# Patterns of Informal and Formal Caregiving Among Elders With Private Long-Term Care Insurance

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**Purpose:** The purpose of this report is to provide basic descriptive information on community-dwelling, disabled, private long-term care (LTC) insurance policyholders who have accessed policy benefits. We focus on how benefits are used, whether claimants feel they are getting appropriate value from their policies, and what the patterns are of formal and informal service use. Design and Methods: Data were obtained from a nationally representative sample of 693 LTC insurance claimants who were receiving benefits while living in the community and 424 of their informal caregivers. Eight of the largest LTC insurance companies representing about 80% of the market participated in the study. **Results:** LTC insurance benefits are well targeted; they serve those truly dependent on ongoing care. The vast majority of claimants are satisfied with their policies, understand their coverage, and find it easy to file claims. Because of their LTC benefits, substantial numbers of disabled elderly individuals report that they are able to remain at home instead of being forced to seek institutional care. The availability of LTC benefits reduces stress among informal caregivers. For most claimants, formal care did not replace informal caregiving. Implications: As the LTC insurance market continues to grow and mature, there will be changes in the profile of claimants, the service delivery system, and the design of policies. Expansions in the private market will be associated with a greater number of disabled elderly remaining in their homes with a maintenance of and enhanced resiliency of informal support networks.

Key Words: Chronic care service use, Home care, Longterm care claimants

The population of Americans who require or are at risk of requiring help with personal care and other daily functional tasks is growing rapidly. This is primarily due to the growth rate of the elderly population, especially those aged 85 and older. The percentage of elderly people requiring personal assistance ranges from 8% of those aged 65 to 69 to well over 50% of those aged 85 and over (Spector, Fleishman, Pezzin, & Spillman, 1998). Long-term care (LTC) expenditures (i.e., expenses for nursing homes and related facilities, in-home registered nurses and home health aides, and other home- and community-based services) now account for almost 12% of total personal health expenditures—a threefold increase since 1960. Among people aged 65 and older, LTC expenditures account for 28% of personal health expenditures (AARP, 1997).

Those elders who do require formal (paid) LTC are likely to rely on out-of-pocket payments to fund such care. Although Medicare pays 55% of the acute medical expenditures of older Americans, its LTC coverage is limited, covering just 20% of their LTC expenditures (Feder, 1999). By contrast, out-of-pocket spending represents only 14% of medical care expenditures for elders, but it accounts for 28% of their LTC costs. Medicaid finances a much greater share of LTC services than acute care expenditures for persons aged 65 and older (38% as compared to 4%; Feder, 1999).

Exposure to catastrophic risks of this nature typically stimulates expanded public financing, a demand for private insurance, or both. Over the past decade, the potential for private LTC insurance to become a significant source of financing for formal LTC services has been much debated (Cohen, Tell, Greenberg, & Wallack, 1987; Crown, Leutz, & Capitman, 1992; Friedland, 1990; Meiners, 1984; Mulvey & Stucki, 1998; Rivlin, Wiener, Hanley, & Spence, 1988; Wiener, Hanley, & Illston, 1992; Wiener, Tilly, & Goldenson, 2000). Even as the debate continues, recent actions suggest that the federal government may look to private insurance to help address the LTC financing challenge. Private LTC insurance typically reimburses the costs of care pro-

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vided in nursing homes and assisted living facilities as well as in-home personal care services such as home health aides, personal care services, therapies, and nursing services.

The Health Insurance Portability and Accountability Act of 1996 included tax incentives for the purchase of LTC insurance. More recently, the President recommended that a new LTC insurance program be established for federal employees and that a tax credit of up to \$1,000 per year be available to those caring for disabled relatives.

Prior to 1985, the private LTC insurance market barely existed. By the end of 1999 it is estimated that more than 6 million LTC policies will have been sold, and in-force premiums will exceed \$4 billion (Health Insurance Association of America [HIAA], 1998; National Institute for Health Care Management, 1999). It is likely that the LTC insurance market will continue to expand. This is because of the increase in the number of employers as well as insurers entering the market and the increasing interest among younger elders (HIAA, 2000).

