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Working Paper No. 283

Financing Long-Term Care: Options for Policy

by

[Walter M. Cadette](#)

The Jerome Levy Economics Institute

For several years, Social Security and Medicare have been center stage in an ongoing national debate about the role of government in American life. Commission after commission has examined whether to amend the programs to make them more responsive to today's needs and, more important, to put them on sound financial footing ahead of the aging of the post-World War II baby boom. It is a matter of time before consensus--and, in turn, political will--as to what to do and how to do it emerge.

In contrast, little attention has been paid to the financing of nursing-home and other long-term care--a looming national problem coming out of the same demographics. During the next 30 years, the nursing-home population will more than double, not only as the baby-boom generation grows old but as continued advances in medicine extend life expectancy for many of its members into their late eighties and nineties. The down side of those advances is that many more Americans will live long enough to suffer from a chronic disease of old age like Alzheimer's and to require, in all too many cases, years of institutionalized care. Moreover, the cost of a nursing-home stay, which now averages upwards of \$50,000 per year, promises to continue to rise more rapidly than the price level as a whole. Expenditures for long-term care already have skyrocketed, having quadrupled in real terms since 1980 (chart 1).

The challenge of financing long-term care looms large even now, long in advance of the baby-boom generation's reaching old age. Traditionally, most of the care of the disabled elderly has been by family members--typically woman who have cared for their parents at home. With most women now in the paid work force, caring for disabled elderly parents at home will become even more difficult. Indeed, financing long-term care poses a formidable, even if neglected, challenge to the nation--and not a few decades hence when the baby boomers reach old age but in the immediate future when their parents do. It has already become a major workplace issue as employees--especially women--have become increasingly hard-pressed to juggle work and home responsibilities.

The nation is ill-equipped to deal with that challenge. Most long-term care is financed out-of-pocket, an option open to relatively few because of cost, and by Medicaid, the state-federal program for the medical care of the indigent which pays for nursing-home care after residents have "spent down" their assets (table 1).² Private insurance, in contrast, finances only a small fraction (7%) of long-term care.³ It has been hobbled by high cost and by the opportunity for middle-income Americans, who in all too many cases are able to end-run the spend-down requirements, to rely on Medicaid.

Table 1

Sources of long-term care financing, 1997
(Billions of dollars)

	Home health care	Nursing- home care
Total	32.3	82.8
Private	14.7	31.3
Out-of-pocket payments	7.0	25.7
Private health insurance	3.7	4.0
Other payments	3.9	1.6
Government	17.7	51.4
Federal	15.4	34.5
State and local	2.3	16.9

Source: "National Health Expenditures, 1997," *Health Care Financing Review*, Fall 1998, Vol. 20, No. 1

WELFARE MODEL BY DEFAULT

By default more than by design, the nation has fashioned a welfare strategy for long-term care, pushing Medicaid far afield of its original purpose of financing the medical care of the indigent, in particular those on Aid to Families with Dependent Children

and successor welfare programs. Strikingly, more than one-third of the Medicaid budget is dedicated to long-term care, most of which finances the stay of disabled elderly in nursing homes (Braden et al. 1998). The care of two out of three nursing-home residents is paid, in whole or in part, by Medicaid. Measured by patient days, the count is as high as 80%, reflecting the dependence on Medicaid of those in nursing homes for relatively long stays (Moses 1999).

Whether that large a slice of the Medicaid budget has crowded out the medical care of the poor for which the program was designed is hard to say. Congress, after all, has had the opportunity to vote appropriations that would cover both broad uses of Medicaid funds. Having the opportunity and taking it, however, are two different things at a time of spending constraints coming out of the large and once seemingly intractable budget deficits of the 1980s and 1990s.

A welfare model has also led to two-tier nursing-home care, with private payers, irrespective of their need for care, often given preferential treatment in admissions, and with Medicaid beneficiaries often consigned to second-rate facilities because state budgets do not stretch to pay comparable fees. Even in the best of circumstances, cross subsidies, which are inherently inefficient, result.

A welfare model, moreover, has been an open invitation to transfer assets to children or other heirs in advance of the need for nursing-home care. For some, this is indistinguishably different from any other "welfare cheating." For others, it is perfectly legitimate estate planning, akin to minimizing estate taxes.

Insurance--public or private or some combination of the two--would be a greatly better answer to the nation's long-term care needs. Indeed, long-term care is almost perfectly suited to an insurance model.

An extended nursing-home stay is a low-probability but high-consequence, event--the classic insurance risk. Two out of five Americans over the age of 65 are apt to spend some time in a nursing home (Kemper and Murtaugh 1991, cited in Moses 1999)--most of them, however, only for several months of rehabilitation following, say, hip replacement surgery or a stroke. Medicare ordinarily pays most of the costs associated with such a nursing-home stay. One in ten Americans over 65 will require nursing-home care for five years or more, however, and will incur costs that if paid directly from their own assets would bankrupt all but a small fraction of families. If every family were to try to save to meet the cost of such a stay, the resulting saving would be excessive. Pooling of the needed saving through insurance premiums is the natural economic response, but one frustrated by apparent market failure.

