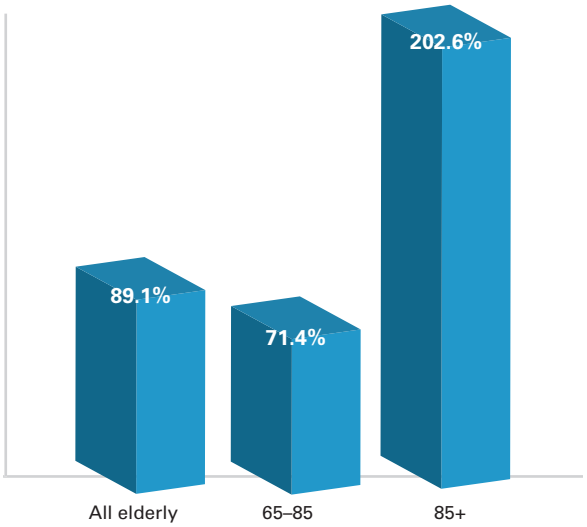
Informal home based care is a less viable option for a growing number of seniors because there are fewer family members who are able to provide such care. In the past, long-term care was routinely provided at home, informally, with friends and family serving as primary caregivers. Even today, up to 15 million Americans provide

unpaid care for a person with Alzheimer's disease or another form of dementia.[17] But families have become smaller and more geographically disbursed, a greater percentage of women are in the labor force, and retirement among both men and women is increasingly delayed. For these reasons, it is likely that over the coming decades there will be a further shift away from informal and toward formal care.

A growing number of seniors requiring long-term care and a greater cost per recipient will result in a 64 percent increase in total long-term care expenditures by 2030 ($392 billion). By 2050 expenditures are expected to increase by 153 percent ($605 billion) (Figure 2).[18] Currently, about 2.7 percent of all seniors reside in a nursing home, 4.4 percent receive some form of home health care, 1.6 percent reside in an assisted living facility, and about 175 thousand use adult daycare.[19] Assuming recent utilization rates, it is expected that between the year 2010 and 2030 the number of seniors requiring any form of paid long-term care will increase from 5.7 to 10.0 million (Figure 3). Furthermore, by 2050 the number of seniors requiring long-term care will increase to 14.7 million, more than two and one-half times greater than in 2010. These large increases are primarily driven by the number of very old, those 85 and older, who make up the majority of the nursing home population.

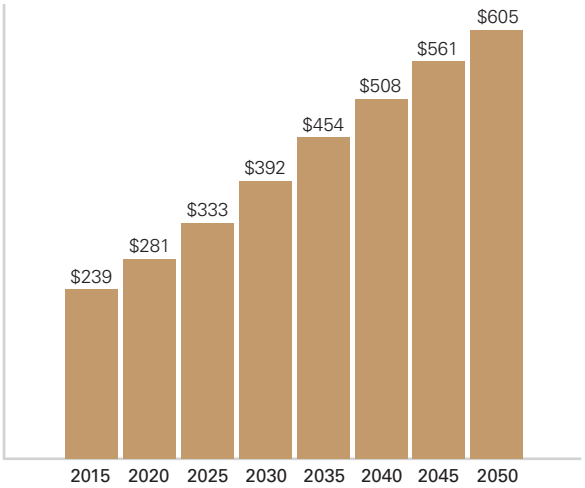
Total U.S. expenditures on long-term care are determined by the expected number of people requiring these services and the expected cost per recipient, both of which will increase in coming years. Since 2005 the cost of nursing home care has grown by 4.5 percent annually, compared to an overall inflation rate of 2.5 percent. If this trend were to continue, the average cost of a one year stay in a nursing home will increase from about $81,000 per year in 2014 to $146,000 in 2030.[20]

FIGURE 1: Percent Change in Elderly Population 2015–2050



SOURCE: U.S. Census Bureau (see http://www.census.gov/population/www/projections/2008projections.html).

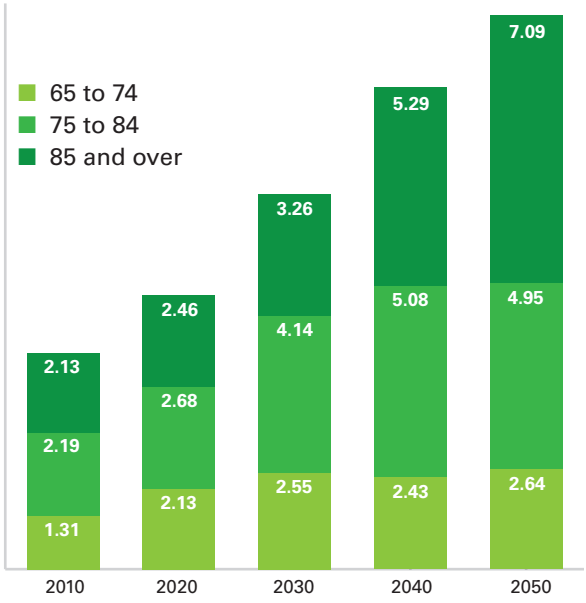
FIGURE 2: Total Long-Term Care Expenditures, 2015–2050



NOTE: In 2014 USD. Includes seniors only (age 65 and over). Based on nursing home care and home health care.

