

Private Long-term Care Insurance: Value to Claimants and Implications for Long-term Care Financing

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Purpose: The purpose of this study was to obtain a profile of individuals with private long-term care (LTC) insurance as they begin using paid LTC services and track their patterns of service use, satisfaction with services and insurance, claims denial rates, and transitions over a 28-month period. **Design and Methods:** Ten LTC insurance companies contributed a random sample of 1,474 qualified individuals who were interviewed in-person by a trained nurse and then interviewed telephonically every 4 month for a 28-month period. Used in the analysis were descriptive statistics and techniques for analyzing longitudinal panel data. **Results:** About 96% of those filing claims were approved for payment. At baseline, 37% received home care, 23% assisted living care, 14% were in a nursing home, and 26% had not yet begun using paid care. Few claimants reported that their policies restricted their choice of providers and most care costs were covered. The average number of care transitions was 1, typically occurring within 4 month of baseline. The less impaired and those in home care settings were most likely to transition between service settings. **Implications:** Having private LTC coverage enabled claimants to exercise their preference for alternatives to nursing home care.

Key Words: LTC insurance, LTC services use and transitions, claims denial rates, care management

As Congress debates various aspects of health reform, an issue that continues to receive increasing attention is long-term care (LTC) financing. The risk of needing LTC (defined as regular ongoing assistance with ordinary tasks of daily life) rises steeply with age. An estimated 69% of Americans aged 65 years and older will need LTC at some point during their remaining lives. However, need for LTC is not synonymous with need for “paid services” because many chronically disabled elders rely largely on unpaid assistance from family members. Whereas Americans aged 65 years and older who need LTC are projected to need it for an average of 3 years, only a little over half that time is expected to involve paid services (Kemper, Komisar, & Alexih, 2005).

These projected patterns of formal service use and their associated costs assume that LTC financing sources will remain the same and sustain current patterns of decision making about whether and when to begin using paid care in particular settings. Currently, most chronically disabled elders receiving formal services pay out-of-pocket and/or have publicly financed coverage. The latter is predominantly means-tested Medicaid coverage that experts characterize as “nursing home biased” (Kaiser Family Foundation, 2009).

Growth in alternative sources of financing through private or public insurance programs could

alter existing patterns of LTC services use. Affordability and third-party payers' rules might also impose fewer restrictions, bringing individuals' and family caregivers' LTC decision making more in line with their preferences and perceptions of their service needs. Currently, non-means tested public coverage is not available, and even if a public coverage was passed as part of health reform, coverage would not immediately go into effect and it would be well over a decade before its impact on service utilization patterns could be studied.

There is an opportunity, however, to learn about potential impacts by examining patterns of service use in the private insurance market. Private long-term care insurance (LTCI) has been on the market for more than two decades, and a small but growing number of individuals—roughly 7 million—have private LTCI coverage. An estimated 200,000 policyholders are currently claiming benefits (Mulvey, 2009). Private LTCI currently pays somewhat less than 10% of the nation's LTC bill. These figures are expected to increase in the years ahead, as policyholders' age and begin accessing their LTCI benefits (Rowland, 2009).

The merits of private LTCI continue to be debated as critics warn that policies may be of little value because they will not cover enough of the costs of care when it is needed (Feder, 2009). As well, there have been press reports that companies deny legitimate claims prompting Congress to hold investigative hearings in 2007 (Duhigg, 2007a, 2007b, 2007c) and 2009 (U.S. Senate Special Committee on Aging, 2009). Much of the information behind the charges of critics is anecdotal and based on a relatively small number of individuals who may indeed have legitimate grievances based on their personal experience. Clearly, empirical data on an industry-wide basis are needed to definitely validate or dispense with these charges.

What empirical research on LTCI exists tends to focus on affordability of LTCI for individuals based on their income and assets, buyer/nonbuyer motivations, and the actual or projected impact of private insurance coverage on Medicaid LTC expenditures. There has only been one research study focused on the experience of a cross section of LTCI claimants in nursing homes, assisted living facilities, and home care settings, which was carried out in the late 1990s (Cohen & Miller, 2000; Cohen, Weinrobe, & Miller, 2000a, 2000b). That study surveyed claimants and found favorable results with respect to satisfaction with insurance

benefits, especially purchasing power (percentage of service costs covered) and satisfaction with the claims filing process. It did not, however, examine claimant experience or satisfaction with services at the time that an initial claim was filed nor did it focus on the decision-making process and patterns of service use over time. More recent research on private LTCI claimant experience is based on descriptive statistics kept by the Connecticut Partnership for Long-Term Care (Kyzivat & Kelleher, 2008).