The challenge for government is to shift the financing of long-term care toward an insurance, and away from a welfare, model. Debate, as Wiener, Clauser, and Kennell (1995) has emphasized, should center on how to achieve balance between what people can reasonably be expected to provide for themselves out of private insurance and what they should be able to count on government to provide.

Either way, the costs will be large. The demographics, advances in medicine, and the often total dependence of the disabled elderly all but determine that--not the split between public and private responsibility. In all, long-term care spending (for paid home care as well as nursing-home services) is projected to increase some 70% in constant dollars during the next 20 years and some 70% again during the 20 years thereafter--almost tripling over the 40-year period (Congressional Budget Office 1999). Paid home care as well as care in an institutional setting, private as well as public expenditures, are projected to rise dramatically (chart 2).

Paid home care is unlikely to yield economies in the use of long-term care. Experience with publicly funded programs, which a decade or so ago were viewed as a means of keeping disabled elderly in less costly settings, points to little substitution. The experience, rather, has been that publicly paid home care has substituted for unpaid family care, and has added as well to the help available to the elderly. The difficulty of identifying who will enter a nursing home has made it difficult to target services to those who might be deflected from entering a home if generally less costly alternatives like home care were available (Kane 1994).

Chances are high, moreover, that the nation's spending for long-term care will exceed projections. With only a small fraction of the elderly in nursing homes, it would take only a small increase in the number of people in similar need to bring about a sharp increase in long-term care expenditures. The risk is especially large given the finding of the U.S. Department of Health and Human Services (1987) that: "For every person in a nursing home, there are two people outside with an equal level of disability."

Before more stress is put on an inadequate system, the nation would do well to consider alternative approaches to the financing of long-term care. This paper aims to contribute to that discussion by outlining the various possibilities and weighing their pros and cons. Its aim also is to point up the deficiencies of the current system. To assess the alternatives, it is important to understand how and why the welfare model is poorly suited to the nation's long-term care needs, especially as they are to expand significantly in years to come.

A FLAWED SYSTEM

While few Americans insure themselves against an extended nursing-home stay, the vast majority carry health insurance that protects them against small as well as large risks, including such high-probability but low-consequence events as a visit to a

doctor for a cold or the flu. Federal subsidies in the form of the tax exclusion of employment-based health benefits have powered the spread of ordinary health insurance (Cadette 1997), while the market for long-term care insurance has been without subsidy as well as hobbled by high cost and relatively easy access to Medicaid. Only recently have tax benefits been extended to the purchase of long-term care insurance. They are, however, quite limited.⁴

Also among the reasons why private insurance has failed to play a major role in the financing of long-term care, survey data indicate that many Americans believe that Medicare will pay for the cost of an extended nursing-home stay. Medicare reimbursement, in fact, is limited to short stays for rehabilitation after an acute-care illness; extended stays are the responsibility of the residents themselves or of Medicaid after the spend-down of assets.

The cost of insurance is also greatly higher than it might be:

- The advantages of pooling, which distributes insurance risk and thus lowers the cost of insurance, are not there. Long-term care insurance is far down the priority list of middle-age adults, and presumably at the very bottom of the list of people in the twenties and thirties. The insurance pool is thus narrowed to those for whom long-term disability is a distinct possibility--something that greatly increases premiums. (The typical buyer of long-term care insurance is 69 years of age, and pays an annual premium of \$1,800 for a daily nursing-home benefit of about \$85--adequate in many states to cover most nursing-home charges although woefully short of what is needed in states like New York where daily charges range upwards of \$250. (Health Insurance Association of America 1996)).
- Administrative costs are inordinately high. Commonly, 60% of the first year's premium is dedicated to sales, marketing, and other administrative expenses; as much as 10% of subsequent years' premiums (Cutler 1993). Typically, the marketing is to individuals, rather than to groups which would both reduce overhead and generate economies through pooling.
- Bundled pricing introduces moral hazard--the tendency for insurance to be called upon if available (the cost of food and lodging, for example, is imbedded in the cost of a nursing-home stay). And so does decision-making by the children of the disabled elderly, who in many cases would not have their parents pay privately for nursing-home care were it not for the ability to call on insurance benefits to pay for it. (Clearly, moral hazard is rife in nursing-home use for rehabilitation after surgery or a stroke under Medicare. Almost always, residents return home on the very day when Medicare reimbursement runs out and out-of-pocket payment must begin.)
- Adverse selection (an information advantage by the insured vis-à-vis the underwriter) makes it even harder for insurers to generate economies from pooling. When insurers cannot readily distinguish low risks from high, the coverage that can be offered to low-risk consumers is inadequate to be attractive to high-risk consumers (Wolfe 1993). Alternatively, it is too expensive to be attractive to low-risk consumers. Either way, an equilibrium price is hard, if not impossible, to strike.

Both over- and under-pricing thus characterize the market. For consumers, under-pricing has been the greater danger; it has often led to an insurer's abandoning the market and pocketing the accumulated equity after subscribers, facing sharply higher premiums, have allowed policies to lapse. Limited staffing and lack of experience with long-term care insurance in state insurance departments have compounded the problem (Lutzky and Alecxih 1999).