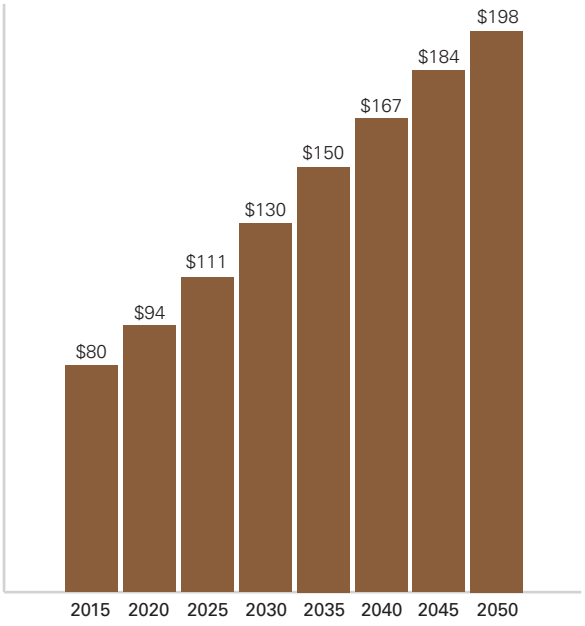
SOURCE: ACLI calculations based on data from Harris-Kojetin et al. (2013), U.S. Department of Commerce, U.S. Census Bureau, and data provided by the Office of the Actuary, Center for Medicare and Medicaid Services via personal correspondence.

FIGURE 3: Long-Term Care Population, by Age, 2010–2050 (Millions)



SOURCE: ACLI projections based on data from U.S. Bureau of the Census and Harris-Kojetin et al. (2013).

FIGURE 4: Medical Long-Term Care Expenditures, 2015–2050



NOTE: In 2014 USD. Includes seniors only (age 65 and over). Based on nursing home care and home health care.

SOURCE: ACLI calculations based on data from Harris-Kojetin et al. (2013), U.S. Department of Commerce, U.S. Census Bureau, and data provided by the Office of the Actuary, Center for Medicare and Medicaid Services via personal correspondence.

The Costs to Medicaid

Absent any significant breakthrough in the treatment of Alzheimer's disease and dementia, and absent a significant change in the system, nursing homes will remain the most costly form of long-term care and will likely dominate Medicaid's long-term care expenditures over the next several decades. Currently, nursing homes comprise about 60.7 percent of Medicaid long-term care expenditures on the elderly. Most long-term care expenditures are paid by Medicaid, followed by Medicare, individuals and families (out-of-pocket), and finally private insurance.[21] Though seniors typically prefer home-based care, the bulk of Medicaid's long-term care budget is spent on nursing home care. As both the number of seniors requiring long-term care and the cost per senior increase, the Medicaid program will be further burdened. If its overall share of expenses does not change, by 2030, Medicaid's portion of total long-term care expenditures will reach $130 billion and by 2050 may be as much as $198 billion (see Figure 4).[22]

Table 1: Number of Employed Adults per Retiree*

Year	Number of Employed Adults per Retiree**
2010	2.9
2020	2.4
2030	2.0
2040	2.0
2050	2.0

* ACLI calculations and projections based on data from U.S. Census Bureau (as reported in the Statistical Abstract of the United States, various issues), and Bureau of Labor Statistics.

**Number of those age 20 and above who are employed full-time, divided by the number of those 65 and over who are not in the labor force (excludes those 65 and over who are employed full-time).

While the demand for and cost of long-term care are rising, the percentage of the population that pays most of the taxes is shrinking. This means that Medicaid and Medicare long-term care spending will outpace growth in tax revenues. At current tax rates, Medicaid and Medicare cannot sustain their current level of coverage. Because the elderly population is growing at a much faster rate than younger age groups, the percentage of working age Americans will soon decline. Today, there are 2.9 employed adults per retiree, but by 2030, this will fall to 2.0 (Table 1). This change is significant because people of working age pay the bulk of taxes which in turn fund programs such as Medicaid.

Congress may be forced to limit Medicaid long-term care spending either by reducing benefit levels or restricting eligibility requirements. In fact, in an effort to reduce costs, since 1991 states have applied for a Home and Community-Based Waiver. Under a Waiver, Medicaid recipients can receive long-term care services in less expensive home and community-based settings (e.g. home health care) rather than in an institutional setting (e.g. nursing home). This has proven to be a good approach for younger long-term care recipients with fewer limitations in activities of daily living (ADLs), allowing many to function in their community. But home and community-based care is often not a good substitute for seniors, particularly those with cognitive impairments or those who struggle with multiple limitations.

There is also some concern that the increased use of waivers will result in a 'woodwork effect', where less debilitated seniors who do not require nursing home care and who would not ordinarily resort to Medicaid, intentionally impoverish themselves in order to qualify for Medicaid.[23] Evidence of a woodwork effect is not yet conclusive. If it does exist, waivers may not result in cost savings but would rather drive up Medicaid long-term care expenditures.

In fact, there is concern that some middle-income seniors do transfer their assets in order to qualify for Medicaid. Although originally intended for the care of people with very low income, Medicaid's eligibility rules are currently such that middle-income seniors may qualify for coverage if they deplete their income and assets. Though the elderly do transfer assets, there is little evidence

Why Long-Term Care Insurance is Important for Women

It is particularly important for women to own a long-term care insurance policy. After age 65 women are far more likely than men to need the services of a nursing home, outnumbering men about 3 to 1. They also reside in nursing homes longer than men. A typical elderly female resident spends 2.6 years in a nursing home, compared to 2.3 years for a typical male.[40]

