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Public Policy Brief

Financing Long-Term Care

Replacing a Welfare Model with an Insurance Model

Walter M. Cadette

No. 59, 2000

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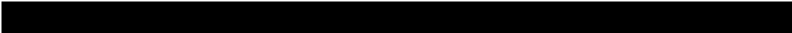

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Preface

Policymakers and the popular press have discussed at great length the fiscal stress that may be placed on the Social Security Trust Funds by the aging of the population over the next 20 to 30 years. They have given far less attention to another problem that will result from this demographic shift. As the number of elderly increases and as medical advances extend the life span, there will be more and more people who require some form of long-term home or institutional health care. The nation is not equipped—with either private or public financing vehicles—to meet this need.

Only a small part of long-term care is paid for privately (that is, paid out of pocket or through private insurance). Most is paid for by Medicaid, the program that was designed to ensure health care for the indigent. The use of Medicaid in this way comes at a high individual and social cost. To be eligible, patients must divest themselves of most of whatever financial assets and income they might have, surrendering their own independence and that of their spouses. Moreover, the system is conducive to abuse by nonpoor heirs who seek ways to circumvent eligibility requirements in order to preserve their elderly parents' assets. Clearly, another way of financing long-term care is needed.

Senior Scholar Walter M. Cadette examines the shortcomings of the present system and discusses several alternatives: voluntary private insurance subsidized through the tax system (by deductibility or income-scaled tax credits) to increase affordability; mandated private insurance with subsidies to ensure affordability; and social insurance (a government program along the lines of Medicare). He makes the case that financing long-term care

following an insurance model, with a safety net in place for those in greatest need, would ameliorate the problems that are now arising from a welfare model based on Medicaid. He recommends an integrated plan—a blend of public money, private insurance, and other private saving—as an efficient and equitable system.

The need for reform will become more pressing as the surge in the need for long-term care approaches with the aging of the baby boom generation. Now is the time to prepare—to examine potential problems and evaluate possible solutions. I hope you find this brief's arguments helpful in starting to think about that task. As always, I look forward to hearing your comments.

Dimitri B. Papadimitriou, *President*
February 2000

Financing Long-Term Care

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 considered how to amend these programs to make them more attuned to today's needs and, more important, to put them on sound financial footing ahead of the aging of the baby boom generation. In time, some consensus—and, in turn, political will—about what to do and how to finance it will emerge.

In contrast, little attention has been paid to long-term care for the elderly—a looming national problem arising from the same demographics. During the next 30 years, the nursing-home population will more than double as the baby boom ages and as continued advances in medicine extend life expectancy. The down side of that longer life span is that many more Americans will live long enough to require years of home care and, in many cases, years of institutionalized care. Moreover, the cost of a nursing-home stay, which in 1996 averaged $47,000 per year (Levit et al. 1997), promises to rise more rapidly than the price level as a whole.

The problem of financing long-term care looms large even now. Traditionally, the disabled elderly have been cared for by family members, typically women, at home. With the majority of women now in the work force, providing that care and financing it poses a formidable problem not a few decades hence as the baby boomers move into old age but now as their parents do. It is already a major workplace issue as employees, especially women, have become increasingly hard-pressed to juggle work and home responsibilities.

The nation is not equipped to deal with this problem. 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 Medicaid eligibility. Private insurance finances only a fraction (7 percent) of long-term care (Table 1).

Table 1 Sources of Long-Term Care Financing, 1997 (Billions of Dollars)

	Home Care	Nursing-Home Care
Total	**32.3**	**82.8**
Private	**14.7**	**31.3**
Out-of-pocket[a]	7.0	25.7
Private health insurance[b]	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
Medicaid[c]	4.7	39.4

[a]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 percent of out-of-pocket payments are from this source.
[b]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.
[c]The Medicaid amounts are from federal and state governments.

Source: Bradley R. Braden et al.,"National Health Expenditures, 1997," *Health Care Financing Review* 20, no. 1 (1998).