The answer to such market failure is to attract consumers when they are relatively young, before health problems that might give rise to the need for long-term care begin to surface. The earlier the insurance is bought, the less the insured will know about the risk of disability later in life, which will limit adverse selection and make it less difficult for buyer and seller to strike an equilibrium price. The earlier the insurance is bought, however, the larger the risk premium created by the passage of time, particularly against the background of the high and uncertain inflation of several decades. Variability in the future price of care is a risk insurers cannot diversify. Insurance markets function well only when the primary component of risk is cross-sectional. Intertemporal risks cannot be diversified since they involve aggregate rather than cross-section hazard (Cutler 1993).

Insurers have attempted to contain risk premiums by offering policies stipulating a given dollar payoff rather a given level of care--a reasonable approach from their perspective but one that often provides too little coverage to be attractive to high-risk consumers. Whether they be high- or low-risk, those who want to protect themselves against the cost of an extended nursing-home stay--cannot know how much insurance to buy and how much to save through other vehicles.

PERVERSE INCENTIVES

Medicaid itself is a major, if not the most important, impediment to the growth of the long-term care insurance market. All but very high income families presumably ask themselves: "Why pay for long-term care insurance when Medicaid ensures virtually everyone against an extended nursing-home stay?" Medicaid, in effect, is universal long-term care insurance--albeit with an outsized deductible (all of the insured's financial assets but for several thousand dollars in the case of those who are unmarried) and a similarly outsized co-payment (all of a nursing home resident's income but for a small allowance for personal items like a haircut and a magazine subscription).

Asset and income limits are designed to ensure that Medicaid funds go to those with the greatest need. Most nursing-home residents become Medicaid-eligible early on in their nursing-home stays or are already on Medicaid when admitted--no surprise considering the high cost of nursing-home care and the relatively high poverty rate among the so-called old-old (those over 85 who make up about half of newly admitted residents). While the incidence of poverty among the over-65 population

has trended down since the mid-1960s, particularly as Social Security benefits have risen in real terms, it has remained quite high among the old-old.

Medicaid funds are directed, however, to many not in greatest need. Asset and income limits have given rise to a whole industry of estate planners adept at helping people meet the letter, although not the spirit, of the limits. With every application for Medicaid, there must be proof that assets--whether real or financial--were not transferred to others during the previous three years, the so-called look-back period. A fortune can be transferred as long as that is done three years or more before the Medicaid application.

Trusts, outright gifts, and other means of effectively transferring assets (e.g., purchase of a luxury automobile, expensive jewelry, a house, or other assets exempt from the spend-down requirements) have become commonplace. Ironically, the higher the per capita income of a state, the more elaborate the estate-planning designed around securing Medicaid eligibility for the nonpoor elderly.⁵

Even without any advance planning, considerable wealth can be transferred without compromising Medicaid eligibility. Indeed, half of a nursing-home resident's financial assets can be sheltered from the spend-down requirement as long as the assets are transferred before an application for Medicaid is submitted--one of the key findings of a task force on Medicaid operations in New York State (New York State Department of Health 1996, cited in Cassidy 1998). States are required by the federal government to impose waiting times for Medicaid eligibility by dividing the dollar amount of any assets transferred within the look-back period by the average monthly charges of a nursing home in that state. A nursing-home entrant thus can transfer half of his or her assets before applying for Medicaid, and use the remaining assets--until they are exhausted--to pay privately for nursing-home care.

If, for example, \$50,000 of a \$100,000 nestegg is transferred to a son or daughter when a parent enters a nursing home in a state where costs average \$5,000 per month, and the remaining \$50,000 is used to pay privately for ten months of care, the parent would become Medicaid-eligible after those ten months because the waiting period as well as the ability to pay from the remaining funds would end then. At the end of the process, half of the nestegg will be in the hands of the next generation; the nursing-home resident will qualify for public assistance; and both the general taxpayer and the subscriber to long-term care insurance will have paid a high price to fund "middle-class welfare."

It is not easy for the authorities to prove intent, nor to recover the transferred assets through the courts. Meanwhile, the nursing home (for which the state has oversight responsibility) must pay its bills, and the resident--who is often cognitively impaired and neither morally nor legally responsible for end-running the rules--has to be cared for.

The New York task force found that half of the state's nursing-home residents had succeeded in sheltering some assets.⁶ A similar finding came out of a nationwide GAO report (U.S. General Accounting Office 1997, cited in Cassidy 1998). An Illinois study concluded that penalty periods specified in federal law for the transfer of property were rarely enforced (State of Illinois, Office of the Auditor General 1993, cited in Moses 1995). Staff determining Medicaid eligibility estimated, however, that 75% of the cases in Chicago had involved property transfers; 50% in suburban offices (Moses 1995).

It is hard to imagine a system more tailored for the abuse of the elderly. Surrender of assets to children deprives the elderly of their financial freedom--and along with that the broader freedom to make their own decisions about their care that money makes possible. While generally perfectly reasonable in a welfare model, spending down to qualify for Medicaid in a nursing home has made many elderly vulnerable to their children's greed as well as their own infirmities.

PREFERENCE FOR PRIVATE PAYERS

While the majority of Americans can rely on Medicaid to pay for long-term care, private insurance and Medicaid are far from perfect substitutes. Private insurance provides asset protection for heirs, which Medicaid--at least according to the rule book--does not. More important, private insurance provides greatly more financial protection for a spouse. Under Medicaid rules, the spend-down is joint, although the assets and income that the spouse who remains in the community may retain are larger than if the nursing-home entrant were single or widowed. Approximately \$80,000 of financial assets and the income considered sufficient for the community spouse's needs--which varies by state and with particular circumstances--may be retained. Typically, the ownership of a family home is not affected, although many states attempt to get possession of real property when both the community spouse and the nursing-home resident die.

