Insurance Crowding Out and Long-Term Care Partnerships

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Introduction

Insurance for long-term care (LTC), i.e., coverage for the costs of personal care for elderly dependent individuals has been markedly underdeveloped compared to insurance for health and longevity risks, especially in Europe. This is puzzling because the costs associated with LTC are high but it is a relatively low-probability, and hence one should expect such a contingency to meet the required insurability conditions. Even in the US, barely 10 percent of the elderly have private LTC insurance when it is estimated that more than 50 percent can afford it (Brown and Finkelstein 2004; 2007), Perhaps, the largest LTC insurance market in Europe is the French one, offering reimbursement insurance to three million policies and covering less than one percent of its population. I offer an explanation based on the interaction between family, government and markets. More precisely, there appears to be some form of crowding out, especially from society or from the existence of strong family ties (Costa-Font 2010).

Is there public insurance crowding out?

Some scholars argue in the context of the US that the expansion of public subsidisation for LTC fuels concerns about private insurance being crowded out by public LTC insurance programmes (Pauly 1990). However, empirical evidence does not appear to confirm this phenomenon (Brown and Finkelstein 2007; Sloan and Norton 1997). The main reason is that LTC programmes have not typically aimed at entirely replacing individuals in activities for which they normally take financial responsibility, but instead have focused primarily on correcting the failures of private insurance markets in providing coverage, and, to an extent, pursuing equity and redistributive goals. In Europe, Germany adopted a compulsory social insurance scheme where very affluent individuals can opt out from public insurance (and buy insurance privately), and Scandinavian countries exhibit different forms of tax financed and locally provided assistance for frail elderly in need of long-term care. However, even in those countries that have implemented generous public financing, public insurance does not cover all costs (and cost sharing arrangements are in place), the market for complementary long-term care insurance is still either small or inexistent.

Family crowding out?

The obvious alternative to market and state financing is personal financing of LTC, either individually or within the family. This form of financing has some advantages. For instance, it has lower transaction costs, can induce altruism and reduce problems associated with information asymmetry. The obvious downside is the limited risk pooling, which implies large sunk and administrative costs in the event that an individual needs long-term care. Finally, self-insurance of LTC costs comes with individuals maintaining a positive fraction of resources to bequeath, which can give rise to some forms of ex ante moral hazard to stimulate care giving within the family (Zweifel and Strüwe 1996). It is important to note that even when different forms of insurance are available, as is the case in the US, the family is still the main LTC provider. In the US, a country exhibiting high LTC insurance development, the value of informal care is estimated to be USD 375 million, whereas the cost of paid services is USD 230 billion, while public expenditure on LTC is 2.9 percent of GDP (Gleckman 2010). Hence, it appears that family ties can crowd out the development of LTC insurance coverage (Costa-Font 2010).

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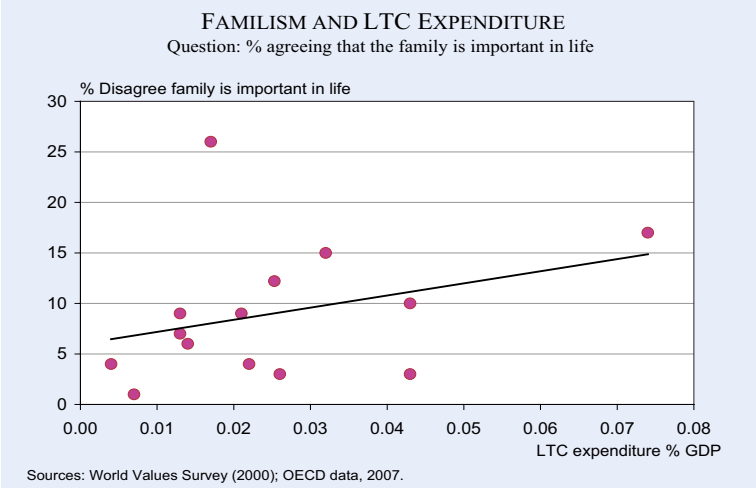
The evidence

Figure 1 shows a negative association between "familism" and LTC expenditure as a percentage of the GDP in a set of European countries where data were available. Furthermore, the 2007 special Eurobarometer survey containing data on long-term care reveals that 30 percent of Europeans believe that the best option for the elderly parent is to live with one of their children; 27 percent believe that elderly individuals should stay at home and receive regular care visits, from either a public or private care-service provider, and about one-quarter of the sample believe that children themselves should provide the care. Consistently, agreement with the idea that close relatives should care for dependent people, even if that means that they have to sacrifice their careers to some extent, ranges from only 7 percent in Sweden to 77 percent in Turkey.

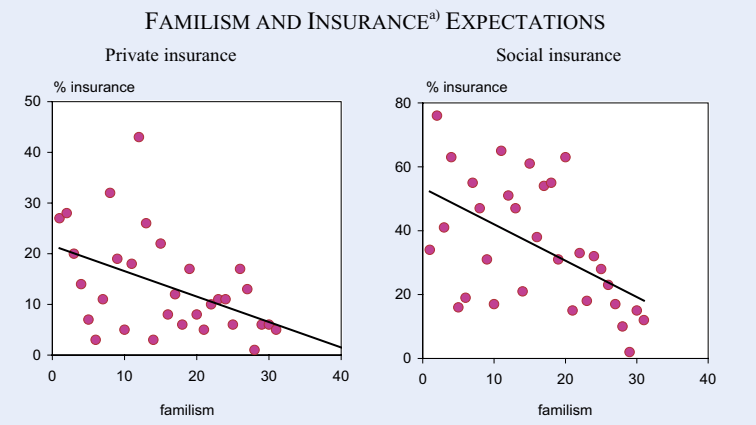
Figure 2 plots the expectations of private and public LTC insurance coverage in different European countries against a measure of familism, namely distance to children. In all cases we observe a negative association between familism and support for insurance schemes for LTC, although the association is steeper for social insurance than for private health insurance. This evidence is supplemented by complementary evidence from Costa-Font (2010) suggesting that family ties reduce the likelihood of individuals to expect both public and private insurance coverage of LTC.

Figure 1



Sources: World Values Survey (2000); OECD data, 2007.

Figure 2



a) Private and public.
Source: Costa-Font (2010).

Conclusion and implications

In light of the evidence we conclude that a stable contract to fund LTC should attempt to circumvent both public and family (or social) crowding out (see Costa-Font 2010 for more details) .That is, insurance designs need to accommodate existing regimes of intra-household transfers.

Two examples of models where such accommodation can take place are the partnership models proposed in the UK and the partnership systems existing in the US. The former refers to a proposal (LeGrand 2003) endorsed by the 2005 Wanless Report *Securing Good Care for Older People*, whereby the state is asked to provide a certain level of coverage, and individuals are encouraged to fund extra care themselves with matched government funding up to the "benchmark" level of public financing.

Partnership models have been extensively implemented in the US from 1980 onwards to allow states to promote the purchase of private LTC insurance by offering consumers access to public insurance (Medicaid) under special eligibility rules, should additional LTC coverage (beyond what the policies provide) be needed. The original demonstration model has been underway since 1992 in California, Connecticut, Indiana and New York and has since expanded to other states.

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