The current study does address key questions about whether on an aggregate basis, individuals applying for benefits under their policies are indeed being paid as expected and receiving the assistance of companies to exercise their service options; whether the insurance is meeting the needs and value preferences of policyholders and therefore can continue to play an increasing role in helping to finance the nation's LTC needs; and whether on a variety of measures, claimants are satisfied that their policies are providing meaningful coverage (in terms of the percentage of costs covered) and enabling them to access the services that they desire.

A longitudinal view of claimant experience can also shed light on the decision-making behavior of chronically disabled elders and their families under a "best case scenario" where a third-party payer (public or private) provides a daily dollar benefit that may be used to purchase various types of care. Constraints imposed by affordability or existing public program eligibility and coverage rules do not override personal preferences, and thus, patterns of services use will reflect consumer choices based on judgments regarding the type and level of care needed as well as lifestyle preferences. This has important implications for understanding the potential impacts of a public insurance program for LTC service utilization and expenditures. It also provides insight into the extent to which claimants "age in place" once they make an initial choice of service setting or tend to move along a "continuum of care" from home to facility settings and from less to more intensive facility settings. This has important implications for LTC infrastructure development.

There is currently little research on the issue of "aging in place," although one opinion survey of the American public (Kaiser Family Foundation, 2007) found that only 4% of adults said that if they needed LTC they would choose to receive it in a nursing home and only 17% said that they would choose assisted living. However, in this context,

use of the word “choose” is synonymous with “prefer.” The survey respondents were not severely disabled elders and family caregivers who were actually faced with making a decision. In actual decision-making situations, choices are not necessarily based on “preferences” alone. They may also involve making judgments about “need” and trade-offs that modify preferences in consideration of needs (e.g., severity of physical and/or cognitive disability) and circumstances (e.g., availability of unpaid help and ability to live alone). Thus, aging in place with family and/or paid care at home may be the preference, but will it prove to be a realistic choice and, if so, under what circumstances?

To explain why so many elders enter nursing homes despite a strong preference for aging in place “at home,” many experts suggest that disabled elders and their families are unaware of paid LTC services options other than nursing home care or are ill equipped to locate alternatives available to them locally. According to this theory, LTC decision-making behavior would change if elders and their families explored other alternatives before making a choice and, in particular, if they had a knowledgeable guide; that is, an LTC case manager to identify and help arrange alternatives to nursing home care. This hypothesis can be tested by examining the extent to which private LTCI claimants use case management services and explore alternatives (with or without a case manager’s assistance) and whether those who used case management services make different choices (other factors held constant) from those who do not.

Methods

Research Design

In order to provide an objective and empirically based view of private LTCI claimant experience, we carried out research over a 28-month period on a sample of 1,474 private LTCI policyholders who began the process of claiming benefits under their LTCI policies. This study was designed to capture and follow an “admission cohort” of claimants “from the point at which they initiated the claims filing process and began using paid LTC services.” Following an admission cohort of LTCI claimants is the key feature of this research design that makes it possible to address several of the important questions about LTCI claimants experience that cannot otherwise be addressed.

Ten LTCI companies contributed sample to this study. These companies generate in excess

of 80% of all LTC claims and are among the major sellers of insurance in the market (America’s Health Insurance Plans, 2005). These include (a) Transamerica, (b) Aetna, (c) Bankers Life and Casualty, (d) Conesco Senior Health Services, (e) Genworth Financial, (f) John Hancock, (g) MedAmerica, (h) Penn Treaty, (i) Prudential, and (j) UnumProvident. In order to qualify for sample inclusion, the following criteria had to be met: (a) an individual had to have begun using paid services in their current service setting within the past 120 days or had to anticipate beginning paid service use within 60 days; (b) they had to have an LTC policy that covered care in all three service modalities: that is, nursing home, home care, and assisted living; and (c) they intended to file a claim or had already filed a claim with their LTCI company.