Assets of \$80,000 or so may be a large sum to many. But, for others, spending down to that level is tantamount to impoverishment. And the income limits, especially for a relatively young spouse, can create genuine hardship. The resulting defense is fictitious, even if legal, divorce or "spousal refusal" to pay nursing-home bills as they come due.

All in all, the financial burden on a spouse of a long-term care system that relies almost exclusively on out-of-pocket payments and on welfare can be very large. No such burden, however, is put on a son or daughter. No one has a legal financial responsibility to pay for a parent's nursing-home bills, nor does Medicaid impose one. The same holds true for a parent who has a disabled adult child.

Private payment, moreover, can buy entry into the best facilities, whereas Medicaid beneficiaries often get refused. Not

infrequently, those facilities cannot cover the cost of caring for a resident from the amount a state government is prepared to reimburse under Medicaid, which typically pays 20% to 30% less than the private-pay charges. With most nursing homes privately owned and operated, it is a straightforward business decision to accept the private payer over the Medicaid beneficiary. "Certificate of need" regulations, which govern the supply of nursing-homes beds and effectively keep the nursing-home industry operating with little or no spare capacity, make that an easy decision.

The Clinton administration has proposed legislation that would prohibit nursing homes from requiring residents to leave once they had spent down and became eligible for Medicaid. More than any other, this practice points up the vulnerability of Medicaid beneficiaries in a two-tier care regime. It also points up the financial squeeze on nursing homes that results from Medicaid reimbursement rates that in all too many cases fail to cover the cost of quality care.

State regulation offers limited defense against two-tier care. State governments, to be sure, regulate nursing homes in elaborate detail, imposing standards on all facilities. The regulators, however, necessarily concentrate on variables that can be easily measured and checked: number of lights in a hallway, the height of a table or chair, number of staff with this credential or that. What makes a facility genuinely first-rate is harder to measure. It often eludes regulatory oversight.

Insuring quality care for Medicaid beneficiaries will become even more difficult in the future now that the Balanced Budget Act of 1997 has entered into force. Among its provisions for economizing on federal health-care spending, it repealed the Boren Amendment, a 1980 amendment to the Medicaid Act which in the past had provided some measure of quality assurance to Medicaid beneficiaries in nursing homes. The amendment required that Medicaid cover the costs needed to operate a home in conformity with federal as well as state standards. Now, states will have almost complete freedom to set reimbursement rates. With those rates already low relative to the cost of first-rate care, Medicaid beneficiaries will go further back in the queue for acceptance at the most desirable facilities.

INSURANCE OPTIONS

Replacing a welfare model with an insurance model would mute, if not remedy, all of these problems. It would cut down on two-tier care practices, on the temptation to transfer assets by middle- and even some high-income people to commandeer limited welfare funds, and on the impoverishment of those who have been willing to "play by the rules." The major concern in this last respect is for community spouses whose resources are depleted in the process. But it is also for those nursing-home residents (admittedly a small minority) who eventually are in a position to return home. Spending down under Medicaid makes it all the more difficult for them ever to live independently again.

The welfare of all the elderly disabled in need of Medicaid benefits is at stake, however, because of two-tier care practices--a problem that promises to worsen as economies mandated by the Balanced Budget Act, for Medicare as well as Medicaid, take full effect over coming years. The broader concern is for "honest government"--one that not only does not fund inheritance protection but that also genuinely protects those with greatest need.

What is called for is a set of policies that would overcome the failure of today's long-term care insurance market. High on the list would be measures that would bring the benefits of pooling to that market to bring down cost. Administrative costs, moreover, promise to be lower under an insurance model than under a welfare model. Of necessity, Medicaid dedicates much of its budget to the enforcement of income and asset eligibility rules that have proved not only difficult but costly to enforce.

Long-term care insurance would remain unaffordable for many, just as ordinary health insurance has. Some form of safety net would have to remain in place--whether subsidization of insurance for those at low and moderate income or Medicaid itself, much as it currently exists. Clearly, however, an insurance model cannot be developed unless the majority of Americans needing long-term care--unlike now--cannot turn to a safety net in the first instance. Medicaid or other safety net funds ought to be reserved for a minority of those needing long-term care--not used, as today, by the majority.

SUBSIDIZING INSURANCE BUYERS

One option would be for government to subsidize the premiums of those who purchase long-term care insurance--either directly or, more likely as a practical matter, through the tax system--in order to promote the development of the market. The subsidies would be voluntary; the insurance they would help buy would be bought like any other private insurance.

Subsidies could be keyed to income under an income-scaled tax-credit arrangement, for example. Or they could be extended to all purchasers through tax deductibility of premiums, which would benefit all by lowering the after-tax cost of the insurance.

Subsidies that would enlarge the long-term care insurance market could well economize on government's long-term care bill, as they could wind up shifting more of the total bill onto private payers. In comparison with Medicaid's cost to support a resident in a nursing home (or even government's cost to provide home care), the subsidies would be shallow. But they would be extended to many more people, including those--presumably the vast majority of new purchasers brought into the market--who would never have reason to call on the subsidized insurance.