By default more than by design, the nation has fashioned a welfare model for financing long-term care, pushing Medicaid far afield of its original purpose of providing for medical care of the indigent, in particular those on Aid to Families with Dependent Children and successor welfare programs. Strikingly, more than a third of the Medicaid budget goes to long-term care, mostly to pay for stays in nursing homes (Braden et al. 1998). Medicaid pays, in whole or in part, for the care of two out of three nursing-home residents; measured in patient days, it pays for as much as 80 percent of all expenditures on nursing-home care (Moses 1999).[1]

The welfare model has also led to two-tier care, with private payers often given preferential admission to first-rate facilities and Medicaid

beneficiaries often consigned to second-rate facilities because state budgets do not stretch to pay higher fees. Even when beneficiaries get into the better facilities, their care must be financed by cross subsidies (that is, subsidies from private payers), which are inherently inefficient.

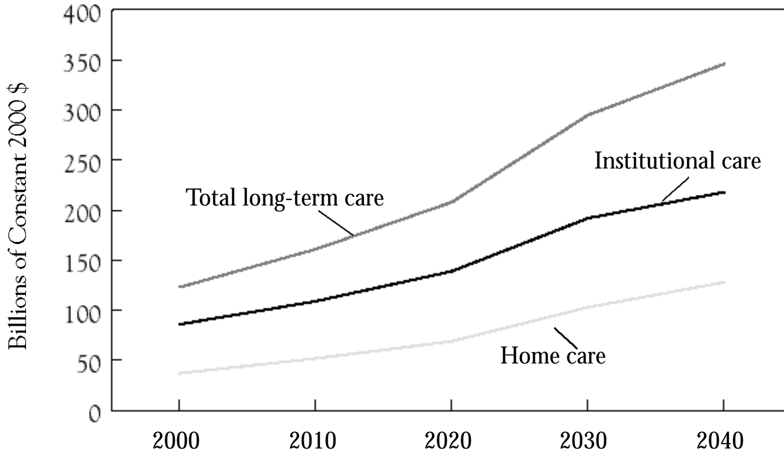
The welfare model, moreover, has been an open invitation for nonindigent Americans to find ways to maneuver around the maximum assets requirements. Some people see the transfer of assets to children in advance of the need for nursing-home care as perfectly legitimate estate planning, akin to minimizing estate taxes. Others see it as indistinguishable from any other "welfare cheating."

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. Two out of five Americans over age 65 will spend some time in a nursing home (Kemper and Murtaugh 1991, cited in Moses 1999). For most, their stay will be for only a few months, say, for rehabilitation following hip replacement or a stroke. Medicare ordinarily pays most of the costs associated with such stays. However, one in ten Americans over 65 will require care for five years or more and will incur costs that if paid directly from their own assets would bankrupt all but a few families. If every family were to try to save to meet the cost of such a stay, the resulting saving would be excessive. Pooling the needed saving through insurance premiums is the natural economic response. But this logical and efficient response has been frustrated by a failure of the private insurance market.

The challenge for government is to shift the financing of long-term care toward an insurance model. Debate should center on how to balance what people can reasonably be expected to provide for themselves out of private insurance and what government should provide (Wiener, Illston, and Hanley 1994).

Whatever the split between public and private responsibility, the costs will be high. Those costs are determined by the demographics, advances in medicine, and the often total dependence of the disabled elderly. Public and private spending for paid home care and institutional services is projected to increase some 70 percent in constant dollars during the

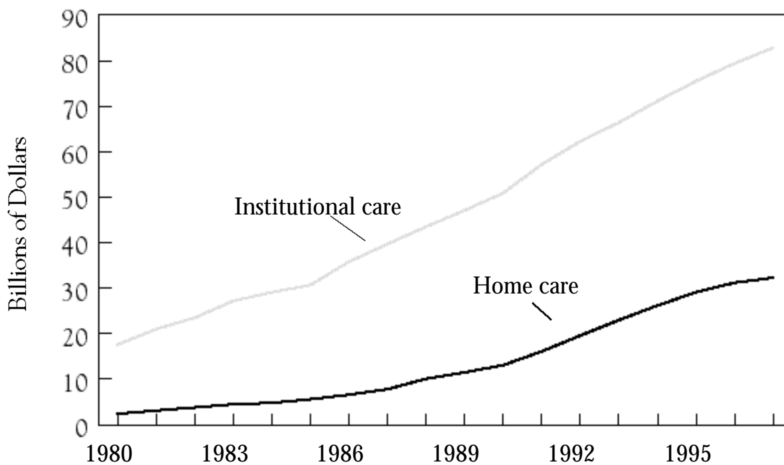
Figure 1 Long-Term Care Cost Projections



Source: Congressional Budget Office, "Projections of Expenditures of Long-Term Care Services for the Elderly," March 1999.

next 20 years and some 70 percent again during the 20 years thereafter—almost tripling over the 40-year period (Figure 1).[2] These increases would come on top of the large rise in long-term care expenditures over the past years (Figure 2). Chances are high, moreover, that spending will exceed projections.