To accomplish sample fulfillment, each of the companies sent all referrals of individuals filing a claim or requesting claims packages in order to file a claim to the research team. Companies did not engage in up-front sample selection, thus assuring that the sample of claimants would reflect the general population of policyholders filing claims under their policy. The research team then called each individual to assure that they met sample inclusion criteria; the vast majority—well more than 80%—met the above criteria. If an individual was “qualified,” they were then asked if they would be willing to participate in a national study that involved a series of in-person and telephonic interviews. As part of the interview process, all participants signed appropriate privacy authorization forms indicating that their information could be shared only with the study team and used for research purposes. Of the total qualified sample, 1,474 individuals agreed to participate, this representing an 81% response rate. (A detailed description of methods and sample attrition is found at <http://aspe.hhs.gov/daltcp/reports/2008/coht28mo.htm>.)

Although each company was given a quota to fill and thus contributed more or less equally, for analytic purposes, their contributions to the sample were weighted to reflect market share. Only weighted results are reported here. We did not select for particular types of policy designs or benefit levels—with the sole exception of requiring comprehensive coverage, which we stipulated in order to be able to study LTC decision making and service use patterns with regard to these alternative settings in the presence of private LTCI.

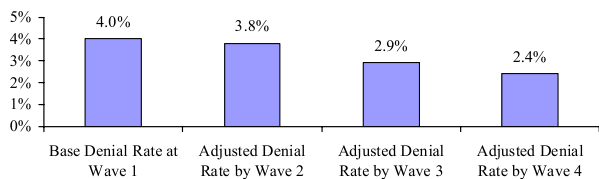


Figure 1. Base and adjusted denial rates for those reporting denied and pending claims at wave 1 over time.

Data Collection

Within 2 days after an individual agreed to participate in the study, an appointment was scheduled with a nurse to conduct a full in-person assessment. All interviewers were experienced nurses with a minimum of 2 years of experience in geriatric assessment. When a respondent could not answer questions due to cognitive impairment or physical weakness, interviewer nurses worked with proxy respondents, typically a spouse or daughter (36% of the in-person interview sample was completed by proxy respondents). Because a high percentage of claimants involved spouses or other family members in the baseline (in-person interview) and because use or nonuse of proxies was not necessarily consistent for the same claimant across all interviews (proxy use tended to increase over time as disability increased), we do not differentiate between claimant and proxy respondents. Moreover, our experience indicates that individual claimants' LTC decision making almost always involves spouses when claimants are married and frequently involves adult children even when claimants are not cognitively impaired. We did not find group (i.e., proxy vs. claimant) differences on major variables of interest at baseline.

The major categories of information collected on the admissions cohort of claimants included basic demographic information (i.e., age, gender, marital status, education, income level, presence of children near household, etc.), service use data (i.e., type, intensity, duration, and start date of formal and family care), use of care management (i.e., was it offered, was it used, is there a care plan, etc.), and health and disability data (i.e., activities of daily living (ADLs), instrumental activities of daily living, Short Portable Mental Status Questionnaire, behavioral assessment, information on number of medications, etc.). We also obtained information on aspects of claimants' current living situation and physical environment.

After the initial in-person assessment was completed, we began a period of follow-up that consisted of a telephonic interview every 4 months,

over 28 months, with all surviving sample members who were reachable and agreed to continue to be interviewed. The seven additional phone interviews after the baseline interview will be referred to as Waves 1–7. None of the study participants exhausted their insurance coverage over this period.

Results

Claims Approval/Denial Rates

Ninety-six percent of sample members receiving paid care reported filing a claim by the time of the first telephonic follow-up interview (4 months after the baseline, in person, interview). The majority (96%) of claims on which a decision had been made within this 4-month time period were approved. Given the nature of the study, we were able to follow-up on these individuals and more than half who were initially rejected resubmitted their claims and had them approved at a later date. Thus, as shown in Figure 1, the adjusted denial rate (total denials over the period) dropped from the initial 4.0%–2.4%.

Sample members whose claims were denied reported having been told that they were not yet disabled enough to qualify for benefits. We cannot independently verify that this was the case because policies, especially older ones, vary in benefit trigger requirements. However, sample members whose claims were denied had an average of 0.74 ADL limitations at baseline and 1.8 ADL limitations 4 months later. Thus, on average, those whose claims were denied did not meet the minimum benefit trigger requirements for severity of ADL disability mandated for federal tax-qualified private LTCI under the 1996 Health Insurance Portability and Accountability Act legislation. Of all those who had submitted claims by Wave 1 (both approved and denied), 94% reported having no disagreements with their insurance companies or that their disagreements had been resolved satisfactorily.

