FINANCING LONG-TERM CARE IN THE TWENTY-FIRST CENTURY: THE PUBLIC AND PRIVATE ROLES

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EXECUTIVE SUMMARY

The coming decades are likely to see a significant increase in the demand for long-term care services, particularly as the first baby boomers reach age 85 in 2030. This increase will assuredly place greater demands on the U.S. system of long-term care, but the magnitude of the problem has been the subject of some debate. For example, while some think that spending for nursing home care alone could more than triple, different assumptions about population growth and levels of disability, future care patterns, and inflation could cut this figure by half.

In any case, Medicaid, which serves as a safety net not only for the poor but also for middle-income elderly persons facing catastrophic long-term care costs, is particularly threatened. Medicaid spending as a share of gross domestic product is expected to double over the next thirty years under current policy. While this growth might be sustainable at the national level, coming demographic shifts mean that the burden will be very unevenly distributed among states. The states that are currently spending the least on long-term care are the very states expected to see the greatest increase in their elderly populations and, presumably, in the demand for long-term care services. They will face a choice between significantly increasing tax burdens on working-age adults or limiting access or quality of care. One consequence may be increasing pressure to federalize the program.

The burden on Medicaid might be reduced if more people made some financial provisions for their own long-term care needs. People could try to save on their own. But not everyone will need long-term care, while the cost for those who do is very high. Pooling risks through some form of insurance is therefore more practical.

Private long-term care insurance has been growing rapidly, but it is still unusual for people to buy it during their working years, when it is most affordable. Some analysts contend that more people would obtain private coverage if they fully understood their likelihood of needing long-term care in the future and the possibility of catastrophic financial losses. There are also proposals to provide broader tax preferences for the purchase of private coverage. Still, it is unlikely that many younger people can be induced to buy coverage.

Even with the most optimistic assumptions, private coverage will not make a significant dent in future public costs. It has other drawbacks as well. Because premiums do not vary by income, private coverage is a highly regressive way to finance long-term care. Moreover, if growth in private coverage meant that fewer middle-income seniors ultimately relied on Medicaid, the result might be a dual system of care, with diminished quality of care for the remaining Medicaid population.

The alternative is some form of social insurance, under which every American could make a fair contribution to a universal pool and in return, receive a guarantee that help will be available when it's needed. A universal program would be likely to have more stable political support than the welfare-based Medicaid system. In addition, depending on the financing structure, such a program could effectively increase the national savings rate, promoting long-range economic growth. A social insurance program could also promote uniform quality standards and improved coordination between acute and long-term care services.

The obvious barrier to such a program is its cost. Given the current concerns about Social Security and Medicare, there is an understandable reluctance to create another open-ended entitlement program that will place unpredictable burdens on future generations. A possible response to this concern is that most of the costs to society will be incurred anyway and will be paid for somehow. The chief effect of social insurance would be to redistribute the burden from individual savings to a universal insurance pool, or from state Medicaid programs to a national program.

One way in which social insurance could increase total spending, rather than merely redistribute it, is through induced demand: people who might have been cared for by relatives may instead rely on publicly financed services. However, induced demand would be just as likely to occur under adequate private insurance. Another concern is that a universal social insurance program would make benefits available to people who have savings of their own that could be used for long-term care. This would mean that, in effect, public funds would be used to help provide larger bequests to their heirs. This question of asset protection tends to be asked only about long-term care. Medicare's acute care benefits allow some very sick people to avoid paying tens of thousands in hospital and physician bills; Social Security increases income and thus potential savings.

Must we choose? Could we encourage private coverage for those who can afford it and at the same time improve the public safety net for those who can't? The two strategies may be incompatible. On the one hand, improved public coverage would reduce incentives to buy private protection. On the other hand, greater reliance on private coverage by middle-income seniors would reduce political support for the provision of adequate care to those who are less well-off. If the current financing system is ultimately unsustainable, the partial security of expanded private coverage may merely distract from the task of developing a more equitable and rational way of meeting long-term care needs.

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INTRODUCTION

The oldest baby boomers are now in their fifties, and the ability of our public and private income security and health programs to meet their eventual retirement needs is drawing increased attention. Much of the current debate has focused on the two major federal entitlement programs, Medicare and Social Security. However, there is also growing concern about how society will meet the long-term care needs of what will be a very large cohort of elderly people.

The coming decades are likely to see a significant increase in the demand for long-term care services, particularly as the first boomers reach age 85 in 2030. The magnitude of this increase has been the subject of debate: some believe that progress in the treatment of disabling conditions may eventually reduce the need for long-term care. Others suggest that the projected longer lifespan for boomers may simply mean they will experience more years of disability before death. Still, even if the incidence of need for long-term care should change, the mere size of this aged population is likely to mean that our current system of financing long-term care services will face major strains. Perhaps because this problem seems less immediate than those facing Medicare and Social Security, the issue of planning for future long-term care needs has drawn less attention. However, there may be a greater opportunity to plan now for equitable and rational solutions precisely because the largest pressures on long-term care financing are still some decades away.

Concern about long-range financing issues should not obscure the fact that our system is already failing to meet the needs of many persons with chronic illness or disabilities. It promotes care in nursing homes instead of the home care most elderly people prefer. It relies heavily on informal caregiving by relatives, yet provides little support as changes in work patterns and other trends make it harder for families to care for their own. It forces people who have worked hard all their lives to spend their final months or years on welfare. While there are a variety of proposals for restructuring long-term care financing, they must be evaluated in part on the basis of their ability to address the deficiencies in the current system, as well as their sustainability over time.

This paper reviews our current system for financing long-term care, along with projections of the growth in long-term care needs over the coming decades. It then assesses the likelihood that a combination of Medicaid and private savings or insurance could meet these needs without compromising access and quality. The paper concludes with a brief overview of the major alternative, some form of universal social insurance program for long-term care.

LONG-TERM CARE TODAY

What Is Long-Term Care and Who Uses It?

Long-term care refers to the supportive services required by people whose ability to care for themselves has been reduced by a chronic illness or disability, whether physical or mental. The need for long-term care is often measured in terms of the extent to which an individual requires assistance or supervision in performing basic "activities of daily living" (ADLs), such as bathing, dressing, toileting, or eating, or "instrumental activities of daily living" (IADLs) such as meal preparation or managing money. Although most current spending for long-term care is for individuals in nursing homes, the majority of individuals requiring personal assistance live in the community. (People are described as living in the community whether they are in their own homes, living with relatives, or in non-institutional settings such as assisted living facilities or continuing care facilities.)

Table 1. Community Residents with Functional Limitations, 1994–95

	Age							
	6–14		15–64		65–79		80+	
	Population (thousands)	Percent of Age Group	Population (thousands)	Percent of Age Group	Population (thousands)	Percent of Age Group	Population (thousands)	Percent of Age Group
Difficulty with one or more ADLs	381	1.1%	3,765	2.2%	2,565	10.5%	1,864	27.5%
Difficulty with one or more IADLs	NA	NA	5,770	3.4%	3,747	15.3%	2,743	40.4%
Needs personal assistance with one or more ADLs or IADLs	272	0.8%	4,347	2.5%	2,814	11.5%	2,312	34.1%
Total population	35,011	100.0%	171,112	100.0%	24,471	100.0%	6,785	100.0%

Source: U.S. Bureau of the Census, *Americans with Disabilities: 1994–95,* Current Population Reports P70-61, 1997.

Table 1 shows the proportions of persons living in the community who had difficulty performing ADLs or IADLs in 1994–95. As the table indicates, rates of disability increase with age, and the need for personal assistance is greatest among very old adults. However, a substantial share of the population needing assistance consists of children and younger adults. While this paper focuses on the needs of the elderly, any comprehensive solution to the problems of the long-term care system will need to address the younger disabled as well.

About 5.1 million persons over age 65 in the community required assistance with one or more ADLs or IADLs in 1994–95. Another 1.3 million, mostly severely disabled, were in nursing homes.[1] Thus about 80 percent of the elderly receiving long-term care are in the

[1] Dorothy P. Rice, "Beneficiary Profile: Yesterday, Today, and Tomorrow," *Health Care Financing Review,* v. 18, n. 2 (winter 1996), pp. 23–46.

community. The vast majority were cared for by spouses, children, or other family members, or by friends or neighbors. Table 2 shows the "first helper," or primary caregiver, for disabled people over age 15 in the community in 1994–95. Only 9.8 percent of those needing help with an ADL, and 8.5 percent of those needing help with either an ADL or an IADL, relied primarily on paid help.[2]

Table 2. Primary Sources of Personal Assistance for Disabled Persons Over Age 15 Living in the Community, 1994–95

	With an ADL or an IADL		With an ADL	
	Number (thousands)	Percent	Number (thousands)	Percent
Persons receiving personal assistance	9,342	100.0%	3,777	100.0%
Relationship of first helper to recipient:				
Spouse	2,607	27.9%	1,298	34.4%
Daughter	1,710	18.3%	688	18.2%
Son	1,183	12.7%	392	10.4%
Parent	800	8.6%	280	7.4%
Other relative	1,231	13.2%	447	11.8%
Non-relative	1,018	10.9%	300	7.9%
Paid help	794	8.5%	372	9.8%

Source: U.S. Bureau of the Census, *Americans with Disabilities: 1994–95,* Current Population Reports P70-61, 1997.

Even though most disabled people are cared for in the community, the risk that anyone who lives long enough will eventually require care in a nursing home is high. Table 3 shows projections of probable lifetime use of nursing home care from a recent study. Thirty-six percent of people aged 45 living in the community in 1995 could expect to enter a nursing home at some point in their lives. On average, these people could expect their first admission in 38.6 years—or in the year 2034. For those older than 45 in 1995, the likelihood of needing nursing home care rises steadily, and the years remaining before the first admission drop.

Table 3. Projected Lifetime Nursing Home Use, Community Residents at Selected Ages in 1995

Age in 1995	Likelihood of Any Use	Years Before First Use	Expected Lifetime Use in Years				
			Less than 1	1–2	2–5	5–10	10+
70	42%	14.2	21%	5%	8%	6%	2%
75	46%	10.1	24%	5%	9%	7%	1%
80	51%	6.7	27%	6%	9%	8%	1%
85	56%	4.1	32%	6%	10%	7%	1%

Source: Calculated from Christopher Murtaugh, Peter Kemper, Brenda Spillman, and Barbara Lepidus Carlson, "The Amount, Distribution, and Timing of Lifetime Nursing Home Use," *Medical Care* 35, 3 (1997):204–218.

