

Individual Decision Making in the Non-Purchase of Long-Term Care Insurance

Leslie A. Curry, PhD, MPH,^{1,2} Julie Robison, PhD,³
Noreen Shugrue, JD, MBA, MS,³ Patricia Keenan, PhD, MHS,² and
Marshall B. Kapp, JD, MPH⁴

Purpose: Although prior research suggests that economic, behavioral, and psychosocial factors influence decisions not to purchase long-term care insurance, few studies have examined the interplay among these factors in depth and from the consumer's point of view. This study was intended to further illuminate these considerations, generate hypotheses about non-purchasing decisions, and inform the design of policies that are responsive to concerns and preferences of potential purchasers. **Design and Method:** Qualitative study using 32 in-depth interviews and 6 focus groups, following a grounded theory approach. **Results:** Five themes characterize decisions not to purchase long-term care insurance: (a) the determination that a policy is "too costly" reflects highly individualized and complex trade-offs not solely economic in nature, (b) non-purchasers are skeptical about the viability and integrity of private insurance companies and seek an unbiased source of information, (c) family dynamics play an important role in insurance decisions, (d) contemplating personal risk for long-term care triggers psychological responses that have implications for decision making, and (e) non-purchasers feel inadequately informed and overwhelmed by the process of deciding whether to purchase long-term care insurance. **Implications:** States are seeking to offset escalating Medicaid long-term care expenditures through a variety of policy mechanisms, including

stimulating individual purchase of long-term care insurance. Findings suggest that economic incentives such as lowering premiums will be necessary but not sufficient to attract appropriate candidates. Attention to behavioral and psychosocial factors is essential to designing incentives that are responsive to concerns and preferences of potential purchasers.

Key Words: Long-term care insurance, Non-purchasers of insurance, Long-term care financial planning, Qualitative methods

Current expenditures for long-term care are substantial and are expected to increase rapidly in the coming decades (Borger et al., 2006). Federal and state governments are seeking to control escalating Medicaid costs through a variety of policy mechanisms designed to encourage greater private responsibility for paying for care, including enforcing estate recovery programs (Kapp, 2006), tightening regulations to minimize Medicaid estate planning (U.S. Government Accountability Office, 2005), and stimulating the purchase of private long-term care insurance (Cohen, 2003).

Advocates for long-term care insurance argue that such insurance can be an effective tool for individuals who prefer to pay a predictable affordable premium rather than bear the risk for a potentially large financial loss (Congressional Budget Office, 2004). They also maintain that government encouragement of long-term care insurance is a prudent policy strategy that relies on the private sector to reduce the burden of growing long-term care costs on state governments during an era of federal minimalism (Meiners, McKay, & Mahoney, 2002). However, others suggest that despite improvements in the quality of long-term care insurance policies and the growing

¹Address correspondence to Leslie A. Curry, PhD, MPH, Division of Health Policy and Administration, Yale University School of Epidemiology and Public Health, 60 College Street, New Haven, CT 06520. E-mail: leslie.curry@yale.edu

²Division of Health Policy and Administration, Yale University School of Epidemiology and Public Health, New Haven, Connecticut.

³Center on Aging, University of Connecticut Health Center, Farmington.

⁴School of Law, Southern Illinois University, Carbondale.

availability of lower premiums through employer-sponsored plans (Silva, 2004), high premium costs are prohibitive for many (Gleckman, 2007). They argue that the non-purchase of insurance may be a rational decision for some (Pauly, 1990) and point to alternative financial planning tools, such as emerging “hybrid” insurance products that combine long-term care insurance with annuities, life insurance, or disability insurance (Freiman, 2007). Despite this lack of consensus, states are strongly motivated to find ways to control increasing Medicaid long-term care costs and are looking to long-term care insurance as one key strategy.

Efforts to expand the role of long-term care insurance have focused on public–private partnership models (Stone-Axelrad, 2005). These models tie private insurance policies to the Medicaid program, offering benefits to pay long-term care costs as well as protection of certain assets in the qualification of Medicaid (Center for Health Care Strategies, 2007). Presently, 19 states, in addition to the four original partnership programs in California, Connecticut, Indiana, and New York still in operation, have received approval from the federal government to implement public–private partnership programs (Connecticut Partnership for Long-Term Care, 2008). Policies in these new programs must satisfy defined criteria including federal tax qualification and specific consumer protection mechanisms.