There is a body of knowledge about who buys policies and what motivates them to do so (American Council of Life Insurers, 2000; HIAA, 2000), but there has been no systematic study of individuals who are receiving benefits under private LTC insurance policies. An understanding of claimants and their behavior should help consumers make more informed choices about financing their potential LTC needs, help the private insurance industry better meet those needs, and inform public policies designed to support and regulate the market.

The purpose of this study is to provide basic descriptive information on community-dwelling, disabled, private LTC insurance policyholders who have accessed policy benefits. We provide information on the sociodemographic and service utilization profile of these claimants and characterize the level and mix of informal and formal support. We address the implications of the receipt of LTC insurance benefits for use of formal and informal caregiving, the amount of care received, the impact of insurance benefits on the disabled as well as on those caring for disabled elders, and the impact on choices about where care is received. Finally, we summarize claimants' reported level of satisfaction with their LTC insurance policy and the company providing it. We conclude with a discussion of the implications of the findings.

#### Methods

Data were obtained from a nationally representative sample of 693 LTC insurance claimants who were receiving benefits while living in the community (a response rate of 82%). Eight of the largest LTC insurance companies who represent about 80% of the private LTC policies sold today and the vast majority of claims activity provided the sample of claimants. Companies that participated in the study included Aegon Companies, Bankers Life and Casualty, Conseco Senior Health, CNA, Fortis Long-Term Care, G.E. Capital Assurance Company, John Hancock Financial Services, and UnumProvident. These companies also represent diverse market segments and policy designs, and employ differing underwriting and claims management strategies. Companies were instructed to take a random sample of "open claims" for individuals aged 65 and over who had policies that covered both nursing home and home health care services. The definition of an open claim was one for which at least one claims payment had been made and there had been no notification of the claim ceasing. All claims were ongoing or "active."

Claimants from seven companies had reimbursement policies that paid expenses up to a daily maximum amount, whereas claimants from one company had policies that paid cash benefits that could be used in any way deemed appropriate by the claimant. For the most part, eligibility for benefits was based on limitations in activities of daily living (ADLs), the presence of cognitive impairment, and, in some cases, medical necessity as determined by a physician.

A trained nurse or social worker interviewed each claimant in his or her home. Each interviewer underwent comprehensive training to assure interrater reliability. The vast majority of questions were closed, but the claimant did have the opportunity to respond to a number of open questions. Information garnered from these interviews was then linked to policy design and claim information generated from the administrative systems of the participating insurance companies. If the claimant was cognitively impaired, then a proxy, identified by insurance company records or by the researchers upon initial contact, was interviewed. Designated contacts were asked who had the most knowledge about the claimant's health and activities. Typically these proxies were the primary informal caregivers of the insured claimants.

During the interview, claimants or proxies were asked to identify their primary informal caregiver, that is, the person who regularly helped them the most with their everyday activities but did not receive monetary payment. The percentage of claimants with at least one informal caregiver was 77%. A separate telephone interview conducted with 424 of those informal caregivers had a 91% response rate. All fieldwork was completed by February 1999.

The interviewer collected information on (a) the functional, cognitive, and medical status of the claimant; (b) the level and types of assistance received from paid and family caregivers; (c) the family's interaction with the insurance company and the service system; and (d) basic sociodemographic information such as living arrangement, marital status, and income level. The administrative data provided from the insurance company had detailed policy design information as well as claims payments history.

#### Results

#### Profiling Privately Insured Claimants

Table 1 compares the demographic profile of privately insured claimants with a sample of privately

