THE SURVEY OF INCOME AND PROGRAM PARTICIPATION

LIVING BENEFITS: CLOSING THE GAP FOR LTC FINANCING

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I would like to thank my wife Allison for many helpful comments on the life insurance industry. Of course, I claim responsibility for all errors of omission and commission.

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Living Benefits: Closing the Gap for LTC Financing

The continuing failure of public officials and private interest groups to come to a politically acceptable compromise on the benefit structure and the financing mechanism for a public long term care insurance program has encouraged the private market to offer new ways to pay for care. Much has been written on the expansion in the private long-term care insurance market (See Meiners & Trapnell, 1984, or Meiners, 1983, for example) Other research has investigated the liquidation of one of the -most widely held assets, home equity (Jacobs, 1986; Weinrobe, 1988). There has been little information, however, on the latest private market solution to capture attention, what has been called "Living Benefits". These living benefits, technically a payment of a portion of the death benefit from a life insurance contract prior to death, could play a role in closing the gap in financing long-term care. How significantly living benefits affect long term care financing, however, depends on the number of persons who own life insurance and the payments they could expect given the face value of their policy, as well as on a number of institutional factors, such as the treatment of such contracts by federal, state, and local authorities and the willingness of individuals to make use of their death benefits in this fashion.

This paper assesses the possible part that living benefits could play in financing long term care for the current elderly by examining the holdings of life insurance in December 1984 by the elderly population in the United States using the Survey of Income and Program Participation (SIPP) The data from the SIPP are used to estimate the distribution of life insurance face value held by persons 65 and older, as well as the probable payment to these individuals, given the structure of current living benefits contracts. These calculations are made for several sub-populations among the elderly including the old-old (over age 75), those in poor or fair health status, and those with certain health conditions which are often used to trigger living benefits payments. In addition, the life insurance holdings of individuals are examined by economic variables such as income and wealth to assess whether living benefits provides help to those currently without sufficient economic resources to pay for care.

The first section below considers previous research on the role of the private market in paying for long-term care. The next section discusses the structure of living benefits policies and provides examples of current contracts offered by the insurance industry. The third section describes the data and presents the results on life insurance holdings of the elderly. A final section discusses and summarizes the results.

Private Solutions to Long-Term Care Finance

Out-of-pocket expenditures for nursing home care are the largest single health care expense for the elderly, accounting for almost half of all private payments (Burke, 1988). At the national level expenditures for nursing home care in 1986 totaled $38 billion, with approximately $26 billion of that amount representing spending on care for the elderly (HCFA, 1987). Given these figures, and the expected growth in the elderly population, it is not surprising to find profound interest in developing alternative ways of paying f or long term care. Before examining

how living benefits can serve to finance long term care, it is useful to add perspective by briefly summarizing two other private sources of payment.

One of the more controversial elements in the discussion of alternative sources of financing long term care focuses on the possibilities of marketing long term care insurance to the elderly. Premium estimates for prototype policies suggested that an elderly person could purchase an insurance policy that would cover, after a 90 day elimination period, 4 years of long term care with a $50 daily benefit for $500 to $1,100 per year (Meiners & Trapnell, 1984). Such a policy seemed to be reasonably within reach of an elderly population whose average resources have grown substantially in the 1970s and 1980s.

Simulations of the purchase of such contracts, however, have cast a shadow over initial optimism. Estimates from the Brookings-ICF Long Term Care Financing Model indicate that only about 26% of the elderly could buy such a policy, and only 7% of all nursing home payments could be paid by long term care insurance (Rivlin & Weiner, 1988; Rubin, Weiner, & Meiners, 1989). Although these estimates are very sensitive to some of the assumptions in the simulations, particularly the assumptions about the resources of the elderly (Jacobs, 1989), there is a growing consensus that long term care insurance is likely to play only a minor role in the future financing of long term care.

While insurance offers one means of financing long term care, some research has suggested that home equity conversion plans provide a interesting alternative for the elderly person with few other liquid resources (Weinrobe, 1988; Jacobs, 1986). Home equity is one of the most widely held assets among the elderly, with 73% of household heads over age 65 owning a home in 1984. For those with a home the mean value of home equity was more than $54, 000 (Bureau of the Census, 1986). Giving the elderly access to this illiquid asset could expand their ability to pay for long term care considerably.