Economies possible through extensive, but relatively shallow, subsidies have prompted a number of states (New York, California, Connecticut, and Indiana) to fashion "partnership" programs that allow people who purchase a certified long-term

care insurance policy to deduct the proceeds of those policies from the spend-down necessary to establish Medicaid eligibility.⁷ New York requires that a participant purchase three years of nursing-home coverage, after which Medicaid eligibility can be established without an asset test. California and Connecticut operate a dollar-for-dollar program, under which insurance proceeds are deducted from the spend-down requirement. Indiana has adopted a hybrid of the two; asset protection depends on the extensiveness of the insurance coverage (McCall and Korb 1998).

Partnerships effectively reduce the price of long-term care insurance to participants--a key element in any strategy to replace a welfare with an insurance model. Participants, in effect, can get considerably more long-term care insurance coverage than they need pay for--an outcome no different in kind from direct subsidization of the premiums themselves.

Despite the subsidization, partnership arrangements have been disappointing. They have not given rise to significant expansion of the long-term insurance market where they have been tried, even in New York where the wealthy can buy virtually unlimited inheritance protection for a relatively small premium. Partnership arrangements have attracted some into the long-term care insurance market, but about two-thirds of the participants, the experience has been, would have bought the insurance on their own. More important, the absolute number of participants remains minuscule (Wiener and Stevenson 1998).⁸

Partnerships do not address head-on the formidable forces that have kept the long-term insurance market small and underdeveloped. Inadequate pooling remains a serious problem. The need for long-term care coverage looms no more pressing to the young and middle-aged because of partnership-type inheritance protection. And, for the elderly, calling on a certified long-term care policy in a partnership state is a prelude to becoming a Medicaid beneficiary anyway. Even if partnerships provide protection for estates, they require following all the rest of the Medicaid's poverty-oriented rules like stringent income limits.

Adverse selection, moreover, plagues partnership arrangements, just as it does ordinary long-term care insurance. Many of those at high risk presumably are even more willing to buy it because of the implicit reduction in price. Those at low risk apparently have not found inheritance protection enough of an enticement to buy insurance intimately linked to Medicaid. The underlying problem is that, at least as of now, the appeal of long-term care insurance is limited to those at relatively high income--the most important segment of the market but one that is understandably unwilling to take its chances on the care available to Medicaid beneficiaries or to accept the welfare stigma that Medicaid traditionally has carried.

Both inadequate pooling and adverse selection would remain under just about any kind of voluntary system for promoting long-term care insurance--including making premiums tax-deductible, an increasingly popular option on Capitol Hill. Tax deductibility, moreover, would create serious problems of its own. The tax exclusion of employment-based health benefits has been a major force behind the rapid rise in health-care costs over the years. It pushed health insurance in the direction of increasingly comprehensive benefits and, then, as moral hazard would have confidently predicted, overuse of those benefits as if "free." It also extends the largest subsidies to those at highest income because of the progressivity of the tax system (Cadette 1997).

MANDATING INSURANCE WITH TAX-CREDIT SUPPORT

A second option would be to require Americans to carry long-term care insurance--and for precisely the same reasons participation in Social Security and Medicare is compulsory. The argument is the same: Voluntary saving is inadequate to finance the needs of those over 65 for retirement income and for medical care; meeting those needs is a desirable societal objective; forced public saving is therefore reasonable to impose.

Clearly, private saving is inadequate to the task of caring for the disabled elderly. It finances, both out-of-pocket and through insurance, only about 40% of what is needed. The rest comes mainly from general public-sector revenue--a reflection of a societal consensus about the need. By default, the rationale would be, society at large has become the major payer of the nation's long-term care bill; it may as well therefore use its status as payer to bring about a financing regime more in keeping with the broader--and, indeed, already acknowledged--public interest.

Opinion will differ as to whether requiring people to carry long-term care insurance would be a legitimate use of the power of the state. But there is precedent for compulsion in auto insurance as well as in Social Security and Medicare. The "free rider" problem that justifies making auto insurance compulsory plagues reliance on Medicaid for long-term care just as well.

As a practical matter, private insurance coverage could not be mandated unless it could also be made affordable to those at low and moderate income. The idea would be to require all adult Americans to carry a specified amount of long-term care insurance (enough, say, to make a claim for Medicaid unlikely), or to substantiate that they are in a position to self-insure their own long-term care. The premiums of those at low and moderate income could be paid through tax credits, at least in part. The credits, which could be made refundable if there were no tax liability, would pay 100% of the premium for a couple whose adjusted gross income was, say, \$20,000; 50% of it at an income level of, say, \$60,000; none of it at an income level of, say, \$100,000.⁹

The tax credits could, instead, be calculated in dollar amount. That way, the cost of long-term care insurance paid out-of-pocket would not rise as people age and necessarily face higher premiums for the same coverage. The choice is between using tax credits to create an insurance plan whose premiums would rise with actuarial risk and one that, like Social Security and

Medicare, would transfer income across generations.