[2] Ibid.

Most people who need nursing home care will need it for less than one year; the average lifetime nursing home stay is projected to be 2.7 years. Still, 7 to 8 percent of those aged 45 or older in 1995 could expect to need 5 years or more of nursing home care in their lifetimes.

Even for those who require care only for short periods, the costs can be devastating. A one-year stay in a nursing home costs over $40,000. One projection of lifetime long-term care costs for people who were age 67 in 1995 found that the average male could expect costs of $56,895, while the average female could expect costs of $124,370.[3] Because neither Medicare nor private health insurance covers most of these costs, and because few people have sufficient retirement income or savings to meet them on their own, many people who require long-term care ultimately become destitute and turn to Medicaid.

How Is Long-Term Care Currently Financed?

Table 4 shows the sources of payment for nursing home and home and community-based care in 1995. (Not all of this care is properly termed "long-term care"; some people require nursing home or home care only briefly—after a hospital stay, for example.) As the table indicates, Medicaid is the major third-party payer for nursing home care, while Medicare has emerged as the largest single payer for home care. In combination, the two programs pay for 56 percent of nursing home and home care. Most of the rest is paid from individual or family income or savings.

Table 4. Long-Term Care Expenditures for the Elderly by Source of Payment, 1995

	Nursing Home Care		Home and Community-Based Care		Total	
	$ (billions)	Percent	$ (billions)	Percent	$ (billions)	Percent
Medicaid	24.2	38%	4.3	16%	28.5	31%
Medicare	8.4	13%	14.3	54%	22.7	25%
Other Federal	0.7	1%	1.7	6%	2.4	3%
Other State and local	0.6	1%	0.5	2%	1.1	1%
Out-of-pocket payments	30.0	47%	5.5	21%	35.5	39%
Private insurance	0.4	1%	0.3	1%	0.7	1%
Total	64.4	100%	26.5	100%	90.9	100%

Source: U.S. House, Committee on Ways and Means, *1998 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means,* Washington, 1998, p. 1059, based on estimates from the Lewin Group for the Office of the Assistant Secretary for Planning and Evaluation.

[3] Health Insurance Association of America, based on LifePlans, Inc., Long Term Care Utilization Model.

Medicaid is the federal-state program of medical assistance for certain groups of the poor, including families with children, the elderly, and the disabled. Ordinarily, people qualify for coverage by meeting stringent limits on income and assets. For the elderly and disabled, these limits are generally those applicable under the federal Supplemental Security Income (SSI) cash assistance program—$494 per month in 1998—but limits can be higher in states that supplement SSI payments.

Most states also allow the "medically needy"—those whose large medical bills reduce their income to the required level—to participate in Medicaid. Even middle-income nursing facility residents may qualify—through a process that is known as "spend-down"—because the monthly cost of nursing home care exceeds their pensions or other retirement income. Some may be eligible immediately upon entering the facility, while others must first spend down their assets by paying for their care until their assets have been reduced to the state's limit, usually $2,000.[4] The medically needy must contribute all of their income toward the cost of their care except for a small personal needs allowance. (This ranged from $30 to $75 per month in 1996.[5])

As of September 1996, 17 states did not permit spend-down. Instead, these states used higher income eligibility limits for persons in institutions than for those in the community—generally 300 percent of the SSI limit, or $1,482 per month in 1998. Until recently, those with incomes that exceeded these limits could not receive Medicaid, even if their incomes were insufficient to cover the costs of their care. The Omnibus Budget Reconciliation Act (OBRA) of 1993 created an arrangement under which such individuals may deposit excess income into a trust, known as a "Miller Trust," and receive Medicaid. The state may recover the funds in the trust after the person's death. This arrangement, which amounts to a sort of delayed spend-down, has reduced the access barriers those in the non-spend-down states may have encountered.

The spend-down system has bred concerns that some people who anticipate a nursing home stay may transfer their assets to children or others, or that they may shelter their income through trust arrangements in order to qualify for Medicaid. To counter these possibilities, Medicaid law restricts eligibility for persons who have transferred assets within a fixed time before admission, and it places limits on how much income can be sheltered in trusts. Still, there are lawyers and estate planners who seek to help some elderly people circumvent these rules. Some observers contend that existing loopholes allow even the wealthy to receive

[4] The value of a house is initially excluded, but may be counted if the resident is deemed unlikely to return home and there is no family member remaining in the house.

[5] This and subsequent descriptions of state policies in this section are drawn from Jane Horvath, *Medicaid Financial Eligibility for Aged, Blind and Disabled: Survey of State Use of Selected Options,* Portland, ME, National Academy for State Health Policy, 1997.

Medicaid.[6] Others point out that relatively few elderly people have significant income or resources to shelter.[7]

In the event that a nursing home resident has a spouse remaining in the community, all states are required to protect specified amounts of the income and assets of the institutionalized spouse for the maintenance of the community spouse. These "spousal impoverishment" rules were enacted in response to concerns that some nursing home residents were consuming all of their income and assets for their care, leaving their spouses to turn to welfare. Protected income amounts for the community spouse in 1996 ranged from $1,295 to $1,919 per month, protected resources from $15,348 to $76,740.

Non-institutionalized individuals may receive home health services if they meet ordinary Medicaid eligibility standards. In addition, every state except the District of Columbia has a federally approved "home and community-based services" waiver, under which people who need home care and would otherwise require institutionalization may be made eligible under standards similar to those that would apply if they were in a nursing home. That is, they may spend down or meet a higher income limit than is usually applicable. However, the number of persons who may participate under these waivers is limited. In addition, many states set very low income limits. In 1996, protected monthly income for a single individual, after any required contributions to the cost of care, ranged from $308 in Illinois to $1,410 in 14 states (those using a limit based on 300 percent of SSI).

The result of these rules is that relatively few people qualify for Medicaid assistance with the cost of home or personal care. While even middle-income people who stay in a nursing home long enough may qualify for Medicaid (after exhausting their life savings), those who are not already very poor must impoverish themselves to receive home or personal care benefits. They may be forced to enter a nursing home because maximum allowable income under the community eligibility standards is insufficient for them to remain at home. As a result, Medicaid is often spoken of as having an "institutional bias": it promotes nursing home admission even for some people who could remain at home with adequate support.

Medicare provides limited benefits for short stays in skilled nursing facilities (SNFs). The benefit is limited to 100 days of coverage per episode of illness, and is available only following hospitalization and only for persons requiring daily skilled nursing or rehabilitation care. As a result, most nursing home residents either fail to qualify for the benefit at the time of admission or exhaust it during the course of their stay. Nevertheless, policy and market changes in recent years have meant that significantly more beneficiaries are obtaining

[6] See, for example, Center for Long-Term Care Financing, *LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle,* Seattle, WA, 1998.

[7] Joshua M. Wiener, *Can Medicaid Long-Term Care Expenditures for the Elderly Be Reduced?,* Washington, Urban Institute, 1996.

Medicare-paid SNF services. In 1996, 1.3 million beneficiaries received SNF services, compared to just 0.3 million ten years earlier.[8] One possible reason for this rise is pressure to shorten inpatient stays under Medicare's hospital payment system. Increasingly, patients who are not ready to go home may be discharged to nursing facilities.

Similarly, Medicare's home health care benefit was designed to be restricted to skilled services, and was originally available only after a hospital discharge. The prior discharge requirement was repealed, and some other restrictions relaxed, in the 1980s. As a result, home health care has been among the fastest growing components of Medicare fee-for-service spending in the 1990s. In 1996, 3.6 million beneficiaries—almost one in ten—received at least one Medicare-paid home health visit. Most got care for a relatively brief period; half of all beneficiaries receiving home health care had fewer than 30 visits. About 21 percent of beneficiaries had 100 or more visits during the year. These high users accounted for 70 percent of total Medicare home health use.[9] They were also more likely to use home health aides than skilled nursing personnel, suggesting that much of their care may have been partially custodial.

In order to slow the growth in spending for these services, The Balanced Budget Act of 1997 (BBA) included changes in Medicare reimbursement methods for skilled nursing facilities and home health care. Now there are concerns that these changes, particularly those for home health care, may restrict access for the most severely disabled users.[10] It also should be noted that some states have attempted to achieve Medicaid savings by maximizing use of Medicare long-term care benefits by beneficiaries eligible under both programs.[11] New Medicare restrictions may simply result in shifting costs from Medicare back to Medicaid, increasing pressure for savings in that program.

Out-of-pocket payments accounted for 39 percent of spending for nursing home and home care in 1995, compared to just 15 percent of spending for other types of health services.[12] In nursing homes, payments by residents or their families included spending for the care of those who had not yet qualified for Medicaid, as well as contributions of income, such as Social Security benefits, by persons who were also receiving Medicaid.

Private insurance spending for long-term care for the elderly amounted to just $0.7 billion, or 1 percent of the total, in 1995. Even though the purchase of long-term care

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[8] Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book,* Washington, 1998.

[9] Ibid.

[10] Harriet L. Komisar and Judith Feder, *The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long-Term Care,* New York, The Commonwealth Fund, 1998.

[11] Joshua M. Wiener and David G. Stevenson, "State Policy on Long-Term Care for the Elderly," *Health Affairs* 17 (May/June 1998):81–100.

[12] Calculated from HCFA, National Health Expenditures series.

insurance has grown in recent years, current spending is small because relatively few policyholders have yet qualified for benefits. (In addition to long-term care insurance, many elderly people have "Medigap," private policies that supplement Medicare. However, long-term care coverage under these policies is generally restricted to payment of required cost-sharing for Medicare-approved services.)

FUTURE PRESSURES ON THE LONG-TERM CARE SYSTEM

Aging of the Population Is Likely to Increase Demand for Long-Term Care

Both the percentage and the absolute number of elderly people in the U.S. are expected to grow significantly over the next 30 years (see Table 5). This is partly because of the aging of baby boomers, but it is also the result of other factors, including a general increase in life expectancy and lower fertility. One in eight Americans is now over age 65; one in five will be by 2030. The number of people aged 85 or older will more than double. At the same time, a smaller percentage of Americans will be of working age as it's now defined (this definition may evolve if, as some believe, many boomers will delay retirement). Meanwhile, note that the proportion of children remains almost constant. This means that growing numbers of people may find themselves caring both for children and for an aging parent. In public policy terms, it will mean continued pressure for increased spending on education, health care, and other services to children at the same time that greater spending is needed for the elderly.