Despite the uncertainty and potentially high cost of needing long-term care services—classic economic rationales for purchasing insurance—demand for long-term care insurance has been modest (Gleckman, 2007). A number of explanations have been proposed for low purchase rates, including economic, behavioral, and psychosocial factors. One set of explanations for non-purchase centers on the functioning of long-term care insurance markets (Norton, 2000; U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation, 2004). The high cost of policies has consistently been identified as a major reason for non-purchase (America’s Health Insurance Plans [AHIP], 2007; Cramer & Jensen, 2006; Kumar, Cohen, Bishop, & Wallack, 1995). The high cost of insurance can be a result of adverse selection (when insurance is purchased disproportionately by people with greater likelihood of needing insurance) and moral hazard (when people use more care as a result of having insurance; Phelps, 1991). In addition, long-term care insurance is typically purchased individually, which exacerbates selection concerns and increases marketing costs (in contrast, e.g., to employer-based

health insurance, where health risks and administrative costs are shared over a larger group). Potential incentives to encourage purchase address price through tax deductibility of premiums, fixed premiums, public coverage when policies are exhausted (AHIP, 2007), and government incentives such as tax credits for premiums and public–private partnership programs (Gleckman; Nixon, 2006). Additional features of the long-term care insurance market have been identified as disincentives for purchase, including the existence of a lower cost alternative in the form of Medicaid (Brown, Coe, & Finkelstein, 2006; Sloan & Norton, 1997), and inaccurate or incomplete consumer information (McCall, Mangle, Bauer, & Knickman, 1998).

Other sets of explanations emphasize behavioral and psychosocial factors that may affect non-purchase decisions. Theories in the field of behavioral economics, which uses psychological principles to explain individual financial decisions, offer a useful framework for understanding the complexities of the decision-making process (Barberis & Thaler, 2002; Kahneman & Tversky, 1979). Behavioral economics examines tendencies such as loss aversion (feeling the pain of loss more acutely than the pleasure of gain) and mental accounting (judging financial risks in isolation), which may occur in long-term care insurance purchasing decisions (Chen, 2003). Evidence indicates that behavioral and psychosocial considerations are germane to long-term care planning decisions generally (Bradley et al., 2002; Curry, Bradley, & Robison, 2004) and to the purchase of long-term care insurance specifically. Such considerations include attitudes toward personal responsibility for planning, family dynamics and decision making (Stum, 2001, 2005), negative attitudes toward insurers (AHIP, 2007), and preferences for informal unpaid care including family (AHIP; Pauly, 1990). Research regarding the role of availability of informal care (Mellor, 2001) and underestimation of personal risk for needing long-term care (Finkelstein & McGarry, 2006; Taylor, Osterman, Acuff, & Ostbye, 2005) is mixed. However, much of this research has not comprehensively examined the multifaceted nature of long-term care insurance decision-making process in great depth, and very few have used qualitative approaches. Findings from a recent study using qualitative methods highlight the complexity of purchasing decisions, particularly in the context of spouses as a family unit, and illustrate the value of qualitative approaches in exploring long-term care insurance decision making (Stum, 2006).

Our study framework is informed by this literature and assumes that non-purchase decisions reflect a complex combination of economic, behavioral, and psychosocial explanations. Understanding the interplay of these factors in non-purchase decisions is particularly important in the design of insurance policies that are responsive to the varied and inter-related concerns and preferences of potential consumers. Accordingly, we used qualitative methods to characterize the experiences and views of non-purchasers of long-term care insurance. This study was intended to further illuminate economic, behavioral, and psychosocial factors previously measured primarily quantitatively to generate hypotheses about non-purchasing decisions and to inform the development of a survey to be used in a quantitative study of non-purchasers (Krause, 2002).