Estimates of the possibilities of paying for long term care insurance through a reverse mortgage payments suggest that 57% of elderly homeowners could pay premiums for a policy similar to the prototype mentioned above using their reverse mortgage (Jacobs, 1986). In other words, approximately 40% of the entire elderly population could, if they were willing, -use their home equity to pay for this sort of insurance policy. Even if this level of insurance coverage could be reached, however, the 'Brookings estimates suggest that the insurance would only pay 11% to 15% of all nursing home payments, leaving a substantial need for other sources of financing.

In summary, despite widespread interest in these private solutions to paying for long term care, estimates suggest that there will still be substantial need for out-of-pocket payments for long term care by the elderly. These private solutions provide no panacea for financing long term care. Thus, there is a continued search for additional means of financing care.

The Structure Of Living Benefits Life Insurance

Whether living benefits can play a major part in financing long term care will depend crucially an the structure of the insurance contract. The contract arrangements will not only determine the payment, but will influence regulation and restriction of sale of such policies. In addition, demand for the product will also depend on the provision of a contract that is comprehensive, widely available, and easily understood. Table 1 summarizes the results from a recent survey of living benefits life insurance contracts offered by American insurance companies Life Association News, 1990).

As the table indicates, most companies currently offer living benefits as a rider to universal or whole life policies. This restriction is an important one. In 1984 19% of all life insurance policies sold were some form of term insurance. Living benefits are not typically available on such policies, a factor which is especially important since term contracts are much less expensive than universal or whole life. Furthermore, the lower premium expense of term contracts allows individuals with fewer resources to purchase insurance with a larger face value amount. Thus, more than 20% of life insurance contracts with a face value amount over $25,000 are likely to be term contracts.

This fact is important because, although this is not shown on the table, many companies restrict attachment of a living benefits rider to contracts with a face value over $25,000. This restriction means that even if a person with low income can afford the premiums for life insurance with a large face value, they may not be able to afford to buy universal or whole life, and thus will not be able to attach the living benefits rider.

More than half of the companies listed restrict the sale of living benefits riders to persons age 65 or less, thus locking out many of the current elderly. Some companies, however, are allowing those who currently have a universal or whole life policy to attach the living benefits rider, even if they are over age 65.

Insurance companies are currently divided into two basic camps on the events triggering a payout of living benefits. one group of companies uses a doctor's letter certifying that the individual has a "terminal illness" typically understood to mean an illness that is expected to lead to death in 6 months or less. Obviously, there is uncertainty as to how such determination will be made and what might occur if, by chance or medical intervention, the individual lives more than 6 months. Other companies, obviously concerned about the subjectivity of this standard, use a number of conditions to trigger the payout. The standard group of conditions consists of heart attack, stroke, bypass, cancer, and kidney failure. Some companies have also added a few other conditions, including Alzheimer's disease.

Most companies are offering the payout as a percentage of the face value of the insurance contract, with the industry standard appearing to be between 25% and 50% of face value. Some companies restrict the use of the payout to coverage of medical care costs, though most companies place no restriction on the use of the living benefit.

Finally, note that many states do not allow the sale of living benefits policies. The mixed nature of the insurance contract-both life insurance and health insurance--has left many state legislatures which regulate the industry in a quandary. The difficulties of structuring a contract to meet the different standards in 50 states will slow the growth of living benefits. To make living benefits available to much of the population will require some consensus and consistency, either through cooperation by the states or federal legislation, which will clarify the tax treatment of benefits and regulation of the contracts.

The table presents the first illustration that living benefits may be only a limited component in the system of long term care finance. First, the restriction of the rider to universal or whole life means that many persons of limited means will not be able to attach a living benefits rider to their insurance policy. The further restriction by some companies of-linking the payout to a terminal illness means that many of the elderly would not be able to take advantage of the policy, even if they required nursing home care. Many illnesses or events which require long term care--Alzheimer's disease, stroke, hip fractures, etc.--would not be eligible for payout under these contracts.