Sociodemographic Characteristics	All Privately Insured Home Care Claimants (n = 686)	LTC Insurance Policyholders <sup>a</sup> (n = 1206)	All Elders Aged 65 and Over <sup>b,c</sup>
Average Age	79 years	68 years	75 years
65-69	5%	40%	32%
70-74	18	29	2.3
75-79	28	19	19
80-84	28	9	15
85+	21	3	11
Gender		č	
Male	32	39	31
Female	68	61	69
Marital Status	00	01	0,
Never married	4	6	4
Married	46	62	55
Divorced/separated	5	6	7
Widowed	45	27	34
Any Children Within 25 Miles	15	27	51
Vec	54	61	69
No	46	39	31
Education Level	10	52	51
Less than high school graduate	10	7	3.3 <sup>d</sup>
High school graduate	25	28	35
Technical/trade/business/some college	25	20	17
College graduate	20	20	17
Race	57	50	15
White (not Hispanic)	97	98	85
Non-White	3	2	15
Living Arrangement	5	2	15
Alone	34	Not Available	34
With spouse	44	Tot Itvallable	53
With relative	11		13
Other	11		15
Total Income	11		
<\$30,000	52	55	65
>\$30,000	48	45	35
Total Income (Detailed)	10	15	55
Less than \$10,500	7	6	19 <sup>e</sup>
\$10 501_\$19 999	22	20	28
\$20,000-\$30,000	28	29	19
\$20,000-\$30,000	13	20	17
\$40,000-\$49,999	9	9	8
\$50,000-\$74,999	11	10	8
>\$75,000-\$74,222	10	10	8
Estimated Current Value of Home	10	0	0
Less than \$50,000	7		2.5 <sup>f</sup>
\$50 000_\$99 999	28	Not Available	23
\$100.000-\$149.999	20 19	TNOT AVAILABLE	18
\$150,000-\$177,777 \$150,000-\$199,999	12		10
\$200,000-\$177,777	15		10
>\$250,000-9277,777	11 22		7
= \$20,000			/

Table 1. Sociodemographic	Characteristics of Privately	/ Insured Home Care	Claimants and All E	lders Aged 65 and C	Over, in Percentages
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<sup>a</sup>Cohen & Kumar (1997).

<sup>b</sup>Administration on Aging (1998).

LifePlans, Inc. analysis of 1995 survey of 1,000 randomly selected individuals aged 65 and over.

<sup>d</sup>U.S. Census Bureau (1999).

<sup>e</sup>U.S. Census Bureau (1998). Note that among claimants, 15% of the respondents who were willing to indicate whether their income was greater or less than \$30,000 were not willing to answer the more detailed income question. That is why there is a difference between the estimate for the proportion reporting incomes less than or equal to \$30,000 (52%) and the estimate derived when summing answers for those answering the detailed income question.

<sup>f</sup>U.S. Census Bureau (1997).

insured nonclaimants and with a sample of elders age 65 and over.

In general, privately insured claimants are more likely to be older, widowed, and more frequently White than are elders in the general population. They are also less likely to have children living nearby. Long-term care insurance claimants are wealthier than their counterparts in the general population; they are 1.4 times more likely to have incomes greater than \$30,000 than are elders in the general population. They also have significantly greater housing assets. Compared to other policyholders, claimants are older, more often female, less likely to be married, and are also less likely to have children living nearby.

Currently, most available LTC policies require that an individual have at least two limitations out of six common ADLs or be cognitively impaired in order to qualify for benefits. All tax-qualified policies have such a requirement. Older and nontax-qualified policies do, however, enable an individual to access benefits if LTC services are deemed by a physician to be medically necessary. Most claimants (79%) have two or more ADL limitations. The mean number of ADL limitations is 3.3. We defined a person as limited if they required any of the following levels of assistance for a particular ADL: (a) Cueing assistance, requiring a person to be prompted to do an activity, but no physical intervention; (b) stand-by assistance, requiring a person to be nearby in case help is needed; and (c) physical "hands-on" assistance.

The cognitive status of claimants was determined either by a diagnosis of Alzheimer's disease or other dementia (3%) or by having four or more errors on the Short Portable Mental Status Questionnaire (29%). Thus, 32% of claimants are cognitively impaired. Taken together, these findings suggest that 85% of claimants have at least two ADL limitations or are cognitively impaired; the others are either qualifying for benefits through a medical necessity benefit trigger or they are receiving benefits even though they may not be meeting benefit triggers as specified in the insurance contract at the time of the interview.