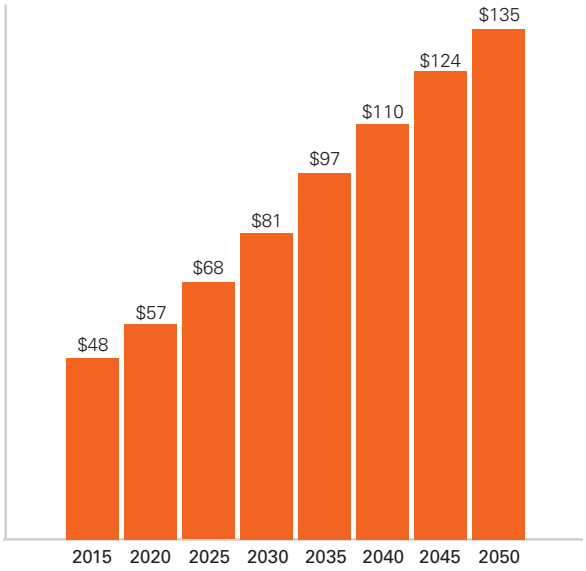
One reason for this difference is that women are more likely to be widowed and to live alone than are men. On average they marry at a younger age than men, with the median age at first marriage being 28.4 for men and 26.5 for women, so they are often younger than their spouses; and, women tend to live longer, with life expectancy for men in the U.S. being 75.6, whereas for women it is 80.8.[41] For these reasons they are more likely to spend their elder years alone.

Women are also more likely to be primary providers of informal care for elderly spouses and other family members. Today, they provide between 60 and 75 percent of family or informal care.[42] Another study reports that two-thirds of unpaid caregivers for elderly adults are women, usually adult daughters.[43] They are also more likely to retire early in order to care for a spouse or elderly parent. One study concluded that "women who help their parents over a two year period cut back their work hours by 367 hours per year, or 41 percent on average".[44]

to suggest that this is routinely done with the intent of qualifying for Medicaid.[24] An important deterrent is the fact that there is a 3 to 5 year 'look-back' period on all assets and income to determine eligibility. Also, because a Medicaid long-term care beneficiary and his/her spouse are allowed to keep very little income or assets, Medicaid does not serve as a good substitute for private long-term care insurance. Further, the array of choices are fewer than those offered by long-term care insurance.

On the other hand, a sizable number of middle-income people do legitimately qualify for Medicaid. About 40 percent of seniors who use long-term care and whose primary source of payment is Medicaid, spent-down their assets before qualifying for Medicaid.[25] Because spending down while receiving long-term care is common, Medicaid has effectively become a safety net both for the poor, and for non-poor who fail to adequately plan for their long-term care needs.

FIGURE 5: Out-of-Pocket Long-Term Care Expenditures, 2015–2050



NOTE: In 2014 USD. Includes seniors only (age 65 and over). Based on nursing home care and home health care.

SOURCE: ACLI calculations based on data from Harris-Kojetin et al. (2013), U.S. Department of Commerce, U.S. Census Bureau, and data provided by the Office of the Actuary, Center for Medicare and Medicaid Services via personal correspondence.

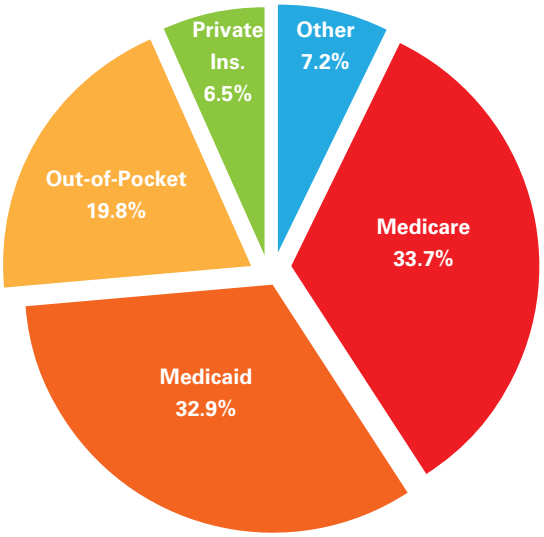
If Americans do not plan ahead and fail to purchase private insurance, much of the burden of rising costs will continue to fall on individuals and their families. Currently, about 20 percent of long-term care costs are paid out-of-pocket by individuals. If this continues to be the case, projected out-of-pocket expenditures will increase from an estimated $46 billion today to $81 billion in 2030 and $135 billion in 2050 (see figure 5). This represents a 76 percent increase in total out-of-pocket costs for long-term care by 2030 and a 193 percent increase by 2050.[26]

Lessening the Burden

To determine the extent to which long-term care insurance can protect Americans from financial hardship and reduce their risk of relying on Medicaid, two scenarios are considered. The first scenario assumes that current financing patterns continue (see Figure 6). The second assumes that one in four adults between the ages of 25 and 70 purchase and maintain a long-term care policy at some point prior to requiring long-term care.[27] The policies purchased are assumed to be three year term with four percent inflation protection, and a $200 daily benefit.[28, 29]

Long-term care insurance can serve as a significant source of financing for long-term care and can greatly reduce both out-of-pocket and Medicaid expenditures. Under the second scenario, the share of expenditures paid by private insurance would increase from 6.5 percent today to 26 percent by 2050, Medicaid's share of expenditures would decline from 34 percent to 25 percent, and out-of-pocket spending would fall from 20 to 11 percent (see Figure 7).

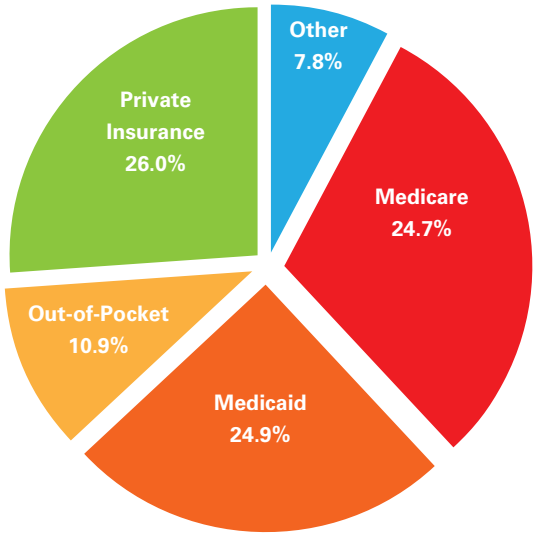
FIGURE 6: Total Long-Term Care Expenditures for the Elderly



NOTE: In 2014 USD. Includes seniors only (age 65 and over). Based on nursing home care and home health care.