Figure 2 Long-Term Care Expenditures



Source: Bradley R. Braden et al.,"National Health Expenditures," *Health Care Financing Review* 20, no. 1 (1998).

Before an already inadequate system is subjected to further demands, the nation would do well to consider alternative approaches to the financing of long-term care. This paper outlines the alternatives of subsidized private insurance (both voluntary and compulsory) and social insurance. It starts by pointing 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.

A Flawed System

Private Insurance Market Failure

Few Americans insure themselves against an extended nursing-home stay, but most do carry protection against not only the cost of a major acute illness but also of such high-probability but low-consequence events as a visit to a doctor for the flu. The spread of ordinary health insurance has been powered by federal subsidies in the form of the tax exclusion of employment-based health benefits (Cadette 1997), while the market for long-term care insurance has been hobbled by the absence of a similar subsidy. Only recently have tax benefits been extended to the purchase of long-term care insurance, and they are quite limited.[3]

Another reason private insurance has failed to take hold is that 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; extended stays are the responsibility of the residents privately or of Medicaid after their assets are exhausted.

The cost of this insurance is higher than it might be for many reasons. First, the advantages of pooling, which distributes insurance risk and thus lowers the cost of insurance, are hard to come by. Long-term care insurance is low on the priority list of middle-aged adults and presumably at the bottom of the list of younger adults. 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 some states but woefully short of what is needed in a state such as New

York, where daily charges range upwards of $250 (Health Insurance Association of America 1995).

Second, administrative costs are inordinately high. Commonly, 60 percent of the first year's premium and as much as 10 percent of subsequent premiums are dedicated to sales, marketing, and other administrative expenses (Cutler 1993). Typically, rather than marketing to groups, which would both reduce overhead and generate economies through pooling, the marketing is to individuals.

Third, moral hazard (the tendency for insurance to be used if available) is introduced by bundled pricing (the cost of food and lodging, for example, is imbedded in the cost of a nursing-home stay). Also, an institutionalized parent's children, who in many cases make the decisions about care, would not decide to have the parent pay privately if the parent did not have insurance to cover that payment. (Clearly, moral hazard is rife in Medicare reimbursement for short nursing-home stays for rehabilitation. Almost always, residents return home on the very day reimbursement runs out and out-of-pocket payment must begin.)

Fourth, adverse selection (the purchase of insurance by consumers who know they have a greater than average chance of making a claim) makes it even harder for insurers to generate economies from pooling. When insurers cannot readily distinguish low risks from high (because of this information advantage of the insured), the coverage they offer to low-risk consumers is too little to be attractive to high-risk consumers (Wolfe 1993). 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.

Both over- and underpricing thus characterize the market. Underpricing has posed a danger in that insurers have often abandoned the market (pocketing the accumulated equity) when subscribers, faced with sharp increases in premiums, have allowed policies to lapse. Imperfect regulation and limited supervision by state insurance departments with little experience with long-term care insurance have compounded this problem of loss of coverage to the insurers' advantage (Lutzky and Alecxih 1999).

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 (particularly against the background of the high and uncertain inflation of several decades) and therefore the higher the risk premium. Variability in the future price of care, being an intertemporal and therefore aggregate risk, is a risk insurers cannot diversify. Insurance markets function well only when the primary component of risk is cross-sectional, that is, spread across the range of the insured (Cutler 1993).