The numbers in Table 5 are the Census Bureau's "middle series" projections, based on specific assumptions about mortality, fertility, and immigration. Changes in these assumptions can yield very different estimates. For example, while the mid-range estimate projects 8.45 million people aged 85 or older as of 2030, the Census Bureau's lowest estimate for that year is 5.8 million, and its highest 12.2 million. Even the lower estimate represents significant growth.

The aging of the population has several consequences, some already widely familiar from the Social Security and Medicare debate. First—and again assuming that people continue to retire by their late sixties—many more people will be drawing on public retirement and health programs, and for a longer time. At the same time, there will be fewer working people for each retiree. Because Social Security is entirely, and Medicare largely, financed through payroll taxes, revenue growth will not keep pace with spending under current tax rates. (Medicaid, financed through federal and state general revenues, faces the spending but not necessarily the revenue side of this double bind.)

Table 5. Projected U.S. Population by Age Group, 1996, 2015, and 2030

	1996		2015		2030	
Age	Population (thousands)	Percent	Population (thousands)	Percent	Population (thousands)	Percent
Under 20	76,632	28.9%	83,163	26.8%	92,867	26.8%
20–64	154,749	58.3%	181,404	58.5%	184,653	53.2%
65–84	30,125	11.4%	39,374	12.7%	60,924	17.6%
85 and older	3,747	1.4%	6,193	2.0%	8,455	2.4%
Total	265,253	100.0%	310,134	100.0%	346,899	100.0%

Source: IHPS, based on U.S. Bureau of the Census, Current Population Reports, Series P25-1130, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050,* 1996.

Future Utilization and Costs Are Highly Uncertain

If current patterns of disability and consequent service utilization continue into the future, these population trends should mean that there will be dramatic increases in the need for and use of long-term care services and in the cost of these services to society.

However, because the Census Bureau's population projections are highly sensitive to different assumptions, utilization and spending estimates that build on those projections and then add further assumptions are—geometrically—even more tenuous. The following review of key factors suggests the degree of uncertainty.

Levels of need. Life expectancy is predicted to increase in the coming decades, but it is unclear whether longer life will mean more years of good health or more years of chronic illness and mental disorders.[13] Projections of future service needs tend to assume no change in morbidity rates: future 85-year-olds are expected to need nursing home care at the same rate as today's 85-year-olds, and so on. However, factors such as lifestyle changes and advances in medical technology could have important effects on the process and experience of aging.

Service modalities. Utilization projections assume that services will be delivered in the same way thirty years from now as today. The frailty of this assumption becomes apparent when we look at long-term care services of 30 years ago: nursing homes or other forms of institutional care were common, but there was almost no paid home health care. Newer modalities such as assisted living and continuing care facilities had not even been thought of. By the same token, it is likely that there will be further innovations in service delivery in the future, with unknown effects on utilization patterns and costs.

[13] For a summary of the different views on this subject, see Rice, "Beneficiary Profile: Yesterday, Today, and Tomorrow."

Supply. Even if the elderly of the future require the same services at the same rate as today, it is not certain that those services will in fact be available. For example, many states continue to constrain the supply of nursing home beds through certificate of need systems. While one study, discussed below, projects that 3.2 million elderly people will be in nursing homes in 2030, the nation had only 1.8 million nursing home beds in 1996.[14] Another issue that may be thought of as one of supply is the availability of informal caregiving by family or others. The entry of more women into the workforce may already have reduced the pool of potential caregivers. In addition, boomers have had fewer children than earlier generations, further limiting the potential availability of informal care.[15] As a result, there is likely to be a steadily increasing demand for paid assistance. Such supply constraints may mean that only certain segments of the population in need of long-term care will receive services.

Inflation. As with other health care services, the cost of long-term care has risen faster than general inflation. For example, in the three years 1994–97, the price of nursing home care rose at an annual rate of 4.7 percent, while the consumer price index rose 2.5 percent per year.[16] Some projections of future long-term care costs assume that this trend will continue indefinitely. Why this should be so is unclear. Excess inflation in the medical sector is usually attributed largely to the cost of new technology, but this factor seems less likely to play a role in long-term care. Recent cost increases may possibly be related to changes in patient mix, such as the increasing number of people discharged early from hospitals who consequently require highly skilled care. Nursing homes may also have responded to increases in available Medicaid reimbursement in many states in the early 1990s.[17] Such factors may have affected spending over a short period, but the rate of cost growth might moderate over time.

Payment sources. Some cost projections assume that the mix of financing sources for long-term care will—in the absence of some intervention, such as measures to promote the purchase of private long-term care insurance—remain roughly stable over time. That is, Medicaid will go on paying for 48 percent of nursing home care, out-of-pocket spending will finance 31 percent, and so on. However, changes in public policy—for example, the expansions of Medicare coverage in the 1980s, or the possible contraction of coverage resulting from the BBA—could change the mix significantly. In addition, the degree of reliance on public payers will be strongly affected by trends in retirement income and savings. Boomers are more likely than their parents to have pension incomes: 82 percent of persons aged 66 to 84 are expected to have pensions in 2030, compared to 50 percent in 1990. On the

[14] Jeffrey Rhoades, D.E.B. Potter, and Nancy Krauss, *Nursing Homes—Structure and Selected Characteristics, 1996,* Rockville, MD, Agency for Health Care Policy and Research, 1998.

[15] American Association of Retired Persons (AARP), *Boomers Approaching Midlife: How Secure a Future?,* Washington 1998.

[16] Based on U.S. Department of Labor, Bureau of Labor Statistics, producer price index (PPI) for nursing home care and CPI, urban consumers.

[17] These increases were often prompted by lawsuits filed by nursing homes against state Medicaid programs under the Boren amendment, which has since been repealed.

other hand, only 51 percent of boomers reported that they regularly saved for retirement on their own in 1996.[18] In addition, the value of pensions and retirement savings will obviously be affected by the long-range performance of financial markets.

These sources of uncertainty have a very important bearing on our understanding of the future long-term care burden and society's ability to carry it. Table 6 shows one projection, by Dorothy Rice, of possible changes in the number of elderly persons with activity limitations and the number who will require nursing home care.

Table 6. Projected Change in Activity Limitations and Nursing Home Use, 1994–2030

	1994	2030	Percent Change
Elderly persons with limitations in activity			
Number	11,846	27,534	132.4%
Percent of all elderly persons	35.7%	39.2%	
Nursing home residents age 65 and older			
Age 65–84	766	1,643	114.5%
Age 85 and older	552	1,545	179.9%
Total	1,318	3,188	141.9%

Source: Rice, "Beneficiary Profile: Yesterday, Today, and Tomorrow."

Other analysts have arrived at very different projections. For example, the Brookings-ICF Long-Term Care Financing Model projects that 3.6 million elderly people will receive nursing home care in 2018—more than Rice projects for 2030.[19] A recent attempt by the American Council of Life Insurance (ACLI) to project the Brookings-ICF figures further into the future estimates 5.3 million elderly nursing home residents by 2030—66 percent more than the Rice estimate.[20]

Obviously these differences translate directly into different projections of future costs. For example, table 7 shows ACLI's projections of total nursing home spending and financing sources in 2030. The total of $330 billion represents a 362 percent increase over a year 2000 base of $69 billion.[21] But this projection assumes not only higher expected nursing home utilization, but also continuation of recent price trends. If instead the Rice utilization

[18] AARP, *Boomers Approaching Midlife.*

[19] Joshua M. Wiener, Laurel Hixon Illston, and Raymond J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance,* Washington, Brookings Institution, 1994.

[20] Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs: Expanding the Role of Long-Term Care Insurance,* Washington, American Council of Life Insurance, 1998.

[21] This base is derived from the Brookings-ICF estimates and appears to reflect utilization by the elderly only; it is lower than the 1996 National Health Expenditures series total nursing home spending figure of $78.5 billion.

projection were correct, and if nursing home price growth slowed to the rate of general inflation by 2020, spending would grow only about half as fast as the ACLI estimates suggest.

Table 7. Projected Nursing Home Expenditures in 2030
(nominal dollars)

	$ (billions)	Percent
Medicaid	134	41%
Out-of-pocket	158	48%
Private insurance	11	3%
Medicare	27	8%
Total	330	100%

Source: J. Mulvey and B. Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?*

Just as the magnitude of future long-term care spending is uncertain, so is the ability of the society to meet growing costs. The most recent Congressional Budget Office projections suggest that long-term care costs for the elderly might grow about 2.6 percent more rapidly than inflation over the next 40 years.[22] If economic growth is robust in the coming decades, spending increases at this level might be easily sustainable; if the economy stagnates, long-term care will compete with other social priorities for scarcer resources. Table 8, based on estimates by Robert Friedland, highlights the importance of assumptions about economic growth. If real gross domestic product (GDP) grows by only 1 percent per year, long-term care spending for the elderly would almost double as a share of GDP by 2030. If GDP grew by 3 percent a year, the share devoted to long-term care would actually drop.

Table 8. Long-Term Care Spending for the Elderly As a Share of Gross Domestic Product Under Different Economic Assumptions, 2000–2030

	2000	2020	2030
If real Gross Domestic Product grows by:			
1 percent per year	1.33%	1.89%	2.44%
2 percent per year	1.33%	1.47%	1.67%
3 percent per year	1.33%	1.20%	1.28%

Source: Robert B. Friedland, National Academy on an Aging Society, presentation at The Commonwealth Fund symposium, *Long-Term Care Options: For Now and the Future,* March 1999. Estimates based on CBO Projections.

Medicaid May Not Be Sustainable in Its Present Form

Medicaid is now the major source of payment for long-term care and serves as a safety net, not only for the poor, but also for middle-income elderly persons facing catastrophic costs. It will thus bear much of the burden for growing use of long-term care services. Because of shifts in the distribution of the elderly population, this burden will fall disproportionately on

[22] Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly,* Washington, March 1999.

states that are now spending relatively little on long-term care. As a result, the current federal-state division of responsibility may not be workable in the future.