SOURCE: ACLI calculations based on data from Harris-Kojetin et al. (2013), U.S. Department of Commerce, U.S. Census Bureau, and data provided by the Office of the Actuary, Center for Medicare and Medicaid Services via personal correspondence.

FIGURE 7: Total Long-Term Care Expenditures Assuming Greater LTC Insurance Coverage, 2050



NOTE: In 2014 USD. Includes seniors only (age 65 and over). Based on nursing home care and home health care.

SOURCE: ACLI calculations based on data from Harris-Kojetin et al. (2013), U.S. Department of Commerce, U.S. Census Bureau, and data provided by the Office of the Actuary, Center for Medicare and Medicaid Services via personal correspondence.

Increased ownership of long-term care insurance can save the Medicaid program $47.7 billion in 2050 and can reduce out-of-pocket expenses by 51 percent, from $135 billion to $66 billion (see Figures 8 and 9).[30] These projections suggest that private insurance will help those who need long-term care and who are at risk of impoverishment avoid Medicaid, effectively reducing the percentage of seniors who spend down. In this way, rather than serving as a safety net for middle-income seniors, the focus of Medicaid-funded long-term care can shift toward the poor.

Prospects for Long-Term Care Insurance

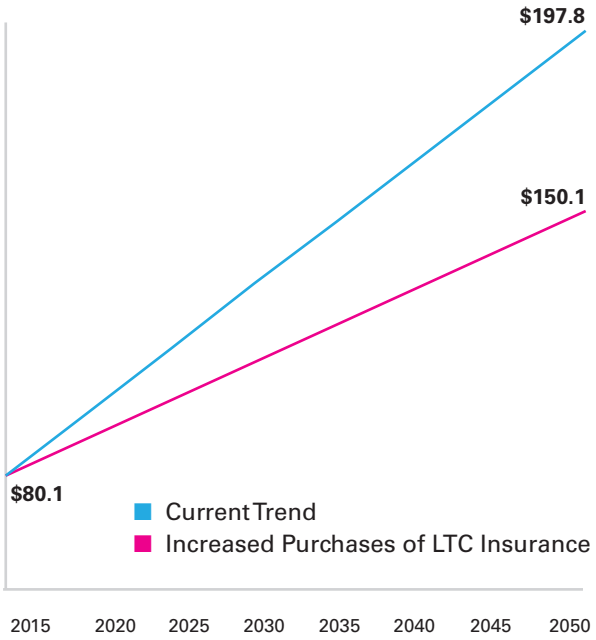
Growth of the Product

Both the individual and group segments of the long-term care insurance market are evolving:

- The market has grown to $11.0 billion in premiums, and now covers 6.9 million people.
- From 2007 to 2013 the long-term care insurance market grew 17 percent in terms of lives covered, and 17.3 percent in terms of premiums.[31]
- The amount that has been paid out in claims has also been increasing with carriers paying $4.9 billion in benefits in 2007 and $7.7 billion in 2013 (Figure 10).

FIGURE 8: Potential Impact of Long-Term Care Insurance on Medicaid Expenditures

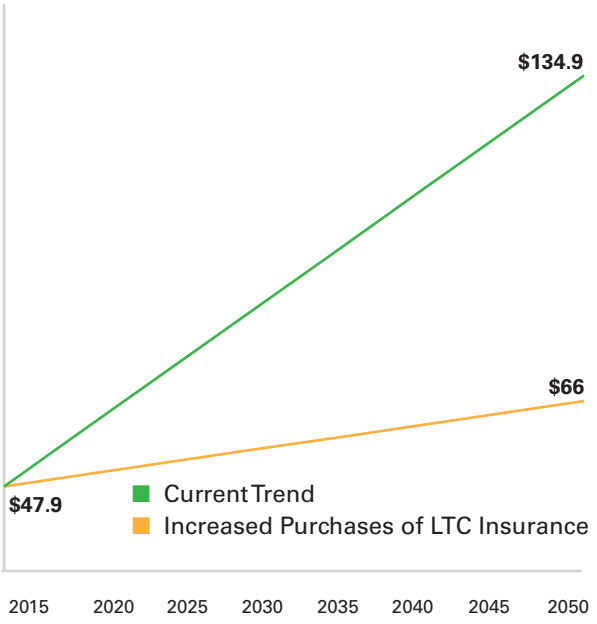
BILLIONS (2014 U.S. DOLLARS)



SOURCE: ACLI projections

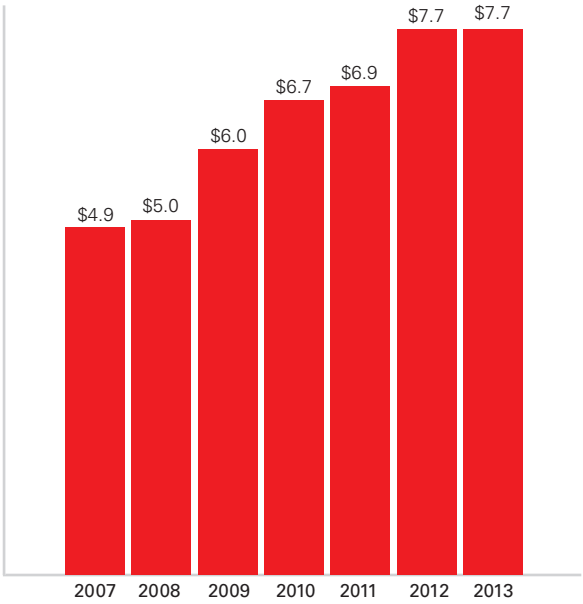
FIGURE 9: Potential Impact of Long-Term Care Insurance on Out-of-Pocket Expenditures

BILLIONS (2014 U.S. DOLLARS)



SOURCE: ACLI projections

FIGURE 10: Long-Term Care Insurance Claims Incurred (Billions USD)



SOURCE: National Association of Insurance Commissioners.