Claimants' Use of Paid Services and Settings

At baseline, three quarters (74%) of the admission cohort was already using paid services; slightly over one quarter (26%) had notified the company that they intended to file a claim but had not yet begun using paid services. Nearly, two thirds of sample members were residing at home, at baseline, either with (37%) or without (26%) paid care. Slightly less than one quarter (23%) of the

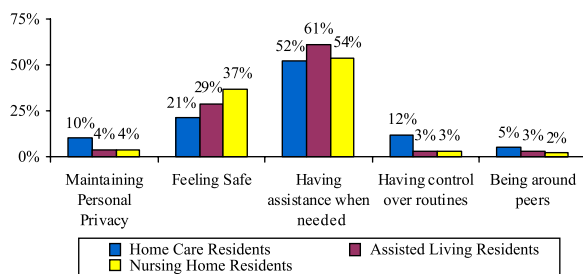


Figure 2. Proportion ranking characteristic as most important when thinking about where to receive paid care.

cohort was receiving services in assisted living; only 14% was receiving care in a nursing home. Thus, although two thirds of the claimants were at home, among the claimants who had begun using paid care, equal numbers initially chose to receive paid care at home and in residential facility settings (predominantly assisted living).

In subsequent waves of follow-up data collection, there was always a sizable minority of claimants who reported not receiving paid care at the time of the telephone interview. These were not necessarily the same individuals at each periodic interview; indeed, a notable pattern was that some individuals who were using paid care early in the study subsequently reported no use of paid care in one or more subsequent interviews. These were predominantly cohort members who continued to reside at home rather than individuals who had moved home from assisted living facility or nursing home care.

At all intervals of data collection after the baseline, the combined total of claimants receiving paid care in residential facilities was always greater than the percentage receiving paid care at home. Indeed, in most waves of data collection after Wave 1 (4 months postbaseline) until Wave 7 (28 months postbaseline), the percentage receiving paid care in assisted living was the same, nearly the same, or slightly higher than the percentage receiving paid care at home. In contrast, the percentage of claimants receiving paid care in a nursing home at any point in time ranged from a low of 13% at Wave 1 to a high of 19% at Wave 5. Only 20% of cohort members who used paid care ever received nursing home over the 28-month study period.

Thus, the great majority of private LTCI claimants (80%) avoided nursing home placement. But, despite the oft-cited preferences of the elderly individuals to remain at home with paid services if required, LTCI claimants frequently chose assisted living rather than paid home care or nursing home care.

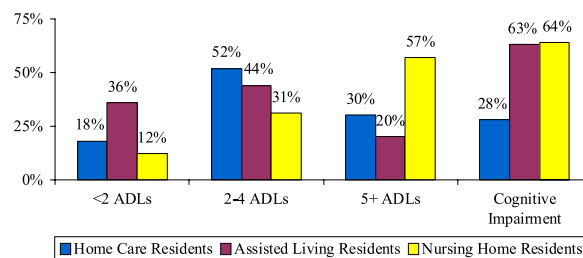


Figure 3. Disability status by care setting.

Reasons for Choosing Service Settings

Claimants who reported, at baseline, that they were already receiving paid care or intended to begin doing so within the next several months were asked to rank their most important reasons for using paid care and for choosing (or planning) to receive paid care in a particular setting (at home, in assisted living, or a nursing home). Having someone available to assist when needed was ranked most important most often among all respondents, regardless of choice of service setting, followed by the desire to feel safe. However, nursing home residents were more likely than those in other service settings to rank having someone available as their top decision-making priority. Assisted living residents were more likely than other respondents to cite feeling safe as the most important consideration (see Figure 2).

Not surprisingly, 93% of claimants who were already using home care at baseline said that this was their first choice. Among paid home care recipients who did not rank this as their first choice, the first choice was typically moving in with family or adult day care rather than nursing home care or assisted living. However, 65% of nursing home claimants and 75% of those in assisted living claimed these settings as their first choice and less than half said that they had considered staying at home. In contrast, very few (7%) of paid home care users considered nursing home care and only 16% said that they had considered assisted living. Few home care users—20%—had visited a facility before commencing their home care use.

Differences in the characteristics of claimants are indicative of factors affecting choice of a particular setting. Figure 3 shows that the most disabled reside in nursing homes and the least disabled reside in assisted living settings. However, nursing home and assisted living residents had comparable levels of cognitive impairment (64% and 63%, respectively), significantly greater than paid home care users (28%; see Figure 3).