As the preceding discussion has suggested, there is much uncertainty about how much the demand for Medicaid services will be increased by the aging of the population. Still, it is clear that, in the absence of policy changes, Medicaid will continue to be one of the fastest-growing components of both federal and state budgets. The Congressional Budget Office estimates that the federal share of Medicaid spending—including the acute care component of the program—will rise from one percent of gross domestic product (GDP) in 1997 to two percent in 2030. Federal spending overall is projected to grow from 22 percent to 25 percent of GDP over the same period.[23] Medicaid would thus account for a third of projected growth in federal spending as a share of GDP.

This level of growth, while high, is not necessarily unsustainable at the national level. However, Medicaid will be competing for federal resources with other programs and priorities—some of them, such as Social Security and Medicare, also driven by demographic changes. So there is likely to be growing pressure for restraint in overall Medicaid spending growth.

Perhaps a greater threat to the program is posed by the fact that growth in demand for Medicaid services is likely to be very unevenly distributed across states. Column two of Table 9 shows state spending on Medicaid long-term care per working age adult in fiscal year 1997.[24] As the table indicates, the state spending burden per working age adult already varies dramatically, from a low of $44 in Utah to a high of $462 in New York. This variation reflects current differences in the ratio of the elderly and disabled to the working age population, as well as differences in Medicaid eligibility, service coverage, and payment policies.

The table then shows the projected change in the ratio of elderly people to working age adults between now and 2025. Nationally, this ratio grows by 87 percent—that is, there will be nearly twice as many people over age 65 for each person of working age. But the rate of change is much greater in some states than in others—from just 24 percent in the District of Columbia to 193 percent in Utah, for example. Utah, the state that has been spending least on long-term care, will see the greatest probable increase in demand (assuming that demand rises with the elderly population). While there are exceptions, this is true overall: there is an inverse relation between a state's current spending per working age adult and the likely growth in its future long-term care burden.

[23] Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options,* Washington, May 1998. These estimates do not reflect CBO's more recent revisions in its shorter-term budget projections.

[24] Although Medicaid is not financed by payroll taxes, as Social Security and Medicare are, it is reasonable to assume that most state revenues are drawn from nonelderly adults.

Table 9. State Medicaid Long-Term Care Spending per Working-Age Adult, 1997 and Changes in Ratio of Elderly to Working-Age Adults, 1997–2025

State	Medicaid Long-Term Care Spending per Working-Age Adult (state share)	Rank	Ratio of Elderly to Working-Age Adults		Percent Change, 1997–2025	Rank
			1997	2025		
United States	$146.13		0.25	0.46	86.5%	
New York	$462.22	1	0.25	0.34	34.9%	49
Connecticut	$350.16	2	0.27	0.39	43.7%	46
Rhode Island	$308.95	3	0.30	0.42	39.5%	48
District of Columbia	$296.43	4	0.24	0.30	23.5%	50
Massachusetts	$279.24	5	0.26	0.39	47.8%	45
Pennsylvania	$254.25	6	0.31	0.43	40.7%	47
Minnesota	$252.92	7	0.24	0.46	94.7%	23
New Hampshire	$249.10	8	0.22	0.44	99.6%	20
New Jersey	$193.58	9	0.26	0.39	52.2%	43
Wisconsin	$176.66	10	0.26	0.46	78.8%	34
Ohio	$166.84	11	0.26	0.40	56.1%	42
Maine	$163.97	12	0.26	0.47	78.4%	35
Vermont	$162.10	13	0.23	0.44	95.6%	22
Nebraska	$153.71	14	0.28	0.50	81.3%	31
North Dakota	$147.92	15	0.29	0.53	81.9%	30
Washington	$147.48	16	0.22	0.55	152.4%	8
Wyoming	$146.59	17	0.22	0.60	169.0%	6
South Dakota	$139.28	18	0.29	0.54	85.4%	27
Delaware	$137.68	19	0.24	0.43	81.3%	32
Maryland	$134.95	20	0.21	0.37	79.2%	33
Hawaii	$130.07	21	0.26	0.47	83.9%	28
Missouri	$129.23	22	0.27	0.47	73.2%	38
Illinois	$127.55	23	0.24	0.37	51.8%	44
Colorado	$123.96	24	0.19	0.51	175.9%	4
Kansas	$119.83	25	0.27	0.47	75.9%	36
Alaska	$116.43	26	0.10	0.29	187.1%	3
Michigan	$111.96	27	0.24	0.37	56.2%	41
North Carolina	$110.14	28	0.24	0.53	124.4%	13
West Virginia	$108.23	29	0.29	0.49	69.4%	39
Montana	$105.93	30	0.26	0.63	140.9%	9
Iowa	$101.69	31	0.30	0.49	61.4%	40
Florida	$96.77	32	0.37	0.78	109.6%	15
Oregon	$96.44	33	0.25	0.64	155.4%	7
Indiana	$94.65	34	0.24	0.42	75.3%	37
Tennessee	$92.79	35	0.23	0.49	108.9%	16
Kentucky	$92.78	36	0.24	0.46	92.9%	25
Arkansas	$89.44	37	0.29	0.60	107.2%	17
Alabama	$88.22	38	0.25	0.49	96.8%	21

Table 9. State Medicaid Long-Term Care Spending per Working-Age Adult, 1997 and Changes in Ratio of Elderly to Working-Age Adults, 1997–2025

State	Medicaid Long-Term Care Spending per Working-Age Adult (state share)	Rank	Ratio of Elderly to Working-Age Adults		Percent Change, 1997–2025	Rank
			1997	2025		
California	$81.12	39	0.21	0.39	83.9%	29
New Mexico	$78.06	40	0.22	0.53	136.5%	11
Virginia	$77.67	41	0.20	0.42	104.7%	18
Texas	$74.53	42	0.20	0.46	132.8%	12
Oklahoma	$73.37	43	0.27	0.55	104.1%	19
Georgia	$72.18	44	0.18	0.44	137.2%	10
Idaho	$69.60	45	0.23	0.67	187.6%	2
South Carolina	$61.06	46	0.23	0.51	120.0%	14
Mississippi	$56.27	47	0.25	0.47	91.1%	26
Nevada	$47.78	48	0.21	0.59	174.0%	5
Louisiana	$46.73	49	0.23	0.44	94.3%	24
Utah	$44.09	50	0.20	0.58	192.8%	1

Note: The state long-term care spending figure reflects the state share of FY 1997 spending for nursing facilities, home health care, personal care, hospice services, home and community-based services (HCBS) waivers, and the PACE program, prior to disallowances, recoveries, or other adjustments. Payments for services in intermediate care facilities for the mentally retarded are excluded, but the included service categories, particularly HCBS waivers, include some spending for the developmentally disabled. Arizona is omitted because it capitates health plans for most long-term care services and does not break out this spending in the federal HCFA-64 report.

Source: IHPS, based on U.S. Bureau of the Census, Current Population Reports, Series P25-1130, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050,* 1996, and HCFA-64 reports (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program).

As a result, some states may face very difficult choices in the years ahead. To maintain the current level of services, they may need to significantly increase the tax burden on active workers. Alternatively, they may adopt cost-cutting measures that could reduce access to care. The latter possibility is particularly troubling, because some of these states may already provide more limited access to long-term care than the typical state. (Of the ten states with the lowest per-worker spending levels, six have no medically needy program.)

If demographic trends lead to a redistribution of the long-term care burden among states, there may be renewed calls for a reassessment of the federal and state roles in financing Medicaid long-term care. There have been proposals in the past for some sort of trade-off of federal and state responsibilities. For example, the Reagan administration suggested that the federal government might accept full financial responsibility for acute Medicaid services, while states would assume the entire cost of long-term care. States facing the greatest future increases in their long-term care burden might propose the reverse of this proposal: they might contend that the burden of an aging population should be spread more equitably among states. States that are already carrying a significant burden and expecting relatively smaller increases in the

future might instead argue that the projected demographic changes would actually work to promote greater equity. Short of full federalization of long-term care, there are less drastic financing reforms that might be considered. One option would be to modify the federal funding formula—which now considers only state per capita income—to include some measures of need, such as elderly population and population in poverty.

In the absence of any restructuring, states may seek to contain the growth in Medicaid long-term care spending through a variety of strategies, of which the most troubling may be supply constraints and reductions in payment rates.[25] In 1997, Congress repealed the Boren amendment, a 1980 Medicaid provision that set minimum standards of reasonableness for Medicaid payments to nursing homes. While the effects of this change are uncertain, it is possible that states will have greater flexibility to reduce payment rates, making Medicaid eligibles less attractive than other patients. If, at the same time, states constrain new construction to a point at which there is competition for available beds, nursing homes may refuse to admit Medicaid patients, as well as middle-income applicants deemed likely to spend down to eligibility in the foreseeable future.[26] Those that continue to accept Medicaid patients might press for relaxation of current quality standards.

In sum, while predictions about the future of long-term care tend to assume that Medicaid will continue to function as it does today, this assumption may be unwarranted. There may be pressure for federalization of the program—potentially opening a discussion of the overall role of the public sector in financing long-term care. Or the Medicaid safety net may erode, particularly in states facing disproportionate growth, jeopardizing access and quality of care.

[25] For a review of current state cost-containment strategies, see Wiener and Stevenson, "State Policy on Long-Term Care for the Elderly."

[26] For a discussion of this issue and of alternative approaches for maintaining access and quality under Medicaid, see Barbara Bolling Manard, *Repeal of the Boren Amendment: Background, Implications, and Next Steps,* Washington, Georgetown University Institute for Health Care Research and Policy, 1997.

ROLE OF PRIVATE LONG-TERM CARE INSURANCE

The insurance industry and some independent analysts contend that increased sales of private long-term care insurance is the best way to assure access to long-term care for all but the lowest-income elderly people. This section describes long-term care insurance, assesses the likelihood that it will play a significant role in financing long-term care for boomers, and considers policy options for promoting expanded use of this financing option.

LONG-TERM CARE INSURANCE TODAY

What Is Long-Term Care Insurance?

A private long-term care insurance (LTCI) policy provides payment towards necessary long-term care services. It may therefore seem to parallel health insurance, which pays for acute care, but LTCI is really much more like life insurance.