Insurers have attempted to contain risk premiums by offering policies stipulating a given dollar payoff rather than 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, consumers 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 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 ensures 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 co-payment (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. Most nursing-home residents become Medicaid-eligible early in their nursing-home stay 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, however, go 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 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 (for example, purchase of a luxury automobile, expensive jewelry, a house, or other assets exempt from the spend-down requirements) have become commonplace. The higher the per capita income of a state, the more elaborate the estate planning designed to secure Medicaid eligibility for the nonpoor elderly.[4]

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 even within the look-back period 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 1998d). States are required by the federal government to impose waiting times for Medicaid eligibility. The waiting period is determined 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 to find the length of stay the assets could have paid for. For example, if $50,000 of a $100,000 nest egg is transferred to a son or daughter when a parent enters a nursing home in a state in which the average cost is $5,000 per month, the parent would become Medicaid-eligible after 10 months. The parent uses the remaining half of the nest egg to pay privately. After 10 months, when the waiting period is up (and when the remaining assets have been exhausted), Medicaid payments begin.

At the end of the process, half of the nest egg 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 to defraud or 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.[5] A similar finding came out of a nationwide GAO report (General Accounting Office 1997, cited in Cassidy 1998d). An Illinois study concluded that look-back 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). The staff in charge of determining Medicaid eligibility estimated that 75 percent of the cases in Chicago and 50 percent in suburban offices had involved property transfers (Moses 1995).

It is hard to imagine a system more conducive to abuse of the elderly. Spend-down requirements and the surrender of assets to children deprive the elderly of the freedom to make their own decisions about 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.

Hardship for Spouses

Even though the welfare model does mean that long-term care can be provided for most Americans, a Medicaid system is not a perfect substitute for an insurance system. Insurance provides asset protection for heirs, which Medicaid—at least according to the rule book—does not. More important, insurance provides more financial protection for a spouse. Under Medicaid rules, the spend-down is joint (although the spouse who remains in the community may retain more assets and income than a single or widowed nursing-home entrant). 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, real assets, such as the ownership of a family home, are not affected, although many states attempt to get possession of real property when both the community spouse and the nursing-home resident die.

Financial assets of $80,000 may seem like a generous exemption, but spending down to that level is tantamount to impoverishment for a community spouse if income from other sources is inadequate. In any case, the income limits can create genuine hardship, especially for a relatively young spouse. The defense against this hardship is often a resort to 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 in a system that relies almost exclusively on out-of-pocket payments and welfare can be heavy. 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.

Two-Tier Care

Private payment, moreover, can buy entry into the best facilities, whereas Medicaid beneficiaries are more likely to be refused because those facilities cannot cover the cost of caring for a resident with the amount a state government is prepared to reimburse 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. State "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 become 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 the failure of Medicaid reimbursement to cover the cost of quality care.

State regulation offers weak defense against two-tier care. State governments, to be sure, regulate all nursing home facilities in elaborate detail. However, the regulators necessarily concentrate on variables that can be easily measured and checked: number of lights in a hallway, height of tables and chairs, number of staff with this credential or that. What makes a facility genuinely first-rate often eludes regulatory oversight.

Ensuring quality care for Medicaid beneficiaries will become even more difficult under the Balanced Budget Act of 1997. Among its provisions for economizing on federal health-care spending is the repeal of the 1980 Boren Amendment to the Medicaid Act, which assured beneficiaries in nursing homes of some measure of quality care. The amendment required that Medicaid cover the costs needed to operate a home in conformity with both federal and state standards. With its repeal, 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 ameliorate, if not remedy, all of these problems: two-tier care, commandeering of limited welfare funds by middle- and high-income people through the transfer of assets, and the impoverishment of those who "play by the rules." The welfare of all the disabled elderly in need of Medicaid benefits is at stake 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. At stake also is "honest government"—one that not only does not fund inheritance protection but that also genuinely protects those with greatest need. Meeting the requirements of a welfare model, moreover, threatens community spouses whose resources are depleted and those few nursing-home residents who have become Medicaid-eligible but eventually are in a position to return home. Spending down makes it financially impossible for them ever to live independently again.

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 to bring the benefits of pooling to that market to bring down cost.

Administrative costs under an insurance model promise to be lower than under a welfare model. Of necessity, Medicaid dedicates much of its budget to the difficult and costly enforcement of income and asset eligibility rules.

Long-term care insurance would remain unaffordable for many, just as ordinary health insurance is. 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.