In terms of demographic characteristics, claimants who used paid home care were more likely to be married (49%) than claimants in nursing homes (36%) and claimants in assisted living (24%). Not all claimants are affluent, especially those in assisted living: one third (34%) of paid home care users had annual incomes less than \$25,000; the comparable percentages for nursing home and assisted living residents were 41% and 50%, respectively.

Having LTCI coverage and being affluent enough to afford such coverage makes cost less important as a decision-making factor than would otherwise be the case. That does not mean, however, that respondents did not consider cost an important consideration, even if it was not the overriding factor in decision making. Differences in income and assets among users of paid care in different settings imply that affordability was probably a factor that motivated the less affluent claimants to choose assisted living. On the other hand, assisted living claimants are more likely to be older widowed women and widowhood is associated with both loss of income and loss of informal support, the presence of which might have made staying at home with paid care more feasible.

At baseline, most claimants already using paid services indicated that they would have made the same decision about where to receive care in the absence of insurance coverage. As time went on, more claimants seem to have reached the conclusion that having LTCI affected their ability to make choices—perhaps because many of them experienced transitions between using paid services and not using paid services and/or movements from one setting to another. In postbaseline telephone interviews, sample members were asked additional questions about the effect of having LTCI on their service use. At Wave 1, 73% said that having LTCI made obtaining services easier, a percentage that rose at each subsequent follow-up interview to a high of 89% at 20 months and then declined to 80% at 28 months. The percentage who said that having LTCI afforded them greater flexibility in choice of service setting increased from 73% at the Wave 1 follow-up interview to a high of 84% at 20 months, then declining to 79% at 28 months.

Very few claimants reported that their policies restricted choice because coverage rules prevented them from using preferred services or providers. Cost tended to be taken into consideration more highly in choosing a particular service provider

than in choosing a care setting. Assisted living residents were more likely to report having compared costs among different providers when choosing their current provider (69%) than was the case for nursing home residents (41%) or paid home care users (35%). Still, cost was seldom reported to be the most important selection factor.

Use of Care Management Services

All participating companies provide care management services at no extra charge, but they define this service differently. Accordingly, in asking sample members about their use of care management, we used a very broad definition that included nurse or other professional care managers hired individually as well as care management provided by the insurer. We were careful to specify that the care management we were asking about was different from the advice provided by a doctor or hospital discharge planner.

At baseline, when three quarters (74%) of the cohort had already begun using paid LTC, the reported use of any care management services was low: 19% among those using paid home care, 11% among those in nursing homes, and only 8% among those in assisted living. Among those who reported using care management services, use of private care managers predominated among assisted living residents; use of private and insurance company care managers was nearly equal among those using paid care; it was only among nursing home residents that use of insurance company care managers predominated.

Reported use of care management services rose between the baseline and first 4-month follow-up interview. At Wave 1, over one third (35%) of home care users reported being in contact with a care manager within the previous 4 month compared with 20% of nursing home users and 12% of assisted living residents. At subsequent waves of data collection, use of case management decreased but remained highest for home care and nursing home users. We conclude from these patterns that most claimants made their initial choice to use paid services in a particular setting prior to contacting their insurer and without accessing either the insurer's or the private care management services. It seems likely that, on filing a claim or notifying the company of intent to file a claim, their insurer offered care management services, which substantial minorities of claimants accepted. Claimants who did receive care management services reported

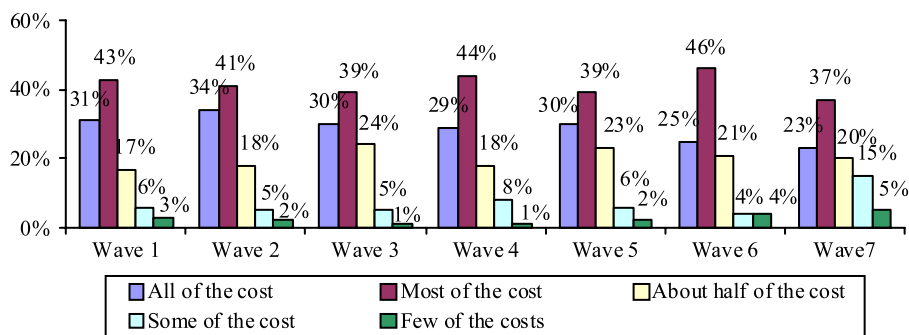


Figure 4. Costs covered by long-term care insurance by wave.