The premiums paid for a health insurance policy during a year cover average expected claims costs for the purchasers during that same year. The premium charged to a 40-year-old reflects annual average costs for 40-year-olds; the premium for a 50-year-old reflects average costs for 50-year-olds; and so on. In contrast, premiums for LTCI policies are set with the assumption that most buyers will pay premiums for some years before requiring services. A 50-year-old who buys LTCI may not need care until she is 80—or never. The rates are set on the assumption that she will go on paying premiums throughout the intervening years, thus building up a pot of money that will be available as the need for long-term care becomes more likely. So LTCI works much as life insurance does, by relying on the long-range accumulation and investment of premiums to meet a distant future cost. Also as with life insurance, the cost of the LTCI policy depends on how early in life one obtains it—younger people can be expected to pay into the pool for a longer period and their likelihood of needing services in the near future is low. Thus, a policy that might cost a 50-year-old $500 a year would cost an 80-year-old $5,000 a year.[27]

Several additional features of LTCI are should be noted for the following discussion:

- LTCI sold to individuals is subject to underwriting. Insurers use medical questionnaires, physical exams, or other screens to exclude potential purchasers thought to have a high likelihood of needing services in the near future. Underwriting is less common for policies sold to employer groups.

- Generally, the premium for LTCI is fixed for the life of the policy. Under most state laws, the insurer cannot increase the premium for an individual because he or she grows older or develops health problems after buying the coverage. However, the insurer may impose a general rate increase applicable to an entire class of purchasers.

[27] Based on Health Insurance Association of America Long-Term Care Market Survey, 1997.

- The coverage provided under most LTCI policies is indemnity coverage in the traditional sense. That is, the policy makes fixed dollar payments for each unit of service (such as a day of nursing home care) obtained, regardless of the actual cost of the service. One can buy a policy that will pay $75 per day of nursing home care or—for a higher premium—$100 a day, and so on. The per diem allowance usually differs for care in different settings. For example, a policy that pays $100 per day of nursing home care might pay $50 per day of home care.

- Because the cost of long-term care will rise over time, most policies offer inflation protection for an additional charge: for example the policy may provide that the allowable per diem payment will increase 5 percent per year.[28] Some policies offer only simple inflation protection; others compound inflation protection.

- LTCI generally pays benefits only for a fixed period—e.g., two years of nursing home care, three years, and so on. Those who buy more limited coverage are protecting their assets if, as is common, they require only a short nursing home stay. But they still face catastrophic losses and ultimate reliance on Medicaid if they exhaust their policy benefits.

- Many policies provide a "nonforfeiture" option, which allows a policyholder who stops making premium payments to recover some of the accrued value of the policy. For example, the policyholder who has stopped making payments may retain an LTCI policy with reduced benefits, or may receive term life insurance. This provides some protection to those who may not be able to continue payments if their income decreases or premiums rise. It may also reassure some buyers who are concerned about paying for a policy for years and getting nothing in return.

Growth in Private Long-Term Care Insurance

Private LTCI emerged in the early 1970s and has grown significantly in the last decade. The Health Insurance Association of America (HIAA) reports that sales of LTCI grew an average of 22 percent per year between 1987 and 1996.[29] As of the end of 1996, 4.96 million policies had been sold, an increase of more than 600,000 in 1996 alone. (Note that this is a cumulative total of policies ever sold, regardless of whether they remained in force in 1996.)

[28] Alternatively, the policy may provide that the policyholder can buy additional coverage at some future date. However, the policyholder would then pay a higher premium reflecting his or her age at the time of the additional purchase.

[29] Data in this and the next paragraph are from a statement by David H. Brenerman, "HIAA Statement: The Role of Private Long-Term Care Insurance in Financing Long-Term Care and the Importance of Offering Long-Term Care Insurance to All Federal Employees," before the House Committee on Government Reform, Subcommittee on Civil Service, Mar. 27, 1998.

While 80 percent of all policies were sold to individuals, an increasing number of employers are offering coverage. HIAA reports that 650,000 policies had been sold through 1,532 employers as of the end of 1996, accounting for 13 percent of all policies ever sold.[30] However, most employers made no contribution toward premiums; in effect, they were simply offering access to coverage at group rates. On average, only about 6 percent of active employees took advantage of available LTCI.

The benefits of individual policies sold vary considerably, in terms of duration of coverage, per diem allowances, and other features such as inflation protection. As might be expected, higher-income purchasers obtain more comprehensive policies. In 1994, for example, the average daily nursing home benefit in policies sold to persons with incomes below $20,000 per year was $77, compared to $92 in policies sold to persons with incomes over $50,000. Only 20 percent of purchasers with annual incomes of less than $20,000 obtained inflation protection, compared to 45 percent of purchasers with incomes of more than $50,000.[31]

Congress has recently taken steps to provide greater incentives for the purchase of LTCI. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made the federal tax treatment of LTCI more comparable to that of health insurance:

- LTCI benefits, up to certain limits, are not taxable as income.

- LTCI premiums paid by individuals may now be counted towards the medical expense deduction. Note, however, that this deduction is available only to itemizers and only to the extent that medical expenses (including LTCI premiums) exceed 7.5 percent of adjusted gross income (AGI).

- LTCI premiums paid by an employer, or long-term care benefits furnished directly by an employer, are deductible for the employer and are not taxable income for the employee. This rule does not apply, however, if the benefits are furnished through a cafeteria plan (under which an employee chooses among tax-exempt fringe benefits and taxable income) or flexible spending accounts (under which an employee may set aside pre-tax income to pay for certain types of expenses).

- The self-employed may deduct LTCI premiums whether or not they itemize deductions. As with health insurance, this deduction is limited to 60 percent of the

[30] The remaining 7 percent of policies consisted of riders to life insurance policies. HIAA reports that growth in the rider market is now minimal.

[31] HIAA Long-Term Care Market Survey, 1994. It is conceivable that lower-income purchasers are also older and therefore have less need of inflation protection.

cost through 2001 and 70 percent in 2002; 100 percent of the cost will be deductible in 2003 and later years, subject to dollar limits that rise with the age of the taxpayer.

Favorable tax treatment is available only for policies that provide certain consumer protections, including guaranteed renewability, inclusion of inflation protection and nonforfeiture options, and prohibitions against some types of benefit limitations.

Is Long-Term Care Insurance a Good Value?

Private LTCI is an efficient way for individuals to save for the eventuality of needing long-term care services. Because not every policy-holder will ultimately need services, premiums are considerably less than the amounts individuals would need to save if they hoped to provide for their long-term care needs on their own. Table 10 shows the American Council of Life Insurance's comparisons of LTCI premiums with the annual amount one would need to save in order to pay for two years of nursing home care at age 85. A 45-year-old could buy a policy with 5 percent inflation protection for $417 a year; the same person would need to save $3,557 a year through age 85 in order to accumulate enough to cover two years of nursing home care.[32]

Table 10. Ways to Pay for Future Long-Term Care

	Age Today	
	45 Years	60 Years
Option 1—Asset accumulation		
Annual savings needed	$3,557	$4,481
Lifetime assets needed at age 85 to pay for 2 years of nursing home care	$489,446	$235,432
Option 2—Purchase private long-term care insurance		
Annual premium contributions	$417	$883
Lifetime value of premiums	$57,907	$47,277
Potential savings from long-term care insurance		
Annual savings from long-term care insurance	$3,140	$3,598
Lifetime savings from long-term care insurance	$431,539	$188,155

Note: Calculations based on a 2-year long-term care policy with inflation protection of 5 percent. All numbers are represented in future dollars and assume a 7 percent return.

Source: American Council of Life Insurance. Note that this table is not identical to the similar table published in J. Mulvey and B. Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?* The figures in the column for 60-year-olds were revised by ACLI in response to a query from the author.

[32] The comparison may be slightly exaggerated. ACLI assumes that the individual who is using savings pays taxes on interest earnings as those savings accumulate. However, the individual could contribute to some form of tax-deferred annuity, and would thus need to contribute less each year to reach the required sum. The interest earnings would still be taxable when withdrawn. However, to the extent that the funds were used to pay for long-term care, the increased taxable income would be almost entirely offset by the medical expense deduction.

While private LTCI thus appears to be a sound investment, it has serious drawbacks, including underwriting, actuarial uncertainties, and inflexible design.

Underwriting. As noted earlier, insurers who sell LTCI screen out people thought to be at high risk of needing long-term care. An insurer may reject applicants because of past use of medical services, because they already have some degree of functional disability, or because they have chronic medical conditions such as emphysema or cirrhosis. One study estimates that between 12 and 23 percent of the population would be rejected under current underwriting criteria, assuming everyone applied at age 65. Between 20 and 31 percent would be rejected if they applied at age 75.[33]

It would be possible to regulate underwriting practices, as has been done for health insurance in the small group market and, in some states, the individual market. However, the same study suggests that insurers' screening criteria do in fact identify the highest-cost applicants. Limiting insurers' ability to screen out these applicants could therefore lead to significant premium increases. This problem is less serious if LTCI is purchased earlier in life. For example, relatively few applicants would be screened out at age 45, and an open enrollment rule applicable for this age group might have little effect on premiums.

Actuarial uncertainty. An insurance company actuary seeking to price a policy that will pay benefits decades from now faces all of the sources of uncertainty cited in the discussion, above, of long-range cost projections. How many policyholders will live to claim benefits? How many will become disabled, and at what age? What kind of care will they require? Insurers selling policies to 40-year-olds have no claims history on which to base their estimates and will not know for many years how good their prognostications were. (In addition, their pricing depends on assumptions, perhaps equally speculative, about the investment returns they can achieve in coming decades.)

This would appear to be a problem for the insurers, not the purchasers. However, even though buyers are in theory promised that they will pay the same premium for the life of the policy, insurers remain free to impose a premium increase if it applies uniformly to all policyholders in a class. The model long-term care insurance regulations promulgated by the National Association of Insurance Commissioners (NAIC) originally placed some limits on the amount by which an insurer could raise premiums over a given period. However, only 15 of 45 states that had adopted the model regulation in whole or in part as of November 1997 adopted the rate stabilization provisions,[34] and they have since been dropped from the model regulations. Even in the states that did adopt them, an insurance commissioner could waive

[33] Christopher M. Murtaugh, Peter Kemper, and Brenda C. Spillman, "Risky Business: Long-Term Care Insurance Underwriting," *Inquiry* 32 (Fall 1995):271–284.