Methods

This article reports findings from a focused analysis of data from a broader study characterizing individual expectations and social norms regarding financing long-term care. In this analysis, we specifically examine the non-purchase of long-term care insurance. We used a triangulation design with in-depth interviews and focus groups, following a grounded theory approach (Glaser & Strauss, 1967). Triangulation is a process by which a single phenomenon is examined using two or more researchers, theoretical perspectives, methods, or data sources (Denzin & Lincoln, 2000; Jick, 1979; Patton, 2002). Our team included multiple researchers with different theoretical perspectives and scientific disciplines, and we used two different data gathering methods to enhance the breadth of data. In-depth interviews generate narrative data that explore individual experiences and perceptions in detail (Britten, 1995). Focus groups are used to discover more about topics that involve social norms and are useful in revealing the diversity and consensus of opinions regarding a given issue (Morgan & Krueger, 1998). We conducted interviews to elicit data regarding individual experiences with long-term care financing decisions and focus groups to learn more about expectations for the respective roles of the public and private sectors in financing long-term care.

Sample

We used purposeful sampling strategies (Miles & Huberman, 1994; Patton, 2002), to identify study participants who had direct experience

regarding the phenomenon of interest and who were willing to express their views in a research study. We identified individuals who had either attended an educational forum on long-term care financing or responded to a statewide survey that included questions about long-term care financing, suggesting they had previously considered this topic and were willing to share their opinions.

The sample for the focus groups was drawn from a list of individuals who had completed a statewide survey for the Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) and indicated they would be willing to be contacted for future research ($n = 786$). A total of 98 of these individuals met our inclusion criteria (ability to speak English, aged 42–75 years, not currently using long-term care services, total assets of at least \$30,000 excluding one's home or car, and inclusion in the Department of Motor Vehicles telephone number database) and were sent a letter of invitation, followed by a telephone call. None of the 98 individuals contacted refused to participate, and 36 were available to attend a focus group at the planned location and date. Because evidence suggests that age plays a role in long-term care planning efforts, and we wanted to reflect the experience of individuals across the state, we assembled stratified homogeneous groups with strata for age (42–65 and 66–75 years) and geographic county. Consistent with standards of focus group study sample size (Krueger & Casey, 2000), we held three sessions within each age strata, yielding six groups with a total of 36 participants.

The sample for the interviews was developed from two sources: attendance rosters from three educational forums sponsored by the Connecticut Partnership for Long-Term Care in 2007 and from the pool of long-term care needs assessment survey respondents described previously. We sent a letter of invitation to 135 individuals randomly selected from the forum rosters ($n = 75$) and the survey respondent pool ($n = 60$), followed by a telephone call. Twenty-two individuals did not have an operational telephone number, and 6 individuals contacted refused to participate. The research assistant selected every third name and enrolled individuals using the criterion of “theoretical saturation,” or the point at which no new concepts emerge from reviewing successive data from a sample that is diverse in pertinent characteristics and experiences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). A total of 32 individuals completed an interview (12 from the forums and 20

from the survey). Inclusion criteria for the interviews were the same as for focus groups. Saturation was achieved in the range generally expected, 30–50 interviews (Pope, van Royen, & Baker, 2002) and four to six focus groups (Morgan & Krueger, 1998).

The study was approved by the University of Connecticut Health Center Institutional Review Board.

Data Collection

We used a standard qualitative interview guide with broad “grand tour” questions for both focus groups and interviews, allowing participants to direct the course of discussion as much as possible while also using probes to clarify concepts and elicit detail (Crabtree & Miller, 1999). The discussion guide evolved as data collection progressed (Glaser & Strauss, 1967). Questions explored plans to pay for long-term care and views on individual and government responsibility for long-term care, including this question in both focus groups and interviews: “If you have done any long term care financial planning, such as considering long term care insurance or consulting a financial planner, please talk a little about that decision and process.” Interviews were conducted via telephone by a trained master’s-level research assistant. Focus groups were held in community-based locations accessible for participants, were 1 hr in duration, and were facilitated by a member of the research team with substantial experience in focus group moderation (Leslie A. Curry). Each focus group participant was reimbursed \$20.00. All interviews and focus groups were audiotaped and independently transcribed.