Because private long-term care insurance is priced on the assumption that an individual will hold the same policy until they need long-term care, premiums vary widely depending on the age of the policyholders upon entry, and the specific benefits and coverage chosen. Additionally, younger candidates for policies are much more likely to pass underwriting screens than are older candidates.[32] For these reasons, consumers are encouraged to purchase insurance while they are still in their 40s and 50s, when premiums are lower and more affordable.

When long-term care insurance was first introduced, most purchasers were in their 60's or 70's. In recent years the average age of new policyholders has declined steadily. For example, the average age of a long-term care insurance purchaser in the individual market decreased from 68 in 1990 to 59 in 2010.[33]

Some reasons for the drop in age of the average long-term care insurance purchaser include:

- Heightened public awareness of the power of long-term care insurance as a tool for financial security in retirement.
- Heightened public awareness of the advantages of purchasing a policy at a younger age.
- The evolution of long-term care insurance products to provide policyholders more choices and flexibility at the time of claim.
- The introduction of combination products.
- The establishment of State Partnerships for Long-Term Care.

A better product is available. When long-term care insurance was first offered, most plans only covered nursing homes. Flexible care options and consumer protections have become available, as have hybrid products which couple an annuity or a life insurance policy with long-term care insurance.

Today, policies allow customers to choose between in-home care, assisted living facilities, and nursing homes.[34] Additionally, plans are now guaranteed to be renewable, have a 30-day "free look" period, offer inflation protection, and cover Alzheimer's disease. Benefits are typically paid when a person needs help with two or more activities of daily living or is cognitively impaired.[35]

Long-Term Care Combination Products

Products which combine long-term care with either life insurance or an annuity are appealing to both consumers and life insurers. Since they were first introduced in 2007, combination products have experienced strong growth due to the product's appeal to consumers and tax favorability conferred under the Pension Protection Act (PPA) of 2006. These products combine long-term care with either life insurance or an annuity, allowing accelerated payment of life or annuity benefits to cover long-term care costs. In the event that long-term care is never required, consumers still receive a cash value. Long-term care from combination products is also less costly for the consumer when compared to a stand alone policy due to the self-insurance aspect of the products. After the self-insurance phase is spent, the insured receives a monthly long-term care benefit payment from the cash value or death proceeds of the product. Further monthly long-term care benefits continue per the terms of the rider in the contract.

The PPA permits long-term care insurance benefits to be paid on a tax free basis for linked benefit life or annuity contracts purchased after January 1, 1997. Long-term care costs are tax free as long as the benefit doesn't exceed the greater of the actual cost of long-term care or daily benefit cap under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Moreover, long-term care costs paid within a combination product are also tax free. Combined with long-term care coverage that extends past the exhaustion of the annuity, combination products can enable annuity owners to double or triple the annuity's face account value.[36]

Because they are tax friendly and, for many consumers, less costly than stand-alone products, combination products sales have grown yearly. Individual life-long-term care combination products have experienced double digit growth for five consecutive years. In 2013 there were 98,000 new policies sold, with premiums reaching $2.6 billion. This continuous strong growth suggests a significant demand. Because combination products appeal to both consumers and producers they offer a vast potential market.

But combination products are not without challenges. They are more complex than stand-alone products and, in most instances, are

single premium, which can be costly for some consumers.[37]

Incentives

According to a recent study by the National Alliance for Caregiving, 6 percent of caregivers quit work to care for an older person; nearly 10 percent have to cut back their work schedules; 17 percent take leaves of absence, and 4 percent turn down promotions because of their caregiving responsibilities. Increased long-term care coverage would allow a significant number of family caregivers to remain at work and maintain their standard of living.

Long-term care insurance typically covers assisted living facilities, which are an increasingly popular long-term care option for people who do not require the intensity of care provided by nursing homes. Assisted living refers to a variety of housing options, all of which offer services to assist older people with daily living, yet allowing them to be independent. Not licensed as medical facilities, assisted living facilities offer a wide range of personal care and health-related services that appeal to people with functional impairments. Though not typically covered by Medicaid, in some states home and community-based services provided in assisted living facilities may be covered under Medicaid Home and Community-Based Waiver programs. Room-and-board costs are not covered.

Partnerships

For several years states have been exploring ways to partner with the private insurance industry to alleviate the growing burden of financing public long-term care. One such way is through the Partnerships for Long-Term Care, a program developed by the Robert Wood Johnson Foundation in conjunction with state governments and with the support of the private insurance industry.

The Partnerships for Long-Term Care allow consumers to purchase a long-term care policy where benefits must be fully used before the policyholder qualifies for Medicaid. When benefits are exhausted, the individual may apply for Medicaid, just as he or she would without private insurance. Because the individual has used the insurance coverage provided under the partnership program, he or she is able to protect a certain level of assets. In this way, partnership programs benefit consumers, Medicaid, and private insurers.