almost universally that the care manager was helpful. Typically, they reported that the care manager found their service use to be appropriate. When the care manager made recommendations, this tended to be for changes to the plan of care. Recommendations to change service setting were quite rare (always less than 10% and usually less than 5%). The highest percentage of change recommendations reported by users of care management services was at Wave 2 (8 months after baseline) when 39% of care management users reported that the care manager had recommended a change in their service plan. Multivariate regression analyses carried out to predict changes in service setting over the entire 28 month period found that use of care management was not a significant variable (Miller, Shi, & Cohen, 2008).

Percentage of Costs Covered by LTCI

LTC can be very costly. According to the 2008 MetLife Market Survey for Home Health and Adult Day Care Services, the national average hourly rate was \$18 for homemaker/companion care and \$20 for home health aide (personal care) services; the average daily rate, nationally, for adult day care was \$64. The average daily rate, nationally, for a semiprivate room in a nursing home was \$191 per day or \$69,715 annually. Assisted living facility rates averaged \$3,031 per month, nationally, or \$36,372 annually.

In this study, sample members were not asked specific questions about the costs of care, but rather patterns of services use. Their paid care costs were then estimated based on the relevant annual MetLife Market Surveys, which provide detailed cost information by ZIP code for a variety of service modalities. By using these data, the research team was able to estimate a monthly expenditure level for each individual sample member (specifically, 1,118 individuals who were surveyed at least

twice) based on where they lived and their service use patterns.

Based on 3,604 person-waves of data (based on 1,117 individuals at Wave 1 down to 269 individuals at Wave 7), nursing home residents incurred the highest monthly cost (\$5,561), whereas assisted living residents had the lowest average monthly costs (\$2,653). Home care recipients spent \$3,601, on average, per month. Those individuals who were not using paid care at the baseline interview but subsequently began using paid care spent an average of \$1,746 per month. For the entire sample, the average monthly cost of care was \$3,385. Claimants were asked whether their policy paid benefits for all, most, half, some, or few of the costs of care. Figure 4 shows the results.

As shown, the vast majority report that their policies are paying for at least half of the paid care they are receiving. In fact, between 60% and 75% reported that their policies were paying for at least “most” if not all their care at any given time.

The majority of claimants over the entire 28-month follow-up period felt that their insurance allowed them greater flexibility with choice of care setting. As well, between 61% and 67% stated that they would have to decrease their use of paid care in the absence of insurance.

Satisfaction With Services

Claimants were asked whether they were very satisfied, satisfied, not very satisfied, or not at all satisfied with the services they were receiving. When looking at satisfaction as a dichotomous variable, satisfaction rates for current providers of paid care in all three settings are quite high across all waves of data collection. However, claimants who used paid home care or assisted living were more likely to report being “very satisfied” with their current providers than those in nursing homes. Moreover, nursing home users experienced the

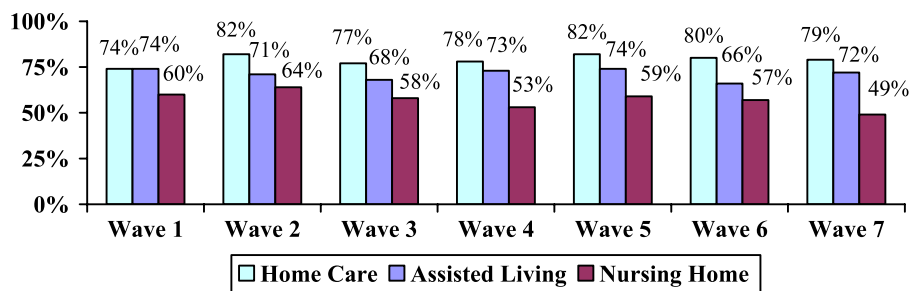


Figure 5. Overall satisfaction with specific care provider by wave by service setting (percent very satisfied).

greatest decline in their level of satisfaction—with less than half reporting that they are very satisfied by the end of the follow-up period. A correlation analysis suggests that over time, consumer satisfaction increases as the percentage of LTC costs covered increases. From answers to other specific questions, we can infer that, even though the majority of nursing home residents felt that they needed that level of care and that their nursing home met their needs, their level of satisfaction may have been diminished by other factors associated with the nursing home experience.