Analysis

We used standard qualitative analysis procedures (Bradley, Curry, & Devers, 2007; Pope, Ziebland, & Mays, 2000). Our analysis was guided by the constant comparative method, a systematic data coding and analysis process (Glaser & Strauss, 1967) during which specific quotes are categorized into themes with codes developed iteratively to reflect the data. The analysis was performed by a team (Leslie A. Curry, Julie Robinson, Noreen Shugrue) with diverse backgrounds in gerontology, law, finance, and public health to promote more in-depth discussion and refined understanding of conceptual content (Patton, 2002; Pope et al.). We

developed the codes in steps (Crabtree & Miller, 1999), drafting a preliminary code structure after line-by-line independent review of the first three focus group transcripts. With subsequent transcripts, we constantly compared the content with previously coded data to ensure consistent assignment of codes. We used the same code structure for the interview and focus group transcripts, synthesizing related concepts and developing new codes as needed to capture concepts from each source. This process of refining codes and describing properties of each (Lincoln & Guba, 1985) continued until no new concepts emerged from the remaining transcripts. We employed the following principles to achieve saturation: development of a cohesive theoretical sample, deliberate consideration of negative cases, definition of narrow focus of inquiry, and regular team assessment of the adequacy and comprehensiveness of results (Morse, 1995). Using this final version of the code structure, the team independently coded all focus group and interview transcripts. We met regularly as a group to reconcile individual coded transcripts, resolving differences in codes through negotiated consensus (Morse, 1997). We developed five key themes, or recurrent and unifying ideas (Boyatzis, 1998) that characterize the views and experiences of long-term care insurance non-purchasers.

Data were entered into Atlas.Ti (version 5.0.67; Scientific Software Development GmbH, Berlin, Germany) to facilitate coding, organization, and retrieval. The following techniques were employed to ensure scientific rigor: consistent use of the discussion guide, audiotaping and independent preparation of the transcripts, standardized coding and data analysis, use of researchers with diverse backgrounds, and the creation of an audit trail to document analytic decisions (Malterud, 2001; Mays & Pope, 2000; Patton, 2002).

Findings

We completed 32 individual in-depth interviews and six focus groups with a total of 36 participants; characteristics of participants are reported in Table 1. We identified five recurrent themes that characterize individual decisions not to purchase long-term care insurance.

Theme 1: The determination that a long-term care insurance policy is “too costly” reflects highly individualized and complex trade-offs not solely economic in nature.

Table 1. Characteristics

Variable	Median	Range
Focus group sample (<i>n</i> = 36)		
Age (years)		
Boomer group	57	45–60
Older adults	68	61–75
	%	<i>n</i>
Gender (men)	58.3	21
Income (\$; monthly)		
2,000–2,999	13.9	5
3,000–3,999	2.8	1
4,000–4,999	8.3	3
5,000–6,999	33.3	12
7,000–8,999	16.7	6
9,000–12,499	16.7	6
12,500 or more	8.3	3
Assets (\$)		
30,000–74,999	8.3	3
75,000–149,999	8.3	3
150,000–249,999	22.2	8
250,000–349,999	16.7	6
350,000–500,000	44.4	16
Interview sample (<i>n</i> = 32)		
	Median	Range
Age mean (years)		
Boomers	56	43–59
Older adults	69	65–70
	%	<i>n</i>
Gender (men)	37.5	12
Income (\$; monthly)		
2,000–2,999	18.8	6
3,000–3,999	6.3	2
4,000–4,999	12.5	4
5,000–6,999	31.3	10
7,000–8,999	21.9	7
9,000–12,499	6.3	2
12,500 or more	9.4	3
Assets (\$)		
Less than 5,000	3.1	1
5,000–14,999	6.3	2
15,000–29,999	3.1	1
30,000–74,999	6.3	2
75,000–149,999	15.6	5
150,000–249,999	25	8
250,000–349,999	21.9	7
350,000 or more	12.5	4

As expected, cost of insurance was central to discussions. However, participants described making complex trade-offs in deciding whether to purchase long-term care insurance. They compared the cost of long-term care insurance with competing considerations such as other expenses, the level of current assets, age at purchase, and specific policy features. Perceptions of the risk of needing long-term care were discussed at length.