Finally, living benefits, like long term care insurance and home equity conversion, suffers from institutional and behavioral constraints which limit both demand and supply for the product. The existence of programs like Medicaid and the restrictions at the state level on living benefits means that the growth of the industry will be slow. Furthermore, the elderly have shown a great reluctance to use their resources to pay for long term care, preferring to transfer them to family members when possible. since living benefits contracts reduce the death benefit as the living benefit is paid, the elderly persons will be confronted with a visible choice of reducing the value of their estate. It is likely that many of the elderly, unless compelled otherwise, would prefer that their death benefit be paid in full to those who survive them. Thus, unless required by federal or state law, even those elderly persons who have life insurance with a living benefits rider may prefer to rely on other public and private sources of payment, leaving their death benefit intact.

Data and Results

The data that are used f or this study come f rom the 1984 panel of the Survey of Income and Program Participation, a nationally representative household survey of approximately 50, 000 individuals in the United States (For details on the survey see Herriot and Kasprzyk, 1984). The survey collected information on the assets held by individuals, including the face value of life insurance held in December 1984. In addition, 4 months earlier, the survey collected information on the health status of individuals. For this paper, individuals age 65 and older who were present for both interviews were used to produce weighted estimates of the life insurance holdings of individuals. The total unweighted sample was 5,737 persons.

The quality of the data on life insurance holdings in a survey such as the SIPP is likely to be quite high. A study evaluating the quality of survey data on life insurance prepared during the' design of the SIPP concluded that, unlike other wealth information, "life insurance does not seem

to be an especially sensitive asset" (Ferber & Frankel, 1978, p.19). Furthermore, this study concluded that non-reporting of ownership represents between ten and twenty percent of the total face value of all life insurance, and that the one characteristic people accurately report is the face value.

Comparison of the data from the SIPP to independent sources of data confirms the high quality of the data. Data from the American Council of Life Insurance shows that the face value of all life insurance in force in 1984 (excluding credit life insurance) was $4.8 trillion (ACLI, 1985). The SIPP estimate of the total life insurance held was $4.1 trillion, or 85% of the ACLI estimate. Given that a significant portion of many assets, including life insurance, is held by very high wealth individuals (see Avery et .al. 1988), it is reasonable to state that SIPP covers 90% to 95% of all life insurance held in the United States.

The SIPP did not collect information on the type of insurance held by the individual, merely on the face value of the contract. In the analysis below, all contracts will be treated as if they are universal or whole life contracts. This procedure will give an upper bound of the percentage of the population and the total amount of living benefits available to the current elderly. The reader should keep in mind that approximately 20% of the insurance contracts in the sample are likely to be term life insurance, and that this percentage is probably higher in contracts over $25,000, since many individuals choose the lower premiums associated with term life in order to allow the purchase of a contract with a larger face value.

On first glance the prospects for using life insurance living benefits to pay for long term care might seem bright. Like home equity, life insurance is a widely held asset (about 60% of the elderly population has some life insurance) and the long history of life insurance sales to the working classes might suggest that this asset might be particularly useful to the low income elderly. Furthermore, since the payout is made in a lump sum, living benefits provide a flexibility that is unavailable through reverse mortgages. The ACLI data show that the average face value of life insurance held per insured family in 1984 was $68,300, implying that significant resources could be released through a widespread living benefits program.

This optimism must be tempered, however, with the reality of life insurance holdings in the current elderly population. Table 2 shows the distribution of the face value of life insurance held in 1984 for all persons 65 and older as well as broken down by certain demographic factors. The final column shows the mean face amount for all persons who held an insurance contract. As the data show only 2.6% of the current elderly hold life insurance contracts with a face value of $25,000, which is the amount often needed to attach the living benefits rider to the life insurance contract.

The table also shows considerable variation in the demographic subgroups. The percentage of females, non-whites, unmarried persons, and the old-old (age 75 and older) holding contracts with a face value over $25,000 is 1% or less in each case. The 10 differences by sex and race are likely to be the result of purchases of life insurance tied to employment, a common

arrangement that would produce higher rates among white males, given the employment patterns of females and non-whites among this cohort. The differences among the old-old are likely to be due both to the gender composition of this group and the fact that some persons are counseled to purchase term insurance until retirement, and then to forgo insurance after retirement.