[34] National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics,* Washington, 1997.

the limits in response to "[u]nforeseen changes … in long-term care delivery, insured morbidity, or insured mortality." Ultimately, then, consumers, rather than insurers, may bear the financial risk for bad guesses by actuaries.

Inflexible design. Some analysts have expressed concern that many LTCI policies are designed and priced on the assumption that, thirty years from now, services for the disabled elderly will be delivered in the same way they are today. As noted earlier, today's long-term care system is very different from the one that existed thirty years ago. People who buy LTCI policies today have no assurance that their coverage will give them access to new forms of care or services that may evolve in the future.[35] However, the industry has begun to address this concern. A number of carriers now offer policies that will provide fixed payments to a policyholder who meets specified disability criteria, such as requiring assistance with two ADLs. These payments will be made regardless of the actual cost of services obtained and might be used to pay for new types of services.

THE ROLE OF LONG-TERM CARE INSURANCE IN THE FUTURE

Insurance industry advocates and some other analysts contend that private LTCI could play an important role in financing long-term care in the coming decades. In this view, society would benefit in several ways if more middle-income people could be induced to buy coverage. Future demand for publicly financed services, particularly Medicaid, would be reduced. People would have superior access to long-term care of high quality and would be less likely to risk impoverishment.

These claims seem plausible enough, although there is disagreement about the potential of LTCI to reduce Medicaid spending (see below). The key question is how people can be persuaded to buy LTCI. Because premiums increase so sharply with age, relatively few of the elderly can afford adequate coverage, and even many of these may be screened out by insurers' underwriting practices. For this reason, there is agreement that LTCI would have the greatest impact if people would buy it during their working years, when rates are lower and underwriting rejections less likely. However, people in their working years have other spending priorities and have displayed little interest in buying LTCI.

Some people think that younger workers might be more likely to obtain LTCI if it were offered through their employers. As noted earlier, however, even in firms now offering LTCI, only 6 percent of workers buy the coverage. Moreover, it is difficult to see how employment-based LTCI can be made to work in an era when many workers have frequent employment changes. Workers who change jobs now often find that they must change health plans (or lose coverage altogether). If the same were true of LTCI plans, a worker who

[35] Joshua M. Wiener, "Can Private Insurance Solve the Long-Term Care Problems of the Baby Boom Generation?" Statement before the Senate Special Committee on Aging, Mar. 9, 1998.

changed jobs could lose his or her accumulated premiums in the former employer's plan (or receive only a limited nonforfeiture benefit, if this is made available). Even if the new employer offered LTCI, the worker would start over, paying premiums that would reflect a higher attained age and a new starting point for inflation protection. Therefore, unless some form of portability or vesting can be devised, employment-based LTCI is likely to make sense only for older workers who do not anticipate another job change before retirement.

Growth in LTCI for younger workers may, then, continue to depend on individual purchasing decisions. Proponents of LTCI offer two basic approaches to encourage greater participation. First, they would make the policies more affordable, chiefly by providing tax incentives or other subsidies for LTCI purchasers. Second, they would seek to educate younger people about the benefits of LTCI. Advocates of this plan point out that many people may not recognize the likelihood of potentially catastrophic expenditures later in life or may not be aware of the limitations in Medicare and Medicaid benefits. If people understood the risks, they say, the purchase of LTCI might become a routine part of planning for retirement and old age. The two strategies are necessarily interrelated, but for the purposes of this discussion, we will consider them separately.

Broadening Tax Subsidies for Long-Term Care Insurance

The clarifications of the tax treatment of LTCI in the Health Insurance Portability and Accountability Act of 1996 were of benefit only to a few groups—those whose employers are contributing to LTCI, rather than merely offering it; the self-employed; and those with medical expenses in excess of 7.5 percent of AGI.

There are proposals to provide broader tax incentives for the purchase of LTCI. For example, the tax bill passed by Congress in July 1999 would phase in an "above-the-line" deduction for LTCI premiums—that is, the deduction would be available to taxpayers who did not itemize and would not be subject to the current requirement that expenses exceed 7.5 percent of AGI. In addition, the bill extends favorable tax treatment for LTCI purchased as part of cafeteria plans and flexible spending accounts.[36] This would permit workers to pay their premiums with tax-free dollars and would presumably encourage the growth of employer-sponsored (but non-contributory) plans. (At this writing, the President is expected to veto the tax legislation.)

Either of these tax changes would have a greater effect on taxpayers in higher tax brackets. However, members of this group may already be more disposed to buy coverage or to accumulate assets sufficient to meet their own long-term care needs. In addition, it is difficult to justify a subsidy targeted at the highest income taxpayers.

[36] H.R. 2488, The Taxpayer Refund and Relief Act of 1999, sections 501 and 502.

An alternative that would spread the benefits more broadly would be to enact a tax credit, rather than a deduction, for the purchase of LTCI.[37] This would reduce the taxpayer's actual tax bill, rather than taxable income, providing the same benefit to buyers at different income levels. A more progressive option would be to provide an income-based subsidy for LTCI premiums, either through the tax system or through direct payment; this would target assistance to lower-income purchasers. For example, taxpayers with AGI up to a specified amount might receive a credit equal to 25 percent of LTCI; the credit would then be phased out for those with higher incomes, becoming unavailable when AGI exceeded some maximum threshold.

Any subsidy options would entail federal revenue losses that would eventually be partially offset by Medicaid savings. However, the revenue losses would be immediate, while the Medicaid savings would come far in the future. A recent simulation of the long-range effects of four different possible tax subsidy schemes found that all resulted in sizable net federal losses on initiation (projected as 1993) and fifteen years later, in 2008. Only one of the options approached break-even after 25 years, in 2018.[38] (No Medicaid savings are assumed in the Congressional Budget Office (CBO) cost estimates for H.R. 2488. It is not clear whether savings are expected only after the ten-year time span used in CBO projections, or whether the issue was simply not considered.)

Leaving aside the potential cost of subsidies, it is not clear that they would make the purchase of LTCI much more attractive than it already is. In 1995, the average federal taxpayer paid at a marginal rate of 14.7 percent.[39] An above-the-line deduction for the purchase of LTCI in that year would have reduced a $500 annual premium for a 40-year-old to $427. Allowing purchase through flexible spending arrangements would also reduce the taxpayer's liability for Social Security and Medicare payroll taxes—a $500 policy would then cost $388. It is not clear whether such price reductions would be sufficient to induce many more middle-income persons to buy coverage during their working years.

Even without subsidies, LTCI is already "affordable" for many younger buyers. ACLI estimates that 58 percent of those aged 45 to 49 could afford a five-year policy without any subsidy, assuming that one can afford the policy if the premium is less than three percent of the buyer's income. (The ACLI figures do not fully account for family size and the number of dependents supported by one person's income. A more reasonable estimate might be that

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[37] The long-term care tax credit proposed in President Clinton's FY 2000 budget is not related to LTCI. It is available to a taxpayer or dependent who actually needs long-term care during the tax year, and is unrelated to any actual spending by or for the individual.

[38] Wiener, Illston, and Hanley. The most successful option assumed an employer-based program with employer contributions of 50 percent of premiums. As employers are already limiting or reducing their contributions for basic health coverage, this assumption is highly optimistic.

[39] Internal Revenue Service, *SOI Bulletin,* Fall 1997, (rev. 11/97), table 3. The figure excludes the 24.5 percent of returns showing no income tax liability.

about 38 percent of individuals in this age range could afford a policy.[40]) Obviously the results would differ if some other criterion for affordability were used—say, five percent of income, or ten. What matters is how much each person is actually willing to spend. Thus, the second component of the private LTCI strategy—education about the need for LTCI—may be more important than any subsidy scheme.

Encouraging the Purchase of Long-Term Care Insurance

Whether or not they are making adequate provision for their retirement, most workers are at least aware that their security in later life depends on the arrangements they make today. As noted earlier, 82 percent of boomers are expected to have at least some pension income—a benefit which they have at least in theory obtained in return for a reduction in current wages—and about half are regularly saving for retirement on their own. If boomers were equally conscious of their likely need for long-term care, they might be similarly willing to forgo some current consumption in exchange for better protection later on.

Of course, the difference between saving for retirement and saving for long-term care is that retirement, for most people, is a happy prospect, while the need for long-term care is an unhappy one. People are likely to buy LTCI only if they fear some sort of disaster, so the core of any educational strategy would be to persuade younger workers that their need for long-term care decades from now is worth worrying about today. What, exactly, should workers worry about?

Asset protection. Some people who see the need for long-term care as a distant prospect may nevertheless be concerned about the potential drain on their assets at the end of life. This issue has been the focus of the Public-Private Partnerships (initially sponsored by the Robert Wood Johnson Foundation), a major initiative to promote the purchase of private LTCI. Under these arrangements, which are currently approved in eight states, individuals buy LTCI policies that meet specified minimum standards. If the policyholder receives long-term care and exhausts the benefits available under the private coverage, he or she can then obtain Medicaid under more liberal eligibility rules that protect an amount of assets equal to the benefits payable under the policy.

For example, suppose that someone with $50,000 in savings has an LTCI policy that covers $50,000 of care. That person might use up this benefit in a year of nursing home care. If the person then applied for Medicaid, the Public-Private Partnership would allow the applicant to retain $50,000 in savings, rather than the $2,000 maximum usually permitted under Medicaid rules.[41] Note that Medicaid doesn't lose anything—if the same person had not

[40] IHPS analysis, based on March 1997 *Current Population Survey,* and assuming that the income available for each member of a family equals total family income divided by family size.

[41] Most of the approved programs use this "dollar for dollar" model. Under New York's program, if the private LTCI covers three years of nursing home care, all assets are protected for persons needing Medicaid after the three years. Richard Price, *Long-Term Care for the Elderly,* Washington, Congressional Research Service, 1998.

purchased LTCI and had used up the savings to pay for a year of nursing home care, Medicaid would still have assumed responsibility at the end of that year. So the program is at worst a break-even proposition for Medicaid, [42] and potentially a winning one for the policyholder.