Voluntary Insurance with Subsidization

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. 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, which would benefit all by lowering the after-tax cost of the insurance. The purchase of insurance would be voluntary; the insurance, although subsidized, would be bought like any other private insurance.

By enlarging the long-term care insurance market, subsidies could well reduce government's long-term care bill, as they could shift 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 who would never have reason to call on the subsidized insurance (presumably, most of the new purchasers brought into the market).

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.[6] 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 have to pay for—an outcome no different in substance from direct subsidization of the premiums themselves.

All in all, however, partnership arrangements have been disappointing. Despite the subsidization, they have not given rise to significant expansion of the long-term insurance market, even in New York where the wealthy can buy virtually unlimited inheritance protection for a relatively small premium. Partnerships have attracted some consumers into the market, but about two-thirds of the participants would have bought the insurance on their own and the absolute number of participants remains minuscule (Wiener and Stevenson 1998).[7]

Partnerships do not confront 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 is no more pressing to the young and middle-aged. And, for the elderly, calling on a certified 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 Medicaid's stringent poverty-oriented rules.

Adverse selection plagues partnership arrangements just as it does ordinary insurance. Partnerships attract even more of those at high risk 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 the appeal of long-term care insurance is limited to those with relatively high income—the most important segment of the market but one that is

unwilling to take its chances on the care available to Medicaid beneficiaries or to accept the welfare stigma that Medicaid traditionally has carried.

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, 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." It also extends the largest subsidies to those with the highest income because of the progressivity of the tax system (Cadette 1997).

Mandated Insurance with Tax-Credit Support

A second option would be to require Americans to carry long-term care insurance as they are now generally required to carry automobile insurance. The argument for compulsory purchase of 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.

Private and voluntary saving is similarly inadequate to the task of financing long-term care. It finances, through out-of-pocket spending and through insurance, only about 40 percent of what is needed. The rest comes mainly from general public sector revenue—a reflection of the desirable societal objective of meeting those needs. By default, society at large has become the major payer of the nation's long-term care bill. Therefore, it may as well use its status as payer to bring about a financing regime (forced public saving) more in keeping with the broader, and 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 a precedent in auto insurance. 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 be made affordable to those with 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, that is, that they can pay for their care out-of-pocket or through private insurance without calling on Medicaid. The premiums of those with low and moderate income could be paid through income-scaled tax credits. For example, the credits, which could be refundable if there were 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.[8]

Another method would be to calculate tax credits in dollar amounts. That way, the cost of long-term care insurance paid out-of-pocket would not rise as people aged and necessarily faced 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 insurance would end the routine claim on Medicaid for long-term care. It would greatly reduce the price of the insurance by bring into the market young and middle-aged adults 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

Another option is social insurance—a universal, compulsory program administered by the government and funded through general or earmarked taxes. In a clear break from the welfare model, 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 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 important, pooling—come to the fore if the insurance is social in nature, just as they do if the insurance is private. And there is an added plus: administrative costs 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 difficult, if not imprudent, to assume.

Wiener, Illston, and Hanley (1994) have estimated that funding a comprehensive social insurance plan by means of payroll taxes to provide nursing-home coverage and to expand access to home care would require a tax rate, without a ceiling on taxable wages, of almost 3 percent today and almost 4 percent by 2018. It would rise sharply after 2018 to reach almost 8 percent by 2048 when the demand for long-term care would peak.

These estimates, it should be stressed, incorporate the cost of financing current public programs for long-term care, which today is about 1.5 percent of payroll. 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, is projected to increase significantly as the baby boom generation ages).

In time, the new payroll taxes would become quite large; the 8 percent of payroll by 2048 is still roughly double current policy costs (an estimated 3.5 percent if current public programs were continued) 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 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—an increase of 4 percentage points or more of payroll (some 3 percentage points or more 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.

Social insurance would yield the same outcomes as mandated insurance backed by income-scaled tax credits. And there need not be much, if

any, difference between the two approaches for the distribution of income. How that distribution would be affected would depend on the revenue sources chosen, the levels of the tax credits and their adjustment for age, the nature of the coverage, and other particulars.

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

Subsidizing Partial Coverage

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 compulsory private insurance. The policy challenge is to move in that direction at reasonable cost.