# Formal and Informal Care Services Among Privately Insured Claimants

It is well known that most long-term care is provided informally by family members, typically spouses, daughters, and daughters-in-laws (National Alliance for Caregiving, 1998; Penrod, Kane, Kane, & Finch, 1995; Tennstedt, 1999). Table 1 revealed that many privately insured claimants live alone and do not have children living nearby. For those without informal caregivers, the LTC policy should facilitate use of formal (paid) support. For those with informal supports, the policy may enable them to decrease reliance on such support—an important motivator for initial purchase (Cohen & Kumar, 1997). Most claimants (77%) rely on a combination of formal (paid) and informal (unpaid) care, but 23% rely solely on formal (paid) services for their care. In contrast, among disabled noninsured elders, only about 4% rely exclusively on formal care (Jackson & Doty, 1999). Thus, privately insured disabled claimants are about six times more likely to rely exclusively on formal care than are nonprivately insured disabled elders living in the community. Home health aides provide most of the formal care given to claimants; two in three claimants receive care from this type of service provider. Less than 10% of claimants rely on skilled nurses for home care services. This represents a significantly lower usage than is observed in the disabled Medicare population (Jackson & Doty, 1999).

In order to continue living independently in the community, claimants also need assistance with instrumental activities of daily living (IADLs). Figure 1 shows that, on average, these claimants receive 59 hours of personal care a week (roughly 8 hours per day), over half of which is devoted to IADL assistance. Not shown in the figure is the fact that privately insured disabled elders receive more weekly care (formal and informal together) than do similarly disabled nonprivately insured elders (Robert Wood Johnson Foundation & Department of Health and Human Services [DHHS], 1999). Thus, any reductions in the level of informal caregiving brought about by the presence of insurance-financed care are more than offset by increases in formal care.

Formal and informal caregivers provide different degrees of assistance. Formal caregivers split their assistance fairly evenly between ADL and IADL activities. Informal caregivers generally provide greater amounts of IADL assistance (14 hours per week) than ADL assistance (9 hours per week). It should be noted that the averages for care are pushed up by the fact that roughly 10% of the sample receives roundthe-clock care—24 hours per day, 7 days a week most of it standby assistance.

Much of the cost of formal care is paid for by insurance benefits. In fact, insurance pays all of the costs of care for more than 70% of claimants. The average monthly insurance benefit paid to claimants is \$1,527. (These data were obtained from the administrative claims systems from each of the insurance companies.) How does this compare to the primary public payer of home- and community-based care for disabled elders—the Medicaid waiver program? The Medicaid waiver program pays an average of about \$485 per month for care (Ladd, Kane, & Kane, 1999).

# Impact of Private LTC Insurance on Claimants and Informal Caregivers

Claimants and informal caregivers were asked how having an LTC insurance policy has influenced the level and type of care received (by claimants) and provided (by informal caregivers). For claimants, the greatest impact of insurance benefits is on their level of paid care. To measure this, we asked claimants, "In the absence of the policy, would you be able to afford the amount of care that you currently receive?" as well as, "In the absence of your policy, would you receive fewer hours of paid care?" Only 40% indicated that they would be able to afford their current level of services, and some 57% re-



Figure 1. Average weekly hours of informal and formal care. Source: 1999 National Claimant Study (n = 692).

sponded that they would have to consume fewer hours of paid care. This implies that an absence of insurance would be associated with more unmet or undermet need. How would such needs be fulfilled? Claimants were asked, "In the absence of your policy, would you have to rely more on family, friends, or other volunteers to provide assistance?" Fifty-four percent indicated that they would have to rely more on informal supports. It is unclear from these data alone whether such informal supports would be able to compensate for the loss associated with lower levels of formal (paid) care.

We asked a similar, although more detailed, set of questions to informal caregivers.

- 1. Do they provide more, less, or the same amount of care now that insurance benefits are being paid to the claimant than when they first began caring?
- 2. In the absence of the claimant's policy would they provide more, less, or the same amount of care as they currently provide?
- 3. In the presence of policy benefits, has the nature of the care they provide changed and if so, how?