In theory, these programs lead to no actual increase in Medicaid spending, but they did give rise to a perception that public funds were somehow being used to protect private fortunes. The Omnibus Budget Reconciliation Act of 1993 (OBRA) requires that, in any new program not already approved as of the date of enactment, Medicaid must retain the right to recover any long-term care expenditures from the policyholder's estate, including the assets that were supposedly sheltered. Since this requirement eliminates the key feature of the partnership programs, some additional states that were preparing to replicate the original programs have abandoned their efforts.

While the OBRA policy could be reversed, it is not clear that the partnerships will have a significant effect. Of the states that have implemented programs, two have been unable to find any insurer willing to offer coverage under their program rules. In addition, states with active programs had only about 21,000 people with policies in force as of the end of 1996. [43] In any event, the real effects of the partnerships cannot be evaluated until well into the future. Most participants are fairly young—for example, the average age was 61 in Connecticut and 68 in Indiana—and are unlikely to require long-term care for many years.

Inadequacy of the current safety net. Many boomers might develop an interest in private LTCI if they understood the limitations of public coverage, particularly the chance that they could be impoverished and perhaps forced into nursing home care because of the current structure of Medicaid.

Of course, a public education strategy built around this concern only works if we assure that Medicaid remains inadequate, a point that will be considered further below. It is also unclear why creating a broader awareness of the shortcomings of Medicaid should lead to increased purchase of LTCI rather than to public pressure for improvements in the program.

These issues aside, it is at best uncertain how effective a public education campaign—launched in the midst of a sea of other messages about things people ought to be worrying about—would be. LTCI premiums will necessarily compete with workers' many other spending priorities, including growing out-of-pocket costs for current medical coverage. Absent some form of mandate or very strong tax incentives, it seems unlikely that many younger workers will buy LTCI in the foreseeable future. However, it is at least worth

[42] Price points out that Medicaid might actually achieve savings if participants are less likely to transfer assets or engage in other Medicaid estate planning schemes.

[43] University of Maryland Center on Aging, *Partnership for Long-Term Care Overview,* 1998 (www.inform.umd.edu.EdRes/Colleges/HLHP/AGING/PLTC/overview.html).

considering what the impact would be if the purchase of LTCI became routine among middle-income workers.

Will Private Long-Term Care Insurance Solve the Long-Range Financing Problem? If every American who could afford LTCI—however affordability is defined—bought coverage, reliance on both Medicaid and private out-of-pocket spending would be reduced. Table 11 shows the ACLI's projections of financing sources for nursing home care in 2030, with and without the vastly expanded purchase of LTCI.

Table 11. Financing Nursing Home Expenses in 2030: Two Scenarios

	Under Current Trends	With Increased Long-Term Care Insurance
Medicaid	41%	32%
Medicare	8%	8%
Out-of-pocket	48%	31%
Private insurance	3%	29%

Source: J. Mulvey and B. Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?*

The estimates assume that everyone age 35 or over buys a policy in the year 2000 covering at least two years of care if the policy is "affordable," and that three-fourths of purchasers continue paying for the policy through 2030.[44] As the projections indicate, the potential impact of private LTCI on public spending is limited. While there is a significant shift of costs to private LTCI, about two-thirds of the shift comes from out-of-pocket spending rather than from Medicaid. Medicaid spending is reduced by only 22 percent.[45] This is because many of the people projected to buy LTCI would already have been able to finance all their own care or at least, if Medicaid-eligible, to contribute substantially to their own costs. ACLI projects Medicaid spending will grow 143 percent in constant dollars between 2000 and 2030 without expanded purchase of LTCI, but Medicaid costs would grow 91 percent even with the expanded purchase. Meanwhile, there is no change at all in Medicare spending, because LTCI policies routinely exclude coverage of any services eligible for Medicare reimbursement.

So private LTCI solves only a fraction of the future public financing problem, even with the most optimistic assumptions. Moreover, it will take a long time to work. Remember that relatively few elderly people can afford private LTCI and that it will therefore be most effective if younger people are encouraged to purchase it. This would mean that LTCI might

[44] A policy is affordable if it costs no more than 2 percent of income for ages 35–44, 3 percent for ages 45–54, 4 percent for ages 55–59, and 5 percent for age 60 and older.

[45] Wiener, Illston, and Hanley show slightly larger savings in 2018 under certain scenarios; however, these savings are entirely offset by revenue losses from tax incentives for LTCI. The ACLI estimates assume no tax incentives.

begin to have a significant effect only when today's workers begin to reach the age at which they are likely to need long-term care—anywhere from two to six decades from now. There will remain the problem of how we will meet growing long-term care costs in the interim.

In short, we cannot rely on encouraging expanded purchase of LTCI as the nation's only strategy, or even its principal strategy, to address future long-term care needs. The private sector strategy raises some additional concerns:

Regressive financing. Because LTCI premiums do not vary with income, lower-income workers would need to set aside a higher share of their incomes to obtain the same protection as higher-income workers. This is true of private health insurance as well, but it is in contrast to the wage-based financing system for Medicare. An income-based tax credit could lessen the greater burden on lower-income buyers to an extent. (A flat credit would have no effect, while a deduction would make the system more regressive.) However, such a credit would be costly, and would probably offset any potential Medicaid savings.

Dual system of care. Under our current financing system, there is already a degree of economic segregation in the delivery of long-term care. For example, some nursing homes are reluctant to accept Medicaid patients because of low reimbursement rates. Still, 93 percent of all nursing home beds were Medicaid-certified in 1996,[46] because even patients who can finance their own care at the time of admission may eventually exhaust their assets and qualify for Medicaid. If more middle-income patients could finance all but the longest stays with LTCI, nursing homes would be likely to give preference to these patients; they might even withdraw from Medicaid entirely. This would leave a residual group of nursing homes that might serve the low-income elderly almost exclusively. The effect on quality of care could be significant. There is already evidence that facilities that have no private-pay patients have worse outcomes in some respects than mixed private/Medicaid facilities.[47] Quality in Medicaid facilities might deteriorate further if there were no Medicaid-financed middle-income residents. More globally, support for adequate Medicaid financing is likely to erode if fewer middle-income people have to face the possible prospect of relying on the program later in life.

[46] Rhoades, Potter, and Krauss, *Nursing Homes—Structure and Selected Characteristics, 1996.*

[47] W.D. Spector and H.A. Takada, "Characteristics of Nursing Homes that Affect Resident Outcomes," *Journal of Aging and Health* 4, n. 3 (1991):427–454.

THE SOCIAL INSURANCE OPTION

Our current system of financing long-term care exposes individuals and families to catastrophic losses and impoverishment, promotes institutionalization, and provides inadequate support to family caregivers. Expected growth in demand for long-term care, and the uneven distribution of this growth among states, raises concerns that Medicaid coverage may erode, further compromising access and quality. While private long-term care insurance could provide greater security for many middle-income people, its role in future long-term care financing will remain limited even under the most optimistic assumptions.

Although projections of future needs are subject to many uncertainties, it is likely that society will be spending considerably more on long-term care in the future than it is today. This spending is not discretionary; unless we are prepared to see increasing numbers of elderly and disabled people pauperized, inadequately served, or both, the bill will need to be paid. The issue is how it will be paid. How should spending be allocated between the public and private sectors? How should public expenditures be funded? What is the proper mix of public, individual, and family responsibility?

These questions were resolved more than thirty years ago in the cases of acute care for the elderly and many of the disabled. Medicare provides a basic level of protection to all elderly people, regardless of means. It is funded largely by taxes on current workers, with the understanding that their support for the program today is part of a covenant under which they can expect help as they in turn grow older and need more medical care. In addition, Medicare frees young adults from the worry of paying for their own parents' medical care. There are questions now about whether Medicare's sources of financing are adequate over the long run, and whether the program should be restructured to provide services more efficiently. Few, however, have questioned society's basic commitment to preserve the program and assure some minimum level of care to future generations of elderly people.

No equivalent commitment has been made in the area of long-term care. While current workers are paying much of the cost for such care through the general taxes that support Medicaid, they have no promise that their own needs will be met later in life. Those with sufficient means can try to secure their own futures through savings or the purchase of LTCI, although even they face impoverishment if their eventual long-term care needs prove too great. Others must ultimately rely on a welfare program that varies widely from state to state and that may be curtailed at any time.

Our current system of financing long-term care developed by accident, not design. There is no reason that we cannot reassess this system and plan more rationally for our future needs. Earlier in this decade there was considerable discussion of the possibility that the United

States should consider a social insurance program for long-term care. (While definitions vary, a social insurance program generally refers to a program that is government-operated or mandated and serves the entire population without a means or income test.) This discussion was muted by concerns over the federal deficit, a general antipathy to new "entitlements," and perhaps the failure of health-care reform. Meanwhile, the problem of long-term care financing has not gone away.

A social insurance option warrants renewed consideration. It offers a number of advantages over the mixed Medicaid/private insurance approaches currently under discussion. It also has drawbacks—some of them real, some largely a matter of perception.

ADVANTAGES

Universal participation and financing. Many working Americans could afford to set aside some amount of income to meet their own future long-term care needs, particularly if their savings were pooled through an insurance mechanism. However, it appears to be unlikely that many will do this voluntarily in the foreseeable future. Those who do not save are at high risk of having to rely on public support eventually. Under a social insurance program, every American could make a fair contribution to a universal pool and receive in return a guarantee that help would be available when he or she needs it. A universal program would have more stable political support than the welfare-based Medicaid system. Depending on the financing structure, such a program could also effectively increase the national savings rate, promoting long-range economic growth.

