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HIGHLIGHTS

## Financing Long-Term Care

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During the next 30 years, the nursing-home population will more than double as the baby boom ages and as advances in medicine extend life expectancy. Many more Americans will live long enough to require years of home care or, in all too many cases, years of institutionalized care.

The nation is not equipped to deal with this problem. By default more than by design, it has fashioned a welfare model for financing long-term care, pushing Medicaid far afield of its original purpose of providing for the medical care of the indigent. Most long-term care is financed either out-of-pocket, which can be done only by those with substantial savings, or by Medicaid, which pays for nursing-home care for those who are too poor to begin with or who have "spent down" their assets to the maximum level allowed for eligibility. Private insurance finances only a fraction (7 percent) of long-term care (Braden et al. 1998). Strikingly, more than a third of the Medicaid budget goes to long-term care, mostly to pay for stays in nursing homes. Medicaid pays, in whole or in part, for the care of two out of three nursing-home residents.

Insurance—public or private or some combination of the two—would be a far better way to

meet the nation's long-term care needs. Indeed, long-term care is almost perfectly suited to an insurance model in that an extended nursing-home stay is a low-probability but high-consequence event—the classic insurance risk. However, the private insurance market has failed to take hold for many reasons.

- Many Americans believe that Medicare will pay for long-term care. Medicare reimbursement, in fact, is limited to short stays for rehabilitation after an acute illness.
- Costs are greatly higher than they might be. There is little pooling, which distributes insurance risk and thus lowers cost. Because long-term care insurance is low on the priority list of middle-aged and young adults, the insurance pool is narrowed to those for whom long-term disability is a distinct possibility—something that greatly increases premiums. Administrative costs are also inordinately high.

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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. This approach, moreover, would benefit heirs in a way wholly inconsistent with the use of public funds. The problem of inheritance protection raises a serious question about any social insurance mechanism, which by its nature distributes benefits as an earned right without regard to income. It points up the need to limit subsidization to those with low and moderate income, lest the subsidies serve only to enrich heirs.

### An Integrated Plan

The policy choices are far from straightforward. Clearly, however, universal insurance has the virtue of putting 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. And it has the virtue of ending the use of Medicaid for purposes those welfare funds are ill-suited to finance. On balance, a new blend of public money, private insurance, and other private saving is called for. An effective solution is one that would:

1. *Integrate front-end care into Medicare, creating a Medicare Part C, building on the Medicare practice of reimbursing care following acute illness.* The disabled elderly would be reimbursed by Medicare for the first six months or a year of home or institutional care, ending the wholly artificial distinction that now exists between rehabilitation after an acute illness and the kind of care required by a chronic condition.

2. *Mandate back-end insurance coverage and support it with income-scaled tax credits.* The income scaling would make long-term care insurance affordable, minimize use of public money for estate protection, and target subsidies appropriately. Moreover, even if heavily subsidized, insurance that is private would be fully funded, an especially impor-

tant feature because of the unfavorable demographics on the horizon.

3. *Cut back Medicare reimbursement for routine health care to finance Medicare front-end long-term care coverage.* The financial stress Medicare faces as the baby boom ages is an opportunity to rethink the scope of the care it finances. 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; a shift to more catastrophic coverage would make the program as a whole more consistent with the logic and purpose of insurance.

**Medicaid itself acts as a major, if not the most important, impediment to the growth of the long-term care insurance market.**  
**Even high-income families presumably ask themselves, "Why pay for insurance when Medicaid insures virtually everyone against an extended nursing-home stay?"**

4. *Tighten Medicaid eligibility.* 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 difficult for people to turn to Medicaid first.

Such an integrated plan could be implemented in stages. A pilot project could be designed to test, first, whether it would be necessary to impose a mandate in order to shift to an insurance model and, second, what it would take by way of tax credits or other subsidy to achieve that outcome. A generous enough tax credit might well spur enough demand for long-term care insurance to make a mandate unnecessary. Chances for the success of a voluntary program would rise even further if access to Medicaid was considerably more difficult than it is today.

There is ample time to put in place a financing structure for long-term care that would be more equitable and efficient than today's reliance on Medicaid. The surge in long-term care related to the baby boom generation is still some time off and the federal government (ultimately the taxpayer) 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 jump is on its way.

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 has pushed health insurance in the direction of increasingly comprehensive benefits and then, as moral hazard would have predicted, overuse of those benefits as if they were “free.”

A second option would be to require Americans to carry long-term care insurance. The argument for compulsory private insurance is the same as for compulsory participation in Social Security and Medicare. Voluntary saving is inadequate to finance retirement and medical care for the elderly; meeting those needs is a desirable social objective; it is reasonable, therefore, to impose forced saving.

As a practical matter, private insurance coverage could not be mandated unless it could be made affordable. 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 demonstrate that they can pay for their own care through out-of-pocket or private insurance payments. Income-scaled tax credits could make premiums affordable for those with low and moderate income. For example, the credits (which could be refundable when there is no tax liability) might pay 100 percent of the premium for a couple whose adjusted gross income was \$20,000, 50 percent at an income of \$60,000, and nothing at \$100,000.