Table 3 shows the distribution of life insurance holdings for two important groups in the elderly population--those who report themselves in poor or fair health, and those with one of -the following conditions in SIPP: heart ailment, kidney illness, Alzheimer's. stroke, and cancer. As the table indicates, among persons age 65 to 74 only 1.6% of persons in poor/fair health and only 2.3% of those with a qualifying condition could take advantage of a living benefits rider. Among the old-old less than 1% of persons in either group would be able to use living benefits.

Table 4 demonstrates another aspect life insurance holdings that limits the effectiveness of living benefits. The vast majority of persons who hold life insurance contracts with face value greater than $25,000 are persons of some means, who may be able to finance long term care without using living benefits. Table 4 shows that almost 75,% of the people with large life insurance contracts have monthly household income of more than $2,000. Furthermore, 43-t of persons with large life insurance contracts have more than $100,000 in household net worth, excluding their home equity, and an additional 25% of this group has household net worth over $50,000. Clearly, persons who could take advantage of living benefits are typically persons who would have few difficulties in paying for long term care out of existing income and assets.

Table 5 shows one final estimate of the effect that living benefits might have on financing long term care for the current elderly. Wallack (1988) provided estimates of the distribution of life time nursing home costs for persons over age 65. These data were used to construct a rough estimate of the total cost of lifetime nursing home costs for the SIPP cohort. The data on the life insurance contracts of persons in SIPP were used to estimate the total amount that living benefits would pay for nursing home care. The latter estimates were made assuming that all persons with a life insurance- face value of $25,000 or more would be willing and able to convert this into a living benefit at 50% of face value. In addition, I assumed that these persons face the same probability of needing nursing home care as the general elderly population. Obviously, this leads to an overestimate of the amount that would be available to the current elderly. Nonetheless, even under these liberal assumptions, living benefits provide only about 6% of the total nursing home costs for this population.

The chief criticism that could be made of these data is that focusing on the current elderly ignores that living benefits may change the behavior of the future elderly. The future elderly may be induced by living benefits to hold onto their life insurance after retirement, providing a much larger payout to the future elderly. To provide some further insight into this question the life insurance holdings of persons age 45 to 64 in the SIPP were examined. Under the assumptions that the cost of 6 months in a nursing home in 1984 was $10,000, that nursing home costs rise 10% per year, and that males enter a nursing home at age 70, while females enter at age 75, I estimated what percent of this future elderly population would be able to pay for long term care

using living benefits. These calculations showed that 73% of the future elderly would receive no living benefits, 14% would receive enough living benefits to pay for 1% to 50% of the cost of a 6 month stay, and 13% would pay able to pay for more than half of the cost of a 6 month stay. For living benefits to significantly impact long term care finance will require not only inducing the future elderly to hold onto their life insurance, but to significantly expand holdings above current amounts.

Summary and Discussion

This analysis of the prospects for living benefits mirrors in many ways previous studies of private methods of financing long term care. Private resources, income and assets to pay for insurance or life insurance in sufficient amounts to provide living benefits, are not available in amounts necessary to sufficiently offset the costs of long term care. This is true even though the recent years have been a period in which the elderly are approaching and surpassing the young in terms of their average economic resources (Crystal & Shea, 1990).

What the private approaches often ignore is the close relationship between economic and physical need in the elderly population. The problem is that the elderly who cannot afford long term care insurance, also do not have home equity, and do not have large life insurance policies and, most importantly, are most likely to require long term care. The Brookings model, for example, assumed that 90% of nursing home admissions came from the disabled elderly population. Of persons in the bottom quintile of the income distribution among the elderly more than 50% have multiple functional limitations (Crystal and Shea, 1990). Those most at risk for needing long term care are not reached by private solutions that require resources like income, home -equity, life insurance. The problem of resources, both economic and health care, among the elderly is not one of size, but of distribution.