Requiring Americans to carry long-term care insurance would end the routine claim on Medicaid for long-term care. And it would greatly reduce the price of long-term care insurance, as it would bring into the market both young adults and the middle-aged to form a large risk pool. Income-scaled tax credits to make such a requirement affordable would target subsidies more effectively than do partnership arrangements or tax deductibility.

Social insurance would yield these same outcomes. And there need not be much, if any, difference between the two approaches for the distribution of income. How that would be affected would depend on the revenue sources chosen; the levels of the tax credits and whether they were adjusted for age; the nature of the coverage under social insurance; and other particulars.

A mandate would be significantly different in one key respect from social insurance. It would put the responsibility for long-term care back in the private sector--in a clear break with today's undue dependence on Medicaid. It would be workable, however, only because of public funding in the form of a sliding-scale tax credit.

Social insurance would also represent a clear break with the past. It would establish long-term care as an earned right, much as it would be under private insurance. Most nursing-home care is provided in the form of public charity, after the passing of a means test, which is all too prone to "gaming." Hospitalization for an acute-care illness of someone over 64 on Medicare, in contrast, is an earned right, not subject to a means test.

All of the benefits of an insurance model--most importantly, pooling--come to the fore if the insurance is social in nature, just as if it is private. And there is an added plus: exceedingly low administrative costs, which are apt to be distinctly lower than would be possible in the private market. Government, moreover, would be in a position to adjust, ex post, the taxes needed to finance social insurance in a way private insurers could not adjust premiums (Cutler 1993). Government, in effect, would be better able to deal with the intertemporal risks insurers find it difficult, if not imprudent, to assume.

COST PROBLEM WITH SOCIAL INSURANCE

Wiener, Illston, and Hanley (1994) have estimated that funding a social insurance plan by means of payroll taxes to provide comprehensive nursing home coverage (and expand access to home care at the same time) would require a tax rate of almost 3% today, almost 4% by 2018. The tax rate, moreover, would be without ceiling on taxable wages. And it would rise sharply after 2018 to reach almost 8% by 2048 when, because of the aging of the baby-boom generation, the demand for long-term care would reach a peak.

These estimates, it should be stressed, incorporate the cost of financing current public programs for long-term care, which today is about 1 1/2% of payroll (as compared with the almost 3% under a comprehensive social insurance plan). The new payroll taxes would replace the claim on general revenue now made by Medicaid (which would also rise sharply after 2018 because of the same demographics). They would also replace that part of the Medicare tax rate that finances home care and post-acute care in a nursing home--that, too, projected to increase significantly as the baby-boom generation ages.

In time, the new payroll taxes would become quite large: almost 8% of payroll by 2048 as compared with an estimated 3 1/2% if current public programs were simply continued--still roughly double current-policy costs but on a much larger base. Financing a comprehensive social insurance plan for long-term care may not require a greatly higher overall tax rate in the near term of the next few years or even 20 years out--a simple reflection of the role Medicaid now plays in financing long-term care and of the relatively benign demographics ahead for a while. But it would require quite a large increase in the overall tax rate--some 4%-plus of payroll, some 3%-plus of GDP--eventually. The increase, moreover, would come on top of any new payroll taxes needed to put Social Security retirement and Medicare on sound financial footing.

REDUCING COST WITH PARTIAL COVERAGE

The nation could, however, move a long way in the direction of an insurance model for long-term care without launching a comprehensive social insurance plan or without making a commitment to similarly costly subsidization of compulsory private insurance. The policy challenge is to move in that direction at reasonable cost.

One approach would be to limit public funding of long-term care to "front-end" coverage--to expenses incurred in, say, the first six months or first year in a nursing home.¹⁰ Social insurance, which could be applied to home care as well as nursing home bills, would end after six months or a year. Alternatively, any subsidies to buy the requisite private insurance would be limited by the premiums on policies that had quite short payoff periods. After that, people would have to pay for long-term care out-of-pocket, call on additional but unsubsidized insurance, or, as a last--not first--resort, turn to Medicaid.

The focus of this approach is on nursing-home residents who could reasonably be expected to live independently once again, and who remain financially independent enough to be able to do so because they were able to rely on insurance benefits to cover much or all of the cost of a short-term nursing-home stay. Even a relatively short stay in a nursing home--unless it follows an acute illness and is thus paid for by Medicare--can easily compromise that prospect.

The alternative would be to fund the "back end" through the public sector. Social insurance or private insurance bought with income-scaled tax credits would kick in only after a specified time--again, for purpose of illustration, six months or a year.¹¹ It would be a form of "catastrophic" coverage; people would be responsible for funding the front end on their own. The objective would be to foster seamless long-term care coverage, in much the same way Medicare has given rise to supplementary health insurance policies to finance the acute care Medicare does not reimburse.

THE DOWN SIDE OF PARTIAL COVERAGE

However useful in limiting the public cost of moving to an insurance model, both front-end and back-end approaches are far from ideal.

The minority of nursing-home residents in a position to return home would benefit if the front end were financed by insurance. But others would not. And it is not at all clear that such limited coverage--whether through social or subsidized private insurance--would do all that much to spur the development of an insurance market for the back end. The net effect could well be quite small in the total picture, leaving the nation with Medicaid as the mainstay of long-term care financing.

The back-end approach has more promise for systemic change--in particular, for encouraging people to buy supplementary policies. But many low- and moderate-income Americans would not be in a position to do so; they would still have to turn to Medicaid to pay the front-end costs.