With a lot of insurances you stop and think about how likely you are to need to use it or not use it. I think sometimes about like auto insurance, of course you have to have it and of course it's easy to have an accident . . . so you are likely to use it. Or umbrella insurance, you are less likely to use it but it saves everything that you own. But long term care insurance is a little more difficult to make the decision about because you are using money you might put away for retirement, you are not sure if you will have to use it.

The classic economic dilemma of current versus future possible consumption emerged in discussions about the trade-offs involved in the insurance purchasing decision. Participants described insurance considerations in the larger context of retirement planning, and the importance of future savings in maintaining a certain standard of living in their later years. For instance,

I have been thinking that I would use my own assets. I would love to be able to leave a large amount of money to my two daughters but I believe you have to pay what you owe. . . . I have not done much research in terms of insurance and I probably should, although I am mid fifties too and whether I could find something affordable I don't know. My wife and I are doing what we can to build a sizable estate so we will have money available. I'm hoping that does not wind up all being spent for long term health care but we are prepared to do that.

When contemplating the trade-off between savings and paying insurance premiums, participants expressed the view that the money spent on premiums might be spent on more gratifying things, such as supporting children or a charitable cause.

I have looked into it a couple of times and I have chosen not to get it. I have really chosen to go to the route of maybe thinking about putting aside or investing my own money my own funds for it. Probably also because there is a certain amount of denial in thinking well, I can use that money for other things that would be more enjoyable.

The focus groups in particular generated impassioned discussions regarding how much individuals and families should be required to contribute to paying for their long-term care through long-term care insurance, as compared with “the government.” One participant observed that government programs are funded by individual taxpayers, suggesting that the dichotomy between public and private is not useful.

At some point, though I personally believe that the government has a role to play, a central role to play, to take care of us. We've paid all these taxes

all these years and I am still perfectly willing to buy a long term care policy as being part of my responsibility, at some point and time the government has to step up too.

Theme 2: Non-purchasers are skeptical about the viability and integrity of private long-term care insurance companies and seek an unbiased source of information.

Participants who had not purchased long-term care insurance described several concerns regarding insurance companies and agents. Discussions of participants' experiences with private insurers were lively and occurred in each focus group; individual experiences were also recounted in the interviews. Perceptions included the risk that insurers might take advantage of opportunities to maximize profits at the expense of policyholders and the aggressive sales tactics employed by insurance company agents.

I stopped going to these seminars. . . . They [insurance agents] left you with enough questions so that you have to go to step two, and once you go to step two that is where they kind of box you in and say you just sign right over here. The high pressured sales stuff, sometimes it was very sophisticated. . . . [T]hey are smooth talkers, so I just shut it down.

Participants also expressed concerns about the long-term fiscal viability of insurance companies and likelihood that the company will be operating in a future time when benefits might be needed.

[C]ompanies go out of business and companies are acquired. [Company X], which is a big provider in this field, sold out all of its insurance operations, so you no longer have the [X] company behind you. They are still rated highly but I don't know what they are going to be in 20 years.

Available information sources lack credibility for potential consumers. They seek unbiased and neutral information sources and typically referred to government entities or government-endorsed organizations. Statements suggested an underlying assumption of trust in governmental entities, and there was no commentary expressing skepticism about such a role for public agencies.

It has to do with credibility. . . . [T]here has got to be a more credible source, unbiased, not prejudiced, not in somebody's back pocket. You like to think that there might be a government office, committed, dedicated to serve the citizens of the state.

Theme 3: Family structure and dynamics play an important role in deciding not to purchase long-term care insurance.

Participants discussed several ways in which the decision regarding insurance purchase was influenced by one's family. In some instances, one spouse is primarily responsible for financial decisions and may choose not to purchase a policy based on younger age and low perceived risk. In other cases, the relative risk of needing insurance among women and men was a key consideration. One participant reported that she had wanted to purchase long-term care insurance; yet, when her spouse became uninsurable, she felt forced to forgo a policy for herself.