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 first year in a nursing home.[9] Social insurance, which could be applied to bills for home or institutional care, would end after six months or a year; any subsidies to buy the requisite private insurance would be limited to 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 front-end approach is of particular benefit to nursing-home residents who could be expected to return to independent living. They could retain the financial means to do so if they could rely on insurance benefits to cover much or all of the cost of a short nursing-home stay. Even a relatively short stay (unless it follows an acute illness and thus is paid for by Medicare) can compromise financial independence.

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 time, say, six months or a year.[10] 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 the advent of Medicare gave rise to supplementary health insurance policies to 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 minority of nursing-home residents in a position to return home 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 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 diminish the insurance character, and emphasize the welfare character, of any social insurance mechanism.

Wiener, Illston and Hanley (1994) have argued that estate taxes 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.

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 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 practice of reimbursing care after an 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 necessitated by a chronic condition (Rivlin and Wiener 1988).

2. *Mandate back-end insurance coverage and support it with income-scaled tax credits.* 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 subsidized under partnership arrangements. 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 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. Funding would also prevent the public cost of long-term care from ever reaching the heights it would rise to under pay-as-you-go social insurance.

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 not only to shift the program toward catastrophic coverage but also to rethink the scope of the care Medicare now finances.[11] 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.[12] 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 the average income of the elderly compared with that of the population at large was much lower.

4. *Tighten Medicaid eligibility by lengthening look-back periods and otherwise making it difficult for people to count on Medicaid to finance 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.

Such a program could come into effect in stages. A pilot project could be designed to test, first, whether it would be necessary to impose a mandate 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.[13] 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 Medicaid eligibility were made 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.

Notes

1. 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. Any inadequacy in that respect is not necessarily due to the slice; Congress, after all, has had the opportunity to vote appropriations that would cover both 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.
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 to the help available to the elderly. The difficulty of identifying people 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).
3. The Health Insurance Portability and Accountability Act of 1996 made long-term care premiums tax deductible, but only within limits and only if they and other nonreimbursed medical expenses exceed 7.5 percent of adjusted gross income. The benefits also became exempt from income tax.
4. My own experience may not be typical, but it is surely not uncommon. Several years ago, my mother (then in her early eighties) spent several months in a nursing home in New York for postoperative care. During that time and for another year or so thereafter, I was called by at least 20 firms offering their “asset protection” services.
5. Wiener (1996a, b) 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.
6. Massachusetts canceled its partnership program on grounds that it did not want state support for long-term care to be viewed as an entitlement.
7. 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).
8. To be sure, unaffordability is the reason such a large number of Americans lack health insurance. Inability to develop a consensus for universal health care, however, need not block the nation from addressing other health-related issues, such as long-term care. The use of funds for long-term care competes in the political arena with all uses of federal dollars, not only with those directed to health care.

9. This is the thrust of legislation sponsored by Senator Edward Kennedy (D–Mass.).
10. Legislation for back-end social insurance was sponsored by former Senator George Mitchell (D–Maine).
11. The alternative is less and less reimbursement for the same service. The assumption implicit in the Balanced Budget Act 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.
12. 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.
13. Such a pilot project would have to look carefully at ways to minimize moral hazard. Death and retirement are easy to adjudicate; disability is not. Copayments and deductibles (income scaled to reflect the objective of replacing Medicaid with insurance) would help to minimize moral hazard.

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About the Author

As a senior scholar at the Levy Institute, Walter M. Cadette has written on health care finance and regulation, Social Security reform, and public capital formation. He is also chairman of the investment committee of the Holy Cross Health System and an adjunct professor at Columbia University. He is a retired vice president of J.P. Morgan & Co. Incorporated, where he was editor of and frequent contributor to its publications *Global Data Watch* and *World Financial Markets.* Cadette's Levy Institute publications include several briefs: *Prescription for Health Care Policy* (No. 30); *Safeguarding Social Security* (No. 34); with S Jay Levy, *Overcoming America's Infrastructure Deficit* (No. 40); and *Regulating HMOs* (No. 47). He received a B.A. from Fordham College and an M.A. from Georgetown University and did further study in economics and finance at New York University.

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