More important, back-end coverage would benefit heirs in a way that is wholly inconsistent with the use of public funds--something that raises serious question about any social insurance mechanism, which by its nature distributes benefits as an earned right without regard to income. This problem could be dealt with if deductibles and co-payments were scaled to income. That, however, would mute the insurance (and build up the welfare) character of any social insurance mechanism.

Estate taxes, Wiener, Illston and Hanley (1994) have argued, could (and probably should) be used to finance back-end care, for precisely that reason. It is not at all clear, however, how much scope there is for a rise in estate taxes beyond levels that many believe have become confiscatory, especially as they affect family-owned businesses. With the federal estate-tax deductible now scheduled to rise to seven figures, many quite significant estates would be protected by social insurance for back-end care unless that deductible were cut substantially. Financing social insurance for back-end care by means of estate taxes would eliminate the gaming that now plagues Medicaid. But public money would still be directed to ends that are hard, if not impossible, to justify.

Inheritance protection is much less of a problem for income-scaled tax credits for the purchase of private long-term care insurance. It nevertheless points up the need to limit subsidization to those at low and moderate income, lest the subsidies serve no more useful public purpose than enriching heirs.

COMPONENTS OF AN INTEGRATED PLAN

All in all, the policy choice is far from straightforward. Clearly, however, universal insurance has the virtue of putting explicit responsibility for long-term care on society as a whole rather than on those relatively few individuals unlucky enough to require expensive, often institutionalized, care at the end of their lives. Ultimately, the policy choice is about incidence.

On balance, a new blend of public money, private insurance, and other private saving is called for. While no choice is surely best, the "second-best" solution is one that would:

1. *Integrate front-end care into Medicare, creating a Medicare "Part C," building on the Medicare practice of reimbursing post-acute care.* Nursing-home residents would be reimbursed by Medicare for the first, say, six months' or year's stay (or the disabled elderly would access equivalent home care), ending the distinction that now exists between rehabilitation after an acute-care illness and the kind of care needed by an Alzheimer's victim. That distinction, as Wiener and Rivlin have emphasized (1988), is wholly artificial.
2. *Cut back Medicare reimbursement for routine health care to finance Part C.* The financial stress Medicare faces as the baby boom ages is an opportunity not only to shift the program toward catastrophic-type coverage in the form of a Part C but also to take a step in the direction of ability to pay and to rethink the scope of the care Medicare now finances.¹² Some scaling-back of "Part A" and "Part B" benefits for the routine care of middle- and high-income beneficiaries would offer scope for a Part C. And it would make the program as a whole more consistent with the logic and purpose of insurance.¹³ A heavily subsidized health plan that is blind to income for all over the age of 64 may have made sense in the 1960s when Medicare was launched, but not now. Health care commanded less than half the share of GDP it does now. Life expectancies were much lower, and so was the average income of the elderly compared with that of the population at large.
3. *Mandate back-end insurance coverage and support it with an income-scaled tax credit.* Long-term care insurance would become affordable. The income-scaling would minimize use of public money for estate protection. Subsidies would be targeted, as they would not be if long-term care insurance were simply made tax-deductible or partnership-type arrangements were to spread. Moreover, even if heavily subsidized, insurance that is private would be fully funded, an especially important feature because of the unusually unfavorable demographics on the horizon. Funding would prevent the public cost of the program from ever reaching the heights it would rise to if the financing of long-term care were on

social insurance-type pay-as-you-go. Funding would also put much of the burden of financing the nation's prospectively outsized long-term care bill on the large generation that eventually will make the claim on the resources.

4. *Encourage the insurance industry to fashion life insurance policies that carry long-term care riders.* If a requirement to carry long-term care insurance is ruled out, tax credits could be more effective in spurring demand for long-term care coverage if that were linked to other insurance "products." The insurance would not be "lost" if it were not called on, which will make it appealing to relatively young buyers. Equity-building life insurance--more in the nature of savings than of insurance--could well be the appropriate vehicle for many to finance needed long-term care.
5. *Tighten Medicaid eligibility by lengthening look-back periods and otherwise make it difficult for people to count on Medicaid to finance long-term care.* If the nation is unwilling to mandate coverage, or unwilling to apply the principle of social insurance to long-term care, any effort to shift to an insurance model will fail unless Medicaid rules are stiffened. The object is not to deny needed support to the disabled elderly, but to make it more costly for people to rely on Medicaid in the first instance. Serious consideration ought to be given to the constitutionality of outlawing estate-planning services designed to end-run Medicaid spend-down rules.

IMPLEMENTATION IN STAGES

Such a program could come into effect in stages. A pilot project could be designed to test, first, whether it would be, in fact, necessary for a mandate to be imposed in order to shift the paradigm from welfare to insurance and, second, what it would take by way of tax credits or other subsidy to achieve that outcome. If a tax credit were generous enough, it could well be effective in spurring enough demand for long-term care insurance to make a mandate unnecessary. Chances that a voluntary program would take hold would rise even further if Medicaid eligibility were made considerably more difficult than it is today.

Such a pilot project would also have to look carefully at ways to minimize moral hazard. Death and retirement are easy to adjudicate; disability is not. Co-payments and deductibles--they too income-scaled to reflect the objective of replacing Medicaid with insurance--would help in minimizing moral hazard.