To be honest, we were torn as to whether or not we would simply pay out of pocket or if we would have an insurance policy. When it looked like everything was going to be about \$2,500 per year, I would rather have paid for the policy. After this [change in spouse's health], they said if he is insurable, his would probably go to about \$7,000 a year. So at that point we would probably take a chance and pay out of pocket. We haven't really made that total decision yet.

The relationship between the desire to bequeath wealth and the decision to purchase long-term care insurance is complex. Some individuals who want to leave a legacy decide not to buy insurance to save that premium money for their heirs or to purchase some form of life insurance rather than long-term care insurance.

I don't think you have to leave enormous amounts of money to your kids, you have a life insurance policy, that's what you should leave to them and spend the money that you have. Have a life insurance so you know exactly what you are going to give them and that's it.

Theme 4: Contemplating personal risk for needing long-term care triggers psychological responses that have implications for decision making.

Participants described the role of denial of disability and fear of needing long-term care in their decisions. There were candid discussions about the fact that some individuals simply did not want to think about long-term care planning (some characterized this as procrastination). Others were more dismissive of the need for planning ahead, recounting family histories in which parents or grandparents died at an early age without needing long-term care.

I actually took long term care insurance out over the spring and I rescinded it. . . . I think that because it's kind of tied to mortality, a little bit, people don't want to think about long term care, they certainly don't want to think about their own demise or death.

Theme 5: Non-purchasers feel inadequately informed and are overwhelmed by the process of deciding whether or not to purchase long-term care insurance.

Participants expressed feeling overwhelmed by the process of deciding whether to purchase long-term care insurance and described a lack of confidence in their ability to make an appropriate decision. They reported that comprehensive information about long-term care insurance is typically incomplete or inaccessible and they perceived the limited available information as confusing and overwhelming.

I don't feel the government is responsible to take care of me but I do like the idea that there is a dedicated somewhere that I can go if I want to learn, and that dedicated somewhere is dispensing information to those of us who have worked, who are tired, who have tried very hard to live a good life and now we don't even know where to ask for the help, don't know the questions to ask. . . . [W]e deserve to have the information in a clear, concise way and dispersed to a lot of people, not only those who can look for it but to those who might not look for it.

The last sales person that tried to sell me a policy was my financial advisor. . . . He sends me something in the mail after we went through this whole thing. It said you have to send a check for ½ the amount, \$4,000. Wait, that's \$8,000? Where did you get that figure \$8,000? This was never brought up at the meeting that we had. . . . [I]f you told me \$8,000, I would have said right then and there forget about it, it's too expensive. . . . This other plan through X company . . . was \$5,500 for the two of us. The plans are so different and the amount you pay per day is so different, the amount of years is different. So, like I said, inflation is one cost . . . the whole thing is complex.

Discussion

This study extends and enhances existing knowledge regarding non-purchase of long-term care insurance in several ways. First, whereas quantitative evidence shows that high cost of premiums is a primary reason for non-purchase, our findings also suggest that the assessment of whether a premium is too costly is complex and shaped by behavioral and psychosocial considerations. Second, incomplete or inaccurate consumer information has previously been identified as a contributor to non-purchase. In addition, we found that consumers do not trust industry-based information sources and feel that available information is

not only incomplete but also biased in nature. Perceptions of insurers are also characterized by disapproval of approaches perceived as aggressive and by skepticism about the viability of insurance companies. Third, this study confirms and expands recent evidence regarding the importance of the role of the family (Stum, 2006) and enhances understanding of the various ways in which family structure and dynamics shape purchase decisions. Finally, prior research indicates that perceived risk of needing long-term care may be relevant. Our findings suggest that contemplating personal risk for needing long-term care triggers psychological responses such as fear and denial that have implications for decision making.

If these types of behavioral explanations are important, low purchase rates could occur even if other economic considerations were addressed—at the extreme, even if long-term care insurance prices were heavily subsidized and Medicaid were not available. One study in behavioral finance found that individuals had incomplete participation in a retirement savings plan even under circumstances when it was clearly beneficial (an employer match and ability to withdraw funds without a penalty) and participation increased negligibly in response to education about the benefit (Choi, Laibson, & Madrian, 2005). At the same time, if behavioral explanations are among the most important reasons for non-purchase, it is possible that policies designed to address these considerations could increase participation even in the context of existing premium costs and Medicaid coverage.