Research shows that although the elderly receive a large amount of their income from public sources, income is more unequally distributed among the elderly than among the young (Crystal and Shea, 1990). The truth is that American public policy does not deal well with distributional issues. Yet, the f act remains that the solution to long term care finance must involve some redistribution of resources within the elderly population. The divisive debate over the Medicare Catastrophic Coverage Act demonstrates that consensus on the method and nature of this redistribution will be difficult to find. Living benefits, like private long term care insurance and reverse mortgages, provide no magic bullet for problems in financing long term care. Closing the gap on long term care requires closing the gap between the rich and the poor among the elderly.

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Table 1
Common Living Benefits Riders Offered by Life Insurance Companies

Company	Policies Rider Can Can be Attached To	Age Limit on Purchase	Events Causing Payout	Percent of Face Value Paid
American General	Universal & Whole Life	20-65	Terminal Illness	50%
Commonwealth	Whole Life	65	Terminal Illness	50%
Metropolitan	Whole Life	65	Heart Attack, Stroke Bypass, Kidney Failure, Cancer, Transplants, Alzheimer's, Blindness, Dismemberment	30%
Midland	Universal Life	80	Heart Attack, Stroke, Bypass, Transplants, Renal Failure, Cancer	25%
Old American	Whole Life	80	Terminal Illness	50%
People's Security	Whole Life	65	Terminal Illness	50%
Sentry Life	Whole Life	75	Terminal Illness	50%

Table 2

Face Value of Life Insurance by Demographic factors, 1984

Face Value of Life Insurance

	None	Less than $5,000	$5,000 to $10,000	$10,000 to $25,000	$25,000 to $50,000	More than $50,000	Mean Face Value for Policy Holders
All elderly persons	39.9%	44.1%	7.5%	5.7%	1.6%	1.0%	$7,389
65-74	34.7%	45.2%	8.8%	7.6%	2.2%	1.5%	$8,931
75 and up	48.3%	42.2%	5.5%	2.9%	0.7%	0.3%	$4,560
Male	30.7%	39.5%	13.3%	11.1%	3.2%	2.3%	$11,519
Female	46.3%	47.3%	3.6%	2.1%	0.5%	0.2%	$3,712
White	39.4%	43.6%	7.9%	6.3%	1.8%	1.1%	$7,734
Non-white 45.0%	48.6%	4.4%	1.3%	0.5%	0.2%	$3,774	
Married	34.0%	43.3%	10.2%	8.3%	2.4%	1.8%	$9,745
Not Married	46.6%	45.0%	4.6%	3.0%	0.7%	0.2%	$4,113

Source: Calculations from the 1984 SIPP Panel

Table 3

Face Value of Life Insurance by Health, 1984

Face Value of Life Insurance

	None	Less than $5,000	$5,000 to $10,000	$10,000 to $25,000	$25,000 to $50,000	More than $50,000	Mean Face Value for Policy Holders
Persons 65 to 74							
In Poor/Fair Health	39.6%	46.2%	7.1%	5.4%	0.9%	0.7%	$10,673
With Qualifying Condition	41.0%	45.0%	0.6%	5.8%	1.1%	1.2%	$6,880
Persons 75 and up							
In Poor/Fair health	50.7%	42.6%	4.3%	1.9%	0.3%	0.2%	$5,477
With Qualifying Condition	48.8%	44.7%	3.0%	2.4%	0.6%	0.0%	$4,573

Source: Calculations from the 1984 SIPP Panel

Table 4

Distribution of Income and Wealth Among Elderly with Life Insurance Face Value Above $25,000

	Persons with Income
Monthly Income	
Under $1,000	9.0%
$1-2,000	17.1%
Over $2,000	73.9%

	Persons with Net Worth
Net Worth (excluding home equity)	
Under $25,000	16.9%
$25-50,000	14.5%
$50-100,000	25.3%
Over $100,000	43.2%

Source: Calculations from the 1984 SIPP Panel

Table 5

Anticipated Payout From Living Benefits

Estimated Lifetime Nursing Home Costs for SIPP Cohort	$455,504,231,792

Estimated Living Benefits Payments

	Percent of Population Receiving Amount
None	97.3%
$12,500-$25,000	1.6%
$25,000 or more	1.0%

Estimated Payout Total	$27,971,561,912
Percent of all LTC Costs Paid by Living Benefits	6.14%

Source: Wallack (1988) 6 Calculations from the 1984 SIPP Panel