There is ample time to put in place a financing structure for long-term care that would make a great deal more sense from the point of view of equity and efficiency than today's reliance on Medicaid. Costs for long-term care for many years to come are not projected to rise all that rapidly. And the federal government (ultimately the tax payer) is already the major payer. Eventually, though, the nation must be ready to cope with a quantum jump in the demand for long-term care, and to finance it in a sensible way. Ready or not, that is on its way.

Endnotes

1. The latest official estimate is \$47,000 for 1996 (Levit et al. 1997).
2. The out-of-pocket figures include Social Security paid to beneficiaries, but then paid back to Medicaid to reduce Medicaid's portion of a nursing-home's bills. About 40% of out-of-pocket payments are from this source.
3. This includes the bills paid by ordinary health insurance for the disabled victim of an automobile accident, for example. It thus exaggerates a bit the size of the long-term care insurance market.
4. The Health Insurance Portability and Accountability Act of 1996 made long-term care premiums tax-deductible, although only within limits and only if they and other nonreimbursed medical expenses exceed 7 1/2% of adjusted gross income. The benefits also became exempt from income tax.
5. My own experience may not be typical, but it is not uncommon: Several years ago, my mother (then in her early eighties) spent several months in a nursing home in New York for post-operative care. During that time, and for another year or so thereafter, I was called by at least 20 firms offering their "asset protection" services.
6. Wiener (1996) maintains that asset transfers are a relatively minor problem, judging by the financial and real-estate net worth of the elderly. The distribution of wealth is quite wide among the elderly, however, as well as among the population at large. Wealth data for the elderly also reflect past transfers of assets.
7. Massachusetts canceled its partnership program, on the grounds that it did not want state support for long-term care to be viewed as an entitlement.
8. The University of Maryland Center on Aging and the U.S. Bureau of the Census have estimated that partnerships in California and New York combined (which have an over-65 population of 6 million) have attracted only 17,000 subscribers (cited in Wiener and Stevenson 1998).
9. To be sure, the problem of affordability is at the heart of the large number of Americans lacking health insurance. Inability to develop a consensus for universal health care, however, need not block the nation from addressing other health-related issues like long-term care. That competes in the political arena with all uses of federal dollars, not only with those directed to health care.
10. This is the thrust of legislation sponsored by Senator Edward Kennedy (D-Mass.).
11. Legislation for back-end social insurance for long-term care has been associated with the name of former Senator George Mitchell (D-Maine).
12. The alternative is less and less reimbursement for the same service. The assumption implicit in the Balanced Budget Act of 1997 and in the budgets of the Clinton administration is that squeezing hospitals and physicians by lowering reimbursement rates will have little or no effect on health-care quality. A dubious assumption indeed.
13. The same could be said about coverage of prescription drugs, which relative to the incomes of some beneficiaries amount to a catastrophic expense, but are small in the total picture for others. Reimbursement of large, but not routine, drug costs would be a more reasonable application of the insurance principle than is embodied in the Clinton

Administration's proposal for subsidized coverage of all prescription drugs irrespective of need.

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Chart 2: Cost projections

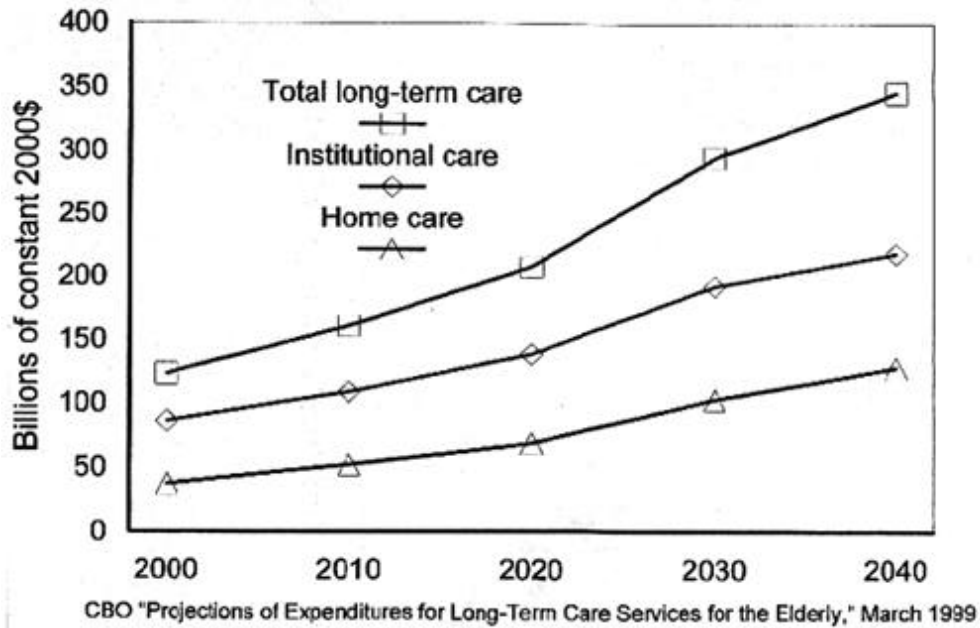


Chart 1: Long-term care expenditures