These findings also identify important considerations for states currently developing policies to increase the purchase of long-term care insurance. First, it is important to note that efforts to raise public awareness alone are likely to have limited impact on purchasing decisions. However, there are potentially appropriate purchasers who might benefit from improved educational outreach mechanisms. States should commit funding to consumer outreach, peer volunteers, and other methods to increase the availability of objective sources of information through governmental forums, employers, community-based “info-lines,” municipal entities, nonprofit organizations, and advocacy groups. For both governments and insurers, effectively conveying tailored detailed information (e.g., potential policy configurations) may increase an individual's confidence in making a fully informed decision. Whereas some may ultimately choose to purchase insurance,

others may make a perfectly appropriate decision not to purchase a policy for reasons other than, or in addition to, financial considerations (Pauly, 1990).

Second, consumer skepticism regarding the viability and integrity of insurers must be addressed. One possible mechanism is to strengthen states' insurance guaranty fund to protect policyholders from insolvent companies through redefining claim and coverage restrictions. Consumer protection policy features must be conveyed by a neutral source and made clear to potential buyers. Consumer expectations of having access to information about private insurance from sources other than the insurance company itself may be a consequence of the lack of consensus around public and private responsibilities for long-term care. Uniform standards for insurance agent training provide an opportunity to address consumer concerns about sales techniques and approaches, as well as the scope and nature of information communicated during the sales process.

Third, long-term care insurance purchasing decisions are often made in a larger family context. Family decision-making models of long-term care financial planning suggest that multiple factors are at play, including competing goals and demands, available resources, and individual perceptions (Stum, 2006). States and insurers may wish to consider policy features that address the diverse needs and interests of spouses or children, such as underwriting or subsidizing premiums for a high-risk spouse.

Finally, other motivations such as a desire to bequeath wealth must be considered in the context of long-term care financing. States and individuals may have competing interests regarding protection of wealth through mechanisms such as Medicaid estate planning (Curry, Gruman, & Robison, 2001; Kapp, 2006). If minimizing Medicaid estate planning is a policy goal, states should communicate the benefits of asset protection through partnership models, with a compelling case as to the relative benefits of long-term care insurance as compared with life insurance and other tools such as trusts. Some participants proposed a prominent role for government in the form of a social insurance program similar to Medicare, arguing that the private insurance market has not proven to be up to the task. Others expressed more positive views of the potential role of long-term care insurance. The lack of consensus regarding the roles of public and private sectors in long-term care has posed significant

challenges to development of a cohesive national policy for at least a decade (Congressional Budget Office, 2004; Herd, 2005; Walker, Bradley, & Wetle, 1998).

This study has a number of limitations. We spoke to English-speaking non-purchasers of long-term care insurance in a single state, and our findings may not reflect the views of people from other states. We did not use potentially important demographic criteria in the development of our purposeful sample and therefore may not have had sufficient representation of breadth on these characteristics. Importantly, Connecticut residents may have a higher awareness of long-term care insurance as a result of over a decade of statewide public education efforts aimed at long-term care. Some participants had attended a long-term care educational forum and it is possible that participation in this educational session may have affected their verbalized attitudes and views. Results should therefore be interpreted in light of this relatively more educated and motivated group, and it should be noted that the challenges expressed by these participants may be even greater for the population at large. The possibility of social desirability response bias exists. However, systematic analysis of the focus group data did not reveal evidence of such bias as participants appeared comfortable in presenting contrasting views. Finally, this qualitative study was intended to generate hypotheses about potential factors, in addition to cost, that inhibit individual purchase of long-term care insurance. Future research using quantitative measures on larger samples of non-purchasers of insurance is needed to illuminate further the role of psychological and psychosocial factors identified in this study.

Although many states are moving forward with efforts to increase purchase of long-term care insurance, there is much to learn about how to attract appropriate candidates to purchase insurance beyond simply lowering premiums. We talked with individuals who had considered purchasing long-term care insurance to understand their decision-making processes and to identify important considerations in efforts to make insurance policies more attractive to those individuals for whom this may be an appropriate long-term care financing tool.

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