

Who might benefit from private long-term care insurance in England?

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Policy Background

- Health care free at point of delivery financed from general taxation
- State support for long-term care (in a care home and at home) is means tested against income and capital
- The 'Dilnot' commission recommended that the state should fund long-term care after an individual has received care to the value of £35,000; excludes 'hotel' costs in care homes
- Debate as to whether this would encourage demand/supply of long-term care insurance (LTCI)
 - covering this more limited liability reduces amount of cover needed and reduces risk for insurer (so should reduce unit cost of insurance cover)
 - but also reduces need for cover

Aims

- To estimate:
 - The expected net benefits (from the perspective of the individual) from taking out pre-funded LTCI **for care home costs** at age 65, for a representative cohort of people aged 65
- Taking account of the effect on entitlement to state support for care costs of:
 - the insurance benefit
 - the depletion of capital needed to fund insurance
- Under current and potential reforms to the mean testing rules

Care home funding in England (April 2010 prices)

- care home fees around £525 per week of which £333 often assumed to be care costs, £192 'hotel' costs
- state funding depends on assessed care needs and a means test
- if capital (usually including housing wealth) > £23,250
 - liable for 100% of the fee
- when capital < £23,250
 - required to put all income except a personal expenses allowance of £22.30 towards the rest of the fee
 - assessable income includes notional weekly income on capital between £14,250 and £23,250 of £1 per £250
 - **assessable income includes any insurance benefit**
- most people who self-fund have to draw on their capital
- entitlement to means-tested cash benefits subject to similar (but not identical) income & capital tests so affected by prior depletion of capital
- receipt of non means-tested disability benefit (AA/DLA) and disability addition in means-tested benefit ceases if receiving state help with care home fees so affected by whether is a self-funder or not.

Why insure?

1. to protect assets for heirs, to reduce out-of-pocket care home costs
2. to afford better quality care
3. to afford care at a lower level of need than state will support
4. to be independent of the state?

Here we focus on 1.

Financial benefits of insuring

Benefits

- out-of-pocket expenditure on care home fees ↓
- assuming single premium paid from capital, capital is lower on entry to a care home but is depleted more slowly (if at all) so:
 - income from capital initially lower but falls more slowly
 - entitlements to means-tested cash benefits *may* be higher initially because capital is lower and self-funding means eligible for disability premium

but

- such entitlements increase more slowly while in a care home because capital is depleted more slowly
- change in income from capital while alive, and in capital to bequeath (how should we value that?)

Step 1: estimate expected length of stay (LOS) in care homes at age 65

- expected LOS in care homes crucial to determining insurance premium and expected benefits
- data on LOS limited but BUPA data provide some guidance on plausible values (Forder and Fernandez, 2011)
- expected LOS needs to be consistent with projections of prevalence of care home residency (from PSSRU model) and overall mortality
- given prevalence rates, exit rates determine entry rates and LOS
- assuming all exits from care homes are the result of death, Monte Carlo methods are used to simulate care home entry and death for 25,000 men and 25,000 women aged 65 in 2010, to produce estimates of expected LOS allowing for age and gender differences in care home residency and mortality
- assumptions:
 - mortality rates for care home population are higher than overall mortality; mortality rates in non care home population are correspondingly lower
 - mortality rates in care homes assumed to be 3.5 (m) and 2 (f) x overall mortality rates (after experimentation)
 - care home entry predicted before mortality

Estimates of expected lifetime LOS in care homes at age 65

	men	women	total
P(care home entry)	.18	.32	.25
E[LOS] (s.d.) weeks	28 (84)	82 (167)	55 (135)
E[LOS entry] (s.d.) weeks	161 (138)	255 (207)	222 (191)
E[duration of liability for care costs with cap at £35k] (s.d.) weeks	15 (35)	30 (46)	23 (42)
E[duration of liability for care costs with cap at £35k entry] (s.d.) weeks	87 (27)	95(21)	92 (24)
Unisex insurance premium assuming loss ratio of 60% and cover for care component of fees at £333 pw			£30,525
	with £35k cap		£12,765 (or less?)

Step 2: estimate benefits from insurance using microsimulation model CARESIM

- uses micro data on older people's incomes and capital (2 years' Family Resources Survey)
- simulates taxes, means-tested benefits and the means tests for residential (and domiciliary) care for people aged 65+
- calculates what each older person in the sample would pay for care *should he/she need it*
- used here to:
 - calculate expected benefit from insurance for a representative sample of 65-69 year olds
 - under different treatments of income and capital including Dilnot proposal for a cap of £35,000
 - allowing for effects on entitlements to means-tested benefits

Funding systems examined

1. current system
2. remove the upper capital limit and assume notional income of £1 per week for every £250 of capital above £14,250
3. raise upper capital limit to £100,000, notional income of £1 per week for every £250 of capital between £14,250 and £100,000
4. raise upper capital limit to £100,000 as in 3. and cap lifetime contribution to care at £35,000 (main Dilnot proposal)

Illustrative effects

- % of 65-69 year olds who could fund the insurance premium out of their capital including housing wealth which we assume can be released at no cost
- of those who could
 - % where expected total out of pocket care expenses (net of receipt of AA/DLA and including opportunity cost of capital used for care) are reduced by insurance (rather than just substituting for state support)
 - % where residual capital with insurance exceeds that without insurance
- Where expected out of pocket expenses are reduced, mean expected expenses with and without insurance
- For different funding systems

Results for 65-69 year olds

	Funding system			
	current	no upper K threshold	Dilnot	Upper K threshold raised to £100k
% who could afford premium (a)	74%	74%	75%	74%
% of (a) for whom out-of-pocket expenses are reduced by insurance (b)	63%	67%	63%	67%
% of (a) for whom residual capital > than without insurance	48%	47%	52%	47%
among (b), expected mean out-of-pocket expenses no insurance	£27,800	£26,800	£21,500	£26,800
among (b), expected mean out-of-pocket expenses with insurance	£10,300	£11,000	£9,400	£11,000

Discussion points and next steps

- how to define “affordability” of premium; most people would need to use their housing equity which is not costless to release. Allow for cost of releasing housing equity? Unlikely people would want to spend ALL their capital on insurance. What about regular payments rather than single lump-sum premium?
- would Dilnot recommendations make insurance more attractive?
 - cap reduces need to insure, but premiums may fall more than we have assumed since risk is capped
- Next steps :
 - exploit variations in prevalence in care home residency by home ownership and marital status in generating expected LOS (but marital status depends on mortality which we assume depends on care home entry!)
 - examine distribution (rather than just means) of net benefits
 - estimate savings to public finances of private insurance to see if there is a case for state to subsidise insurance