Aging in Place and Intermittent Use of Paid Care at Home

Overall, sample members tended to age in place; that is, those who initially chose to receive paid services at home tended to remain at home. Only a small percentage of sample members who were receiving paid home care at baseline subsequently entered either nursing homes (an average of 2% between waves) or assisted living (an average of 3% between waves); they were far more likely to stop using paid care at some point during the follow-up period (though not necessarily permanently) or to die.

Among claimants in nursing homes at baseline, only 14% moved home permanently. Of those who changed settings, they were more likely to move to assisted living than move home and very unlikely to stop using paid care. Although claimants in assisted living at baseline had the highest average age, they had superior functional (ADL) status than claimants in nursing homes or those living at home, which probably explain why they experienced the lowest rate of transition during the 1st year postbaseline. Very few transitioned to nursing homes and even fewer transitioned to paid home care or to no paid care.

We also conducted Logistic Regression analyses to determine the impact of various individual

characteristics on the likelihood of moving from one paid care setting to another. Being female, married, or accessing care management services had no effect. Individuals with higher levels of ADL impairments were less likely to change care settings than those with lower disability levels. The odds of transition for nursing home and assisted living facility residents were lower than for paid home care recipients. Age was also negatively related to movement across settings, and individuals with cognitive impairments were less likely to change care settings than those without such impairments. However, receiving paid care at home had a large positive impact on the likelihood of changing care settings, whereas reporting that care needs were being met in a given setting and satisfaction with the paid care provider had a negative impact on the likelihood of moving to a different care setting (Miller et al., 2008).

Discussion

This study's findings do not support widespread suspicion or fears that private LTCI companies routinely deny legitimate claims. The findings also do not support concerns that private LTCI benefits are typically inadequate to cover a substantial share of LTC costs in the settings where claimants have chosen to reside; this is especially true of comprehensive policies. Clearly, noncomprehensive policies—not the focus of this research—may indeed have been inadequate. At all waves of data collection over 28 months, between 80% and 94% of claimants interviewed reported that their insurance covered all, most, or about half their LTC costs.

The great majority (80%) of LTCI claimants used their benefits to pay for home care or for assisted living. Clearly, having private coverage enabled a large majority of claimants to access alternatives to nursing home care. A minority of claimants—one in five over 28 months—did choose

nursing home care. Their decision making appears quite rational insofar as, on average, such claimants had more severe ADL limitations and/or cognitive impairments than others. Moreover, half reported first exploring home care and/or assisted living alternatives before concluding that this was the setting required to meet their needs. Multivariate analyses did not indicate that consultation with a care manager changed decision outcomes with respect to use of nursing home care or other settings. Finally, two thirds of claimants who ever used nursing home services went into the nursing home either very shortly before or after filing their first LTCI claim, which suggests that nursing home use was often associated with an acute episode and/or precipitous decline in health/functional status.

This study did not support the widespread belief that disabled elders would universally or predominantly choose to receive paid LTC at home if they could. Instead, LTCI claimants elected to receive care in assisted living almost as often as they chose paid home care. One hypothesis, which is based on the correlations reported earlier, is that assisted living is attractive for the less affluent and, potentially, a more attractive alternative to paid home care particularly for older widowed individuals who would otherwise be living alone. Assisted living may offer a more desirable alternative than moving in with adult children or other relatives and receiving both paid home care and unpaid care from family members.

As shown, claimants residing in assisted living at baseline were more likely than other paid service users to report having children living nearby. It may be the case that these claimants are more likely to move into assisted living to be near family yet maintain a level of “intimacy at a distance” that may be preferred when economic considerations do not dictate a shared living arrangement. Assisted living may also be perceived by service users with cognitive impairment and their family caregivers (who are often their proxy decision-makers) to be safer than care at home, yet also offer more privacy than nursing home care and more attention from staff.

The overwhelming majority of claimants were satisfied with their service providers, including those in nursing home care, although nursing home residents were less highly satisfied than assisted living residents or paid home care users. Moreover, LTCI claimants were largely successful at aging in place in the care settings they chose when they first began using services and filed for LTCI coverage.

The findings presented here do point to possible patterns of service utilization that could emerge in the context of greater expansions in either private insurance or implementation of a public insurance program for LTC services. The experience of private insurance suggests that coverage levels must be more than minimal to ensure that individuals can access the types of care they think they need, in the setting of their choice, and age-in-place in that setting.

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