Figure 2 shows that roughly two in three informal caregivers have not reduced the level of care that they provide since insurance benefits started. In fact, half of the caregivers report no change in the amount of care they provide. This suggests that formal care is certainly not a perfect substitute for informal care, a finding consistent with research on the interaction between formal and informal caregiving in the context of public programs (Hanley, Wiener, & Harris, 1991; Jackson, 1997; Tennstedt, Crawford, & McKinlay, 1993; Yordi et al., 1997). Still, about one in three informal caregivers did indicate that they now provide less informal care. As for the caregivers, a slight majority (52%) indicated that if the policy were not paying benefits they would increase the level of care that they provide. These findings are consistent with recent studies showing that formal services are generally used in conjunction with informal care, and secondary to it; substitution of formal services for informal care is limited and temporary (Robert Wood Johnson Foundation & DHHS, 1999; Tennstedt, 1999).

It is noteworthy that 15% of informal caregivers provide *more* informal care following the commencement of insurance benefits and the increase of formal care. This could reflect deterioration in the claimant's condition since the onset of benefit payments, meaning that the informal caregiver has had to increase the amount of care provided. It may also be that the presence of formal caregivers has simply encouraged informal caregivers to provide more but perhaps different care. Thus, in some instances, formal care may be a complementary rather than substitute service for informal caregiving. With respect to the third question, most caregivers (72%) indicate that they have not changed the nature of the care that they provide. For the remaining 28%, most show reductions in ADL and IADL assistance and an increase in companionship services.

Informal caregiving can be very stressful (National Alliance for Caregiving, 1998). Informal caregivers were asked whether the level of stress has changed since the person they care for began receiving insurance benefits. Most (68%) reported that their level of stress had decreased (see Figure 3). This is consistent with the belief that an increase in formal care relieves the family member or friend of the responsibilities of managing and providing care. Even so, other factors unrelated to the presence of insurance-financed benefits also likely affect stress levels.

The entry of formal caregivers could lead to congestion and confusion in service provision. The need to monitor formal caregivers or to interact with the insurer as well as with providers might have led to increased stress for informal caregivers. Such is not the case. Only 4% of informal caregivers indicate that the presence of insurance increased stress levels. One quarter of informal caregivers indicate that the presence of insurance-financed formal services had no effect on their stress level.

Given the fact that both the formal and informal care networks are providing significant amounts of care to disabled claimants, a key question emerges: Are the care needs of claimants being adequately addressed? We focus on whether or not certain needs are being undermet. An undermet need is present when a claimant receives assistance performing a particular activity but indicates that they could use more help or believes that they had to wait too long to receive the help. The presence of an undermet need could reflect the fact that caregivers are not available in a timely



Figure 2. Informal caregivers' perceptions about impact of claimants' policy. *Source*: Analysis of 1998 informal caregiver data (n = 415 informal caregivers).



Figure 3. Caregivers' assessment as to whether presence of insurance benefits has reduced stress. *Source*: Analysis of 1998 informal caregiver data (n = 416 informal caregivers).

manner; or, it could result from scheduling difficulties or because, once in the home, caregivers are not providing care when needed. Additionally, it may be that caregivers do not provide an adequate level of care either because of quality or coordination issues.

In total, 23% of claimants report at least one undermet need. Individuals who receive more hours of ADL assistance are also more likely to report greater undermet need. This is particularly true for individuals who rely more on informal rather than formal caregivers. This suggests that when multiple caregivers are involved in the care of an individual, clearly delineated lines of responsibility may be particularly important in assuring that needs are met. One implication of these findings is that training informal caregivers may better prepare them to respond to the multiple needs of their disabled care receivers. Bathing was the ADL with the highest level of reported undermet need. This is not surprising, given the complexity of the activity and the greater chance for mismatch between service schedules and claimant preferences. Those most likely to report undermet needs are unmarried women and individuals with multiple caregivers.