The partnerships operate or are pending in 42 states. As of December 31, 2010 there were 286,434 partnership policies in force throughout the United States.[38] Partnership policies take two forms: a dollar-for-dollar model, which allows people to buy a policy that protects a specified amount of assets; or a total asset model which provides protection for 100 percent of assets once private insurance coverage is exhausted.

In 1993, shortly after the partnership pilots began, Congress suspended expansion to any additional states because of concerns that a publicly funded program, such as Medicaid, would endorse private insurance programs. There was also concern that the Partnership may increase Medicaid spending. However, as Medicaid costs increased, Congressional representatives from non-partnership states expressed interest in implementing new partnership programs.

Though the Partnership Programs have been in place for a short time, there is evidence that they have had a positive impact on the purchase of private long-term care insurance.[39]

Conclusions

Because people are living longer and spending more years in retirement, planning for long-term care needs is becoming more important. Long-term care insurance can greatly ease the financial burden of disability in old age, and is increasingly recognized as a key component to effective retirement planning. Whether or not private insurance will lower future long-term care costs depends on many factors including: whether Americans realize the possibility of needing long-term care and plan ahead for this possibility; the degree to which awareness can be raised about rising cost of care and the limitations of Medicaid and Medicare and how private long-term care insurance can help; and if the public can recognize that long-term care insurance is an effective solution.

How Today's Trends Make Family-Provided Care Less Likely for Boomers

Informal home-based care is less viable for baby boomers than it was for their parents. Several changes in how we live today limit the ways we can provide informal care to our families. Some of the demographic changes that are likely to lead to fewer options for informal home care include:

- Declining family size
- Increase in job-related mobility
- Greater labor force participation by women
- An increase in divorce rates
- An increase in single person households

In larger families, adult children are better able to share responsibility for their aging parents – either by providing informal care or contributing financially. However, declining birth rates have made families smaller: In 1960 there were 23.6 births per 1,000 people; in 2012, there were 12.6 births per 1,000 – a decline of 46.8 percent (Figure 11).

In addition, working adults are less likely to remain in one place during their careers causing families to be separated geographically. Adult children are less likely to live near their elderly parents and are thus unable to help with home-based care.

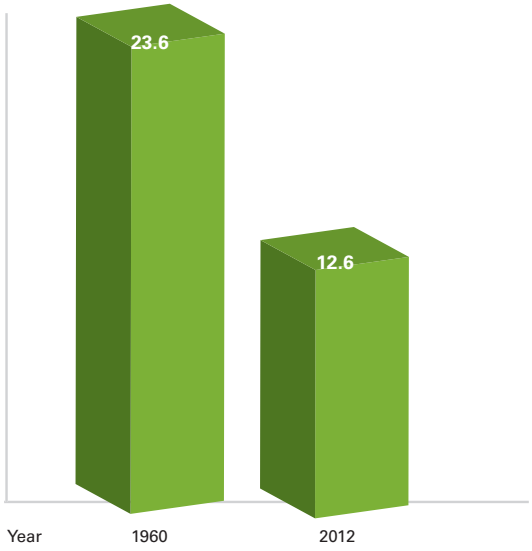
Unlike the distant past, women and men join the labor force at similar rates. Combined with a tendency of people to delay retirement, this means there are fewer individuals outside the labor force who would be available to provide informal care to spouses, partners, elderly parents, or other family members. In 1960, 37.7 percent of working-age women were in the labor force, compared to 57.2 percent in 2013 (Figure 12). A higher retirement age under Social Security standards may further contribute to the depletion of home-based long-term care resources.

A higher divorce rate and more people choosing to remain single means more older people will have no family members to care for them. Many of them will require nursing home or other expensive care which can lead to impoverishment. A 2005 study shows that 70 percent of single people who require long-term care become destitute.

As fewer people can provide informal care for their families, the demand for paid elder care will rise, as will the cost.

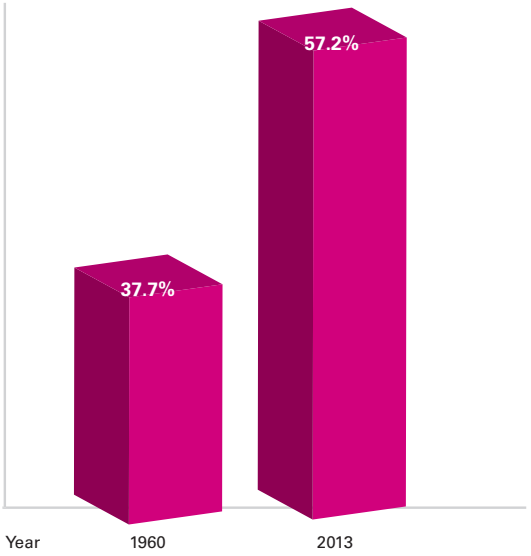
FIGURE 11: Birth Rate in the United States

BIRTHS PER THOUSAND



SOURCE: World Bank, World Development Indicators

FIGURE 12: Percentage of Women in the Labor Force



SOURCE: U.S. Bureau of labor Statistics

Bibliography

AALTCI (American Association for Long-Term Care Insurance), The Sourcebook for Long-Term Care Insurance Information, various editions.

AARP, "Private Long-Term Care Insurance: The Medicaid Interaction", Issue Brief number 68, 2004.

AHIP, "Who Buys Long-Term Care Insurance in 2010-2011?", March, 2012.

Ahlstrom, Alexis; Clements, Emily; Tumlinson, Anne; Lambrew, Jeanne, "The Long-Term Care Partnership Program: Issues and Options", unpublished manuscript, George Washington University School of Public Health and Health Services, 2005.

Basset, William F., "Medicaid's Nursing Home Coverage and Asset Transfers", Working Paper, Board of Governors of the Federal Reserve System, March 26, 2004.