Requiring Americans to carry insurance would end the routine claim on Medicaid for long-term care. It would greatly reduce the price of the insurance by bringing into the market young and middle-aged adults to form a large risk pool. Tax credits to make such a requirement affordable would target subsidies more effectively than would tax deductibility.

A third option would be social insurance (a universal, compulsory program administered by the government and financed out of general or earmarked taxes). It would represent a clear change from the welfare model, but it would require a steep increase in taxation. Wiener, Illston, and Hanley (1994) have estimated that funding a comprehensive plan for long-term care by means of payroll taxes would require a tax rate (without a ceiling on taxable wages) of

almost 3 percent today and almost 4 percent by 2018—roughly double the rate required by today’s publicly funded long-term care. The tax rate, moreover, would rise sharply thereafter to reach almost 8 percent by 2048 when the demand for long-term care would peak. The 8 percent of payroll by 2048 compares with an estimated 3.5 percent if current programs were continued—still roughly double the cost of current policy but on a much larger base.

The nation could move a long way in the direction of an insurance model without launching a comprehensive social insurance plan or without making a commitment to a similarly costly subsidization of private insurance. One approach would be to limit public funding through social insurance or subsidized private insurance to “front-end” coverage—to expenses incurred in, say, the first six months or year in a nursing home. Social insurance, which could be applied to bills for home or institutional care, would end after that initial period; any subsidies to buy the requisite private insurance would be limited to premiums on policies that had quite short payoff periods.

An alternative would be to fund the “back end” through the public sector. Social insurance or subsidized private insurance would kick in only after a specified initial period. It would be a form of “catastrophic” coverage, with people responsible for funding the front end on their own. (Seamless coverage would be provided by a combination of subsidized and unsubsidized insurance, just as supplementary health insurance policies finance the acute care Medicare does not reimburse.)

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 few nursing-home residents in a position to return to independent living would benefit from front-end coverage, but others would not. And it is not at all clear that such limited coverage would do all that much to spur the development of an insurance market for the back end. The net overall effect could well be quite small, leaving the nation with Medicaid as the mainstay of long-term care financing.

The back-end approach has more promise for encouraging a move away from the welfare model, in particular, by encouraging people to buy supplementary policies. But

- Adverse selection makes it even harder for insurers to generate economies from pooling. When insurers cannot readily distinguish low risks from high, the coverage they offer to low-risk consumers is too little to be attractive to high-risk consumers. Alternatively, adequate coverage for high-risk consumers is too expensive to appeal to low-risk consumers. An “equilibrium” price is hard, if not impossible, to strike.

The remedy for 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 greater the risk created by the passage of time and therefore the higher the risk premium. Variability in the future price of care is a risk insurers cannot diversify.

Medicaid itself acts as a major, if not the most important, impediment to the growth of the long-term care insurance market. Even high-income families presumably ask themselves, “Why pay for insurance when Medicaid insures virtually everyone against an extended nursing-home stay?” Medicaid has become, in effect, 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 copayment (all of a nursing home resident’s income but for a small allowance for personal items such as a haircut and a magazine subscription). Asset and income limits are designed to ensure that Medicaid funds go to those with the greatest need, but, in practice, many nonpoor families become eligible through elaborate estate planning designed to circumvent those limits.

It is hard to imagine a system more conducive to abuse of the elderly. Spend-down requirements and the incentive to sur-

render assets to children deprive the elderly of the freedom to make their own decisions about their care and of the ability to live independently should they no longer need institutional care. Spending down to qualify for Medicaid in a nursing home, while reasonable in a welfare model, has made some elderly vulnerable to their children’s greed as well as to their own infirmities.

Moreover, Medicaid beneficiaries are more likely to be refused entry into the best facilities because those facilities cannot cover the cost of caring for a resident with the amount a state reimburses under Medicaid (typically 20 percent to 30 percent 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 and turn away the Medicaid beneficiary.

**Long-term care is almost perfectly suited to an insurance model in that an extended nursing-home stay is a low-probability but high-consequence event—the classic insurance risk. However, the private insurance market has failed to take hold.**

Replacing a welfare model with an insurance model would ameliorate, if not remedy, these problems. A safety net would have to remain in place—whether in the form of subsidized insurance for those with low and moderate income or Medicaid much as it currently exists.

Clearly, however, an insurance model cannot be developed as long as most Americans needing long-term care can turn to a safety net in the first instance. Medicaid or other safety net funds have to be reserved for those in greatest need.

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. For example, subsidies could be keyed to income under an income-scaled tax-credit arrangement or they could be extended to all purchasers through tax deductibility of premiums. The purchase of insurance would be voluntary; the insurance, although subsidized, would be bought like any other private insurance.

Inadequate pooling and adverse selection would remain under just about any kind of voluntary system for promoting long-term care insurance. A system of tax deductibility,

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