Clearly, long-term care insurance is succeeding in bringing formal caregivers into the homes of disabled elders, many of whom rely solely on the insurance to provide access to care. Yet problems with service availability, scheduling, continuity and coordination of caregivers, claimant preference, and the quality of caregivers all contribute to a sizable minority reporting undermet needs.

A great deal of research has focused on whether the use of formal home care services delays or eliminates the use of costly institutional care such as nursing home care (Garber and McCurdy, 1989; Greene, Lovely, & Ondrich, 1993: Kane, 1998; Shapiro & Tate, 1988; Weissert, Cready & Pawelak, 1988; Weissert & Hedrick, 1994; Wolf, 1997). Most of this research suggests that, unless very carefully targeted, home care rarely prevents someone from using nursing home care. There is a growing consensus that home care serves a distinct population that differs in relevant respects from the nursing home population. Still, the decision to seek institutional care is complicated; it involves a myriad of factors, many of which cannot be adequately captured even by the most sophisticated multivariate modeling.

We elected to address this important issue directly. Claimants and informal caregivers were asked whether the disabled claimant would be able to remain in the home if there were no LTC insurance policy to finance formal care. More specifically, claimants were asked, "If your long-term care policy was not paying for home care services, do you think you would be able to remain in your home or would you have to move to an institutional setting like an assisted living facility or a nursing home?" Their primary informal caregivers were asked, "If home care services were not covered by the care receiver's LTC insurance policy, do you think he/she would need to seek institutional care such as nursing home care or assisted living?" Figure 4 summarizes results.

Approximately half of both claimants and informal caregivers responded that in the absence of the insurance-financed services, they would have to seek institutional alternatives. An important matter is whether there is agreement about institutional alternatives between the claimant and her/his informal caregiver. In 31% of the cases where we had responses from both claimant and caregiver, they agreed that institutional alternatives would be needed in the absence of an LTC policy. In 18% of the cases the informal caregiver felt that the claimant would need institutional care and the claimant disagreed, whereas in 9% the claimant felt she/he would need institutional care and the informal caregiver disagreed. Thus, it appears that between one third and one half of disabled policyholders believe that they would not be able to remain in their homes without their insurance-financed formal care services. Although a stated intention to seek institutional care does not always translate into a particular behavior, it is reasonable to assume that given their level of disability, a number of these individuals would qualify and be appropriate candidates for certain institutional settings. While supply constraints may impede their access to such care, many believe that without their home care benefits, they would need to consider this.

Among claimants who thought that they could not remain in the community without their insurance benefits, roughly half said they would need to enter a nursing home and half indicated they would move to an assisted living facility.

#### **Claimant Satisfaction**

Claimants were asked a series of questions related to general satisfaction with their insurance policy. Figure 5 shows that the vast majority of claimants (86%) are satisfied with their policy; slightly less than two in three are very satisfied with their policy.

Despite reported high levels of satisfaction, about one third of claimants felt that they had not purchased enough home care benefits. Given that most policies cover 3 to 4 years of care, and the average claimant has been receiving benefits for slightly more than a year, this deficiency is related to the daily benefit amount chosen at the time of purchase. Although this does not represent an inherent flaw in insurance policy design, it does suggest that these claimants



Figure 4. In absence of policy would institutional care be sought? *Source:* Analysis of 1998 claimant and informal caregiver data (n = 643 claimants; n = 416 informal caregivers).



Figure 5. Level of satisfaction with long-term care insurance policy.

may not have had enough information on the actual costs of care that they might incur. (The issue is not related to affordability. Income level was not related to whether or not claimants felt that they had purchased enough home care coverage.) This finding may also be a response to the actual effect of voluntary coinsurance: When people are actually faced with paying it, they don't like it. The implication is that additional consumer education is needed to assure that at the time of purchase, individuals have an understanding of the relationship between benefit amounts and costs of care.

Most claimants (70%) found the claims filing process to be easy, and 90% of all individuals filing claims had either no disagreements with their insurance companies or had a disagreement(s) that was resolved satisfactorily. About 10% of claimants felt their disagreement was not resolved satisfactorily. Claimants were also asked a question about actions that their insurance company might have taken, but didn't, to help them when they needed benefits. This was an openended question. While about three in four respondents felt there was nothing else that the insurance company should have done, many of the remaining respondents felt that the company could have provided additional customer support, improved claims processing, and given more advice about the policy itself. It is noteworthy that claimants with cash disability policies did express the highest level of satisfaction regarding their interactions with the insurance companies.