To the extent that a social insurance program might constitute a pool of savings, it poses some of the privatization issues now being raised with respect to Social Security. The arguments for and against these proposals will not be rehearsed here, except to note that consideration of a universal coverage scheme does not automatically foreclose discussion of a possible role for the private insurance industry. It is even possible that participants could make their contributions to private insurance plans instead of to the government. The only differences between this arrangement and the current LTCI system would be that participation would be mandatory instead of voluntary and contributions would be based on income, rather than on expected actuarial value of the plan for each participant.[48]

Uniform benefits. Medicare provides uniform acute care benefits to all elderly people, regardless of where they live; Medicaid programs vary dramatically in their eligibility, coverage, and payment rules. It is not at all clear why access to long-term care should depend on where one lives. While some state involvement in program design (e.g., to account for differences in delivery systems and residents' needs) may be justifiable, a social insurance

[48] Of course this would work only if every plan received an equal mix of high and low-income participants, or if funds were somehow redistributed among plans.

program could establish a national floor for long-term care benefits. One possibility is that a national program would provide uniform benefits without a means test, while state Medicaid programs would continue to supplement these benefits on a means-tested basis.[49]

Uniform quality standards. We have seen that there is a risk that our long-term care system will evolve into a two-tier system: there could be one standard of quality for people who have LTCI or other private resources and another, lower standard for people who receive Medicaid. With a universal program, everyone would have an interest in assuring that all participating providers were of the highest quality.

Improved coordination. Many disabled people who need long-term care also require extensive acute care. Under our current, fragmented financing system, no one entity manages the care of such cases across the entire spectrum of acute and long-term care services.[50] In addition, the system provides incentives for cost-shifting. State Medicaid programs and private insurers may seek to maximize the use of Medicare's nursing facility and home health benefits, while Medicare HMOs and other health plans may seek to limit these benefits, forcing enrollees to rely on Medicaid or their own resources. A national long-term care program could be integrated or coordinated with Medicare, as long as there is a mechanism to consolidate dollars from the two programs.

DISADVANTAGES

Cost. The greatest barrier to a social insurance program is that it will cost money, money that will have to be raised through some form of increased taxation or mandatory premiums. In light of the Medicare experience, there is reluctance to create another open-ended entitlement program. Should we make promises today that will place unpredictable burdens on future generations? One possible answer is that, as a society, we will incur most of the costs anyway and will pay them somehow. Social insurance would merely redistribute the burden—from individual savings to a universal insurance pool, or from state Medicaid programs to a national program. There are strong arguments for such a redistribution—in particular, the likelihood that it will be difficult to sustain the current method of financing Medicaid over the long run. At the same time, there are concerns that social insurance would increase overall spending because of induced demand; this issue is considered in the next section.

There is evidence that Americans are willing to bear at least some costs for expanded public long-term care coverage. For example, one recent survey found that 69 percent of

[49] President Clinton's 1993 Health Security Act provided for national minimum benefits funded through grants to states. However, as grant funds would have been limited, states would have been allowed to establish waiting lists for the program.

[50] A few states have begun small-scale experiments with integrated systems. These have been limited in scope, partly because of federal reluctance to turn control of Medicare funds over to states. (Wiener and Stevenson).

Americans would support the expansion of Medicare benefits to cover long-term care even when told that their taxes or premiums would go up.[51] Consciousness of long-term care needs is increasing, particularly as current workers confront the needs of their own parents. The willingness of younger people to accept the burdens of a more comprehensive long-term care financing system is likely to depend on two factors. First is the extent to which the program helps meet their parents' needs. Second is younger peoples' understanding that they have a stake in assuring that they will have access to care for themselves when they need it.

Induced demand. A major concern often raised about proposals to expand public coverage of long-term care is that the availability of paid services will lead many more people to use them. In particular, some argue that paid care would substitute for the informal care now given by family members, friends, or neighbors of the disabled. Of course, substitution could occur under private long-term care insurance as easily as under a public program. If a parent has either public or private coverage for home or personal care, the children might be less inclined to furnish it. In the long run, this tendency might drive up public insurance costs or LTCI premiums.

One might argue that, under LTCI, children would still have some incentive to continue furnishing care, because the premiums for their own future coverage would therefore be reduced. However, one could just as easily argue that, under a social insurance system, children would care for their parents in order to reduce their taxes. There is an obvious free rider problem in either case. For any individual, the burden of caregiving would presumably outweigh any marginal benefit in reduced taxes or premiums.

As a practical matter, the question may be academic in many cases. As noted earlier, the available pool of family caregivers for elderly people is likely to shrink in the future. Baby boomers are having fewer children, and the children they have may be less likely to live near their parents. Therefore, reliance on paid services may be growing anyway. Moreover, there is no clear evidence that paid care substitutes for unpaid care.[52] Finally, a social insurance program could include measures such as cost-sharing to discourage inappropriate utilization, and features like respite care benefits and other supportive services to encourage continued informal caregiving.

Benefits for the wealthy. By definition, a social insurance program (unlike Medicaid) would provide benefits to anyone who needed them, regardless of income or

[51] Henry J. Kaiser Family Foundation, "National Survey Suggests Need for Broad Public Debate About Medicare Reform: Americans Know Medicare Faces Problems, But Not Ready To Make Hard Choices," press release, Oct. 20, 1998.

[52] L.E. Pezzin, P. Kemper, and J. Reschovsky, "Does Publicly Provided Home Care Substitute for Family Care? Experimental Evidence with Endogenous Living Arrangements," *Journal of Human Resources* v. 31, n. 3 (1996):650–676.

savings. Is it fair to ask lower-income working people to pay higher taxes to support benefits for wealthier elderly people? In particular, should benefits be available to people who have savings of their own, so that public funds are used to help provide larger bequests to their heirs?

The first question, about income transfers, has been raised in connection with Medicare and Social Security as well. There have been numerous proposals to charge income-based premiums for Medicare or to make benefits taxable for wealthier elderly people. Already, Social Security benefits are taxable for people above certain income thresholds. A long-term care program could include similar measures, such as income-based cost-sharing or premiums. The key issue here is likely to be one of assuring fair contributions while maintaining the universal benefits essential to ensuring broad-based and stable political support for the program. (One of the key factors in the repeal of the Medicare Catastrophic Coverage Act of 1988, the nation's most recent major social insurance initiative, was a perception among middle- and upper-income elderly people that they were paying more and getting no real benefit.)

The second question, about protection of assets, tends to be asked only about long-term care. In a sense, all social insurance programs can be thought of as helping to protect some people's savings, and hence, their eventual estates. Medicare's acute care benefits allow some very sick people to avoid paying tens of thousands in hospital and physician bills; Social Security increases income and thus potential savings. Perhaps this issue is raised only with respect to long-term care because there is a perception that people who enter a nursing home will die there and don't need their savings any more, while people receiving Medicare leave the hospital and need their savings for a comfortable retirement. This perception is both largely untrue—many people are able to return home after relatively short stays in nursing homes—and irrelevant. If we don't ask people to consume their savings to pay for hospital care, there is no apparent reason that they should consume their savings for long-term care.

Private sector efficiency. Some people contend that the private sector can provide services more efficiently than a public program. This assertion will not be disputed here, even though there is considerable debate over the relative efficiency of public and private health insurance programs. It is important to note, however, that a social insurance program for long-term care would not preclude a role for private insurance plans.

This could work in the same way as it does under Medicare, where beneficiaries may choose between the public fee-for-service program and a variety of private health plan options, with the basic premium for the private health plan paid out of Medicare funds. A social insurance system for long-term care could offer similar options (or Medicare plans themselves could administer the long-term care benefit, potentially offering opportunities for

improved coordination of acute and long-term care services). However, it is important to distinguish the possible role of private plans in such a system from the role long-term care insurers play now. Private Medicare plans do not collect the revenues that go to finance the Medicare trust funds. The government collects those revenues and pays the plans to administer and assume current-period risk for benefits. Similarly, under this model, private long-term care plans would receive government payments for furnishing and managing services instead of accumulating over time the funds to be used to pay benefits, as LTCI insurers do now.

CONCLUSION

This paper has presented two broad options for meeting society's future long-term care needs. The first is to promote greater private responsibility by encouraging the purchase of long-term care insurance. The second is to increase the public role by supplementing—or replacing—Medicaid with a broader social insurance program.

Is it really necessary to choose between these two options? Are they mutually exclusive, or could we promote the purchase of private LTCI for those who can afford it and at the same time strengthen the safety net for those who cannot? While this may seem to be a reasonable middle course, the two strategies may be fundamentally incompatible. With the exception of people interested in estate protection, LTCI is now a reasonable purchase chiefly because the available public protection is inadequate—it provides limited access to care and exposes people to catastrophic expenses. Proponents of greater reliance on private LTCI concede that some public safety net must be maintained for lower-income people who cannot provide for themselves. However, that safety net must be designed to provide a continuing incentive for the purchase of private coverage. After all, if we were to improve public coverage to the point at which it provides care of acceptable quality to those who lack the resources to buy care on their own, there would be little reason for most people to make advance provisions for their care by buying LTCI.

Some analysts propose to resolve this paradox by providing public assistance to elderly people who never earned enough to provide for their own care, and denying coverage to those who earned enough but did not save (or buy LTCI).[53] This attempt to sort out the "deserving" and "undeserving" is not only draconian but impracticable. People's income and assets at the time they need long-term care are the product of what they have earned and spent and saved throughout their working lives and during the early years of their retirement. By the time people need long-term care, there is no way to determine why some people have resources and others do not. We could design a safety net that provides unacceptable care to everyone (as Medicaid arguably does today). But we cannot develop a system that penalizes only the "profligate" and maintains independence and dignity for hard-working and thrifty people who, for one reason or another, reach their retirement years with inadequate protection.

[53] Under a proposal by the Center for Long-Term Care Financing, working adults would decide early in life whether they would finance their own long-term care or rely on a public program. Those choosing the latter would report annually on their income and assets for the rest of their lives: "[N]o one who expects to receive public assistance in the future may spend, divest, divert or shelter wealth that could have been used to pay for long-term care." This provision necessarily implies some sort of annual consumption limit, or minimum savings requirement, for all adults throughout their working lives. And the enforcement mechanism appears to be denial of care later in life to persons who have not complied. Center for Long-Term Care Financing, *LTC Choice.*

At the same time, the private insurance strategy militates against improving access and quality for the segment of the population that must continue to rely on public financing. Encouraging those with adequate means to make their own provisions for long-term care will erode potential support for any efforts to assure access to care for those who are less well-off. The existing political support for Medicaid long-term care spending exists in part because most middle-class people are at some risk of having to rely on the program in the future. In contrast, people with private coverage are less likely to be concerned with maintaining the stability of Medicaid or the quality of services it provides. If the current financing system is ultimately unsustainable, the partial security of expanded private coverage may merely distract from the task of developing a more equitable and rational way of meeting long-term care needs.