Brown, Jeffrey R. and Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long Term Care Insurance Market," American Economic Review, 2008, Vol. 98, no. 3, pp. 1083-1102.

Bundorf, M. Kate; Pauly, Mark V., "Is Health Insurance Affordable for the Uninsured?", NBER Working Paper, October 2002.

Centers for Medicare and Medicaid Services, "Program Information on Medicaid and State Children's Health Insurance Program (SCHIP)", 2004.

Chezum, Brian; Pelkowski, Jodi Messer, "Spend Down and the Probability of Entering a Nursing Home", unpublished manuscript, November 2004.

Coe, Norma B., "Financing Nursing Home Care: New Evidence on Spend-Down Behavior", unpublished manuscript, September 2004.

Cohen, Marc A.; Weinrobe, Maurice; Miller, Jessica, "Inflation Protection and Long-Term Care Insurance: Finding the Gold Standard of Adequacy", the AARP Institute, working paper #2002-09, August 2002.

Congressional Budget Office, "Financing Long-Term Care for the Elderly", April 2004.

Decker, Frederic H., "Nursing Homes, 1977-99: What Has Changed, What Has Not?", Facts from Nursing Home Surveys, Center for Disease Control, 2002.

Desonia, Randy A., "The Promise and the Reality of Long-Term Care Insurance", National Health Policy Forum, Background Paper, July 31, 2004.

Eiken, Steve; Burwell, Brian; Sredl, Kate; "An Examination of the Woodwork Effect Using National Medicaid Long-term Services and Supports Data", Journal of Aging and Society, vol. 25, no. 2, pp. 134-145, 2013.

Friedrich, Carl, "Life/Annuity Long-Term care Combination Products", The Geneva Association, the Four Pillars newsletter, Research on Insurance, Retirement, and Social Security, September 2012.

Gabrel, Celia S, "Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey", CDC, National Center for Health Statistics, April 25, 2000.

Genworth Financial, Genworth Financial 2005 Cost of Care Survey: Nursing Homes, Assisted Living Facilities and Home Health Care Providers, October 2004, May 2005.

Genworth Financial, "Genworth Long Term Care and Alzheimer's Disease in America: A Retrospective", 2005.

Greenhalgh-Stanley, Nadia, "Can Government Incentivize the Purchase of Private Long-Term Care Insurance? Evidence from the Partnership for Long-Term Care", Applied Economic Letters, vol. 21, no. 8, pp. 541-544, 2014.

Harris-Kojetin, L; Sengupta, M.; Park-Lee, Valverde R., "Long-Term Care Services in the United States: 2013 Overview", Hyattsville, MD: National Center for Health Statistics, 2013.

Health Insurance Association of America (HIAA), "Executive Summary Research Findings: Long-Term Care Insurance in 2000-2001", January 2003.

Hebert, Liesi; Weuve, Jennifer; Scherr, Paul; and, Evans, Denis A., "Alzheimer Disease in the United States (2010-2050) Estimated Using 2010 Census", Neurology, vol. 80, pp. 1778-1783, 2013.

Johnson, Richard W.; Uccello, Cori E., "Is Private Long-Term Care Insurance the Answer?", Center for Retirement Research, Boston College, Issue Brief no. 29, March 2005.

Kemper P.; Murtaugh, C.M., "Lifetime Use of Nursing Home Care", New England Journal of Medicine, February 1991, 324(9), pp. 595-600.

Long-Term Care Financing Project, Georgetown University, "Fact Sheet: Private Long-Term Care Insurance", May 2003.

Merlis, Mark, "Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?", prepared for The Kaiser Family Foundation, March 2003.

MetLife, Mature Market Institute, "The MetLife Markey Survey of Assisted Living Costs", October 2004.

MetLife, Mature Market Institute, "The MetLife Markey Survey of Nursing Home and Home Care Costs", April 2002, August 2003, and September 2004.

National Association of Insurance Commissioners, "A Shopper's Guide to Long-Term Care Insurance", 1999.

O'Brien, Ellen, "Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?", Georgetown University, Long-Term Care Financing Project, Issue Brief, May 2005.

O'Brien, Ellen; Elias, Risa, "Medicaid and Long-Term Care", Kaiser Commission on Medicaid and the Uninsured, May 2004.

Stone, Robyn I., "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century", Milbank Memorial Fund, 2000.

United States, Center for Disease Control, Health, various issues.

United States Congress, Senate Finance Committee, Statement of the American Council of Life Insurers On Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net, June 29, 2005.

United States, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost", February 2003.

United States, Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics, "The National Nursing Home Survey: 1999 Summary", Vital and Health Statistics, Series 13, Number 152, June 2002.

United States, Department of Health and Human Services, "Informal Caregiving: Compassion in Action", 1999.

Wiener, Joshua M.; Anderson, Wayne L.; Khatutsky, Galina; Kaganova, Yevgenia; O'Keeffe, Janet; Tumlinson, Anne; Hammelmann, Eric; Stair, Elana, "Medicaid Spend Down: Implications for Long-Term Services and Supports and Aging Policy", The Scan Foundation, March 2013.

Endnotes

1 The elderly population is defined as those age 65 and older.

2 ACLI calculations based on data reported in Harris-Kojetin (2013) and the U.S. Census Bureau. Includes nursing home care, home health care, adult daycare, and assisted living. Calculations assume recent usage rates.

3 ACLI calculations based on data reported in Harris-Kojetin (2013) and the U.S. Census Bureau. Calculations assume recent usage rates.