## Discussion

#### Study Limitations

This research provides much needed information on a topic that has had little focus to date, but a number of limitations should be noted. First, because roughly one in three claimants was cognitively impaired, we needed to conduct interviews with proxies. The vast majority of these interviews were conducted with spouses and adult children, most often identified as the primary informal caregiver of the insured claimant. These proxies' responses to certain questions related to satisfaction, undermet need, and even to the amount of care provided may differ from the views of the claimants themselves. Second, it is important to note that the functional and cognitive status of elders can and does change rapidly (Manton, Corder, & Stallard, 1997). However, the crosssectional nature of the study design does not enable us to adequately capture such changes over time. Thus, while we can estimate the prevalence of disability at a point in time, it is quite possible that had interviews been conducted at another point, these estimates would have differed.

Finally, although the sample of claimants was drawn to be representative, it does represent the first major wave of claimants. Most sales of LTC insurance policies have occurred in the last 5 years, and these new policyholders are not likely to make claims for 5 to 10 years into the future. Patterns of service use, interactions with insurers, and the extent of undermet need and satisfaction levels may vary greatly as insurers and providers are faced with a much larger pool of claimants. Findings here are applicable to this first, relatively smaller, wave of claimants.

### Summary and Implications

Individuals with LTC insurance receive substantial amounts of standby ADL and IADL assistance, typically more than what is received by similarly disabled nonprivately insured elders (Robert Wood Johnson Foundation & DHHS, 1999). Also, the insurance benefits are targeted on individuals with significant ADL dependencies and/or cognitive impairments, as well as on individuals who appear to be on a downward path toward greater disability. For many, in conjunction with the informal care that they receive, the ability to access formal care services through their LTC policy helps them to continue living independently in their homes. A large number of claimants (one fourth) have no available informal support services. As for claimants with informal supports, the availability of insurance benefits has not led to a "breakdown" in informal caregiving by primary caregivers. Rather, most primary informal caregivers have at least sustained the amount of care they provide to their disabled relatives. Taken together, these observations suggest that formal care may substitute for some, but not most, informal care, and that the two systems appear to be working in tandem to meet the LTC needs of claimants.

Findings suggest that while adequate financing of care is a necessary condition for meeting the needs of insured and disabled elders, it is clearly not sufficient. Close cooperation and coordination with the service delivery network is critically important. This holds true for individuals being cared for in institutional settings as well. In such settings, issues related to the quality and training of staff, the amount of staff oversight, and staff ratios will determine whether claimants feel that their needs are being adequately addressed.

Most claimants feel that they are receiving significant benefits from their LTC policy and that it is doing what it is supposed to do, namely, helping to bring paid caregivers into the home or accessing the institutional care that they need. What they believe they need is somewhat better servicing of their claim

About half of claimants and informal caregivers reported that in the absence of insurance benefits, institutional alternatives such as assisted living or nursing home residency would likely be required. This is a particularly important finding. Already, the demand for nursing home care has been declining (Bishop, 1999). Data suggest that an increase in the number of LTC insurance policies covering home- and community-based alternatives, as well as institutional options, will buttress this trend. The preference of disabled elders to remain in their homes for as long as possible is well known; these claimants believe that at the very least, the presence of insurance-financed benefits delays their search for institutional alternatives. However, additional analysis is needed to determine whether these individuals have the level of functional and cognitive disability that would make them appropriate placements in institutional settings.

As the LTC insurance market continues to grow and mature, there will be changes in the profile of claimants, the service delivery system, and the design of policies. New patterns of service utilization will emerge, but facets of existing usage patterns will remain the same. It seems very likely that expansion in the private market will be associated with a greater number of disabled elders remaining in their homes with a maintenance of and enhanced resiliency of informal support networks.

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