4 Brown and Finkelstein (2008).

5 From: Genworth (2014). All reported figures are based on 2014 data.

6 From: U.S. Department of Labor, Bureau of Labor Statistics. The cost of long-term care services is based on Genworth Cost of Care surveys.

7 Only includes nursing home care and home health care for individuals age 65 and over. Includes Medicaid Home and Community-Based Waivers, as well as long-term care services provided by Medicare, out of pocket payments, private insurance, and other. ACLI calculations based on data from the National Health Expenditure accounts, and data provided through correspondence with the Office of the Actuary, Centers for Medicare and Medicaid Services.

8 From: U.S. Bureau of Economic Analysis, National Income and Product Accounts. Long-term care expenditure data is from National Health Expenditure Accounts.

9 Measured in 2014 USD.

10 In 2014 USD.

11 The average age at which a person first enters a nursing home is 83 for men and 84 for women (Brown and Finkelstein (2004)).

12 From: United States Center for Disease Control, *Health,* 2013.

13 From 1950 to 2010 the life expectancy of a typical 65 year old increased by 0.9 years per decade, and from 2000 to 2010 by 1.5 years (U.S. Center for Disease Control, Health, United States, 2013). Estimates for 2030 and 2050 are based on the assumption that life expectancy will continue to increase at a similar rate.

14 From: United States Department of Health and Human Services (February 2003).

15 From: Genworth (2005).

16 Source: Alzheimer's Association (2011), and Genworth (2005).

17 Alzheimer's Association (2011).

18 If inflation is not controlled for total expenditure on nursing home care can reach $580 billion by 2030 and $1.52 trillion by 2050.

19 The total hours of home health care per week varies between individuals.

20 In current USD. This assumes that in 2014 the cost of a private room is $87,600 per year and the cost of a semi-private room is $78,842. Further, it is assumed that 28 percent of residents stay in the former and 72 percent in the later.

21 Medicare covers hospital-based and some post-hospitalization skilled long-term care services for a limited time. It does not pay for non-medical home care.

22 Reported in 2014 USD. Not controlling for inflation, under current trends in 2030 Medicaid is expected to pay $190 billion for long-term care and by 2050 will pay $465 billion. These estimates do not include those under age 65.

23 See Eiken et al. (2013).

24 According to U.S. GAO (September 2005, p. 2): "The evidence on the extent to which individuals transfer assets to become eligible for Medicaid, long-term care is generally limited and often based on anecdotes".

25 From: Wiener et al. (1996).

26 Reported in 2014 USD. Under current trends, not controlling for inflation, in 2030 out-of-pocket payments are projected to be $119 billion and by 2050 $319 billion. Does not include those under age 65.

27 When first introduced, long-term care insurance policies were designed to maintain a level premium (i.e. the premium remains fixed throughout the life of the policy). Due to an unprecedented low interest rate environment and unusually low lapse rates, premiums on many policies were raised. An increase in long-term care insurance policy premiums is permitted "if insurers request an increase for the entire group of people who purchased a particular policy. [However, such an increase can be only be justified by inadequate medical underwriting, premiums that were initially set too low, or insufficient growth in reserves meant to cover future claims] (Desonia (2004, p. 17)".

28 Using this criterion and U.S. income distribution by age as a guide, long-term care insurance is most affordable at age 50. At that point, 41.9 percent of income earners can afford the type of policy specified above. Please note that this estimate is based on conservative assumptions. There are many policies which are more affordable than those assumed in our analysis. Neither academic nor policy literature define

'affordability' in a rigorous way (see Bundorf and Pauly (2002) for a comprehensive literature review). Because 'affordability' is subjective, a single standard of affordability cannot apply to all people. However, for the purposes of this analysis it is assumed that income and the price of premiums are the only quantifiable barriers to purchasing a policy. Because premiums depend on the age at which an individual purchases a policy, it is also taken into consideration. Throughout this analysis, it is assumed that a 25 to 33 year old can afford to devote 1 percent of his/her income toward the purchase of long-term care insurance. This gradually increases to 2 percent by age 40, 3.5 percent by age 50, 5 percent by age 60, and 6.5 percent by age 70.

29 Premium data was obtained from: https://ltcfeds.com/ltcWeb/do/assessing_your_needs/ratecalcOut.

30 Calculation does not include spending on premiums.

31 From: National Association of Insurance Commissioners.

32 For example, for the 40 to 44 year old age group, 89 percent of people pass underwriting screens, whereas for the 60 to 64 year old group 79 percent of people pass underwriting screens (see: Merlis (2003)).

33 From: AHIP (2013).

34 Policies offer the services of a care coordinator at the time of claim to help craft a plan of care and identify local care providers. Other common benefits include: respite care to provide temporary relief to family caregivers; homemaker or chore services; restoration of benefits; coverage of some medical equipment; survivorship benefits; payment of family caregivers; spousal discounts; and paid-up policies.

35 Activities of Daily Living include: bathing, dressing, toilet use, transferring in and out of chair or bed, urine and bowel continence, and eating.

36 Friedrich (2012).

37 In 2011, average single premium for a life combination product was $70,000, for a face amount of about $146,000. Those life combination products that have regular premiums, average annual amount was almost $5,500 for a face amount of $278,000 (see: http://thescanfoundation.org/overview-current-long-term-care-financing-options).

38 See: http://w2.dehpg.net/LTCPartnership/Reports.aspx (accessed in 2013).

39 See: Greenhalgh-Stanley (2014).

40 AALTCI (2010).

41 U.S. Census Bureau, "American Community Survey", 2009.

42 AALTCI (2010).

43 Johnson and Weiner (2006)

44 Johnson and Lo Sasso (2006)

101 Constitution Avenue, NW, Suite 700
Washington, DC 20001-2133
www.acli.com