

HOW CAN WE IMPROVE LONG-TERM CARE FINANCING?

BY HOWARD GLECKMAN*

Introduction

The system for financing and delivering long-term care in the United States is deeply flawed. While families and government spend more than \$200 billion annually for such services, many frail elderly and disabled fail to receive the care they need.¹ This problem is expected to become more severe as the Baby Boom generation ages.

While experts generally agree that the existing system is inefficient and ineffective, they disagree on how it should be reformed. This *brief*, the fourth and final in a series, will review several options for change.² These options include enhancing private long-term care insurance, replacing the current welfare-based system with a public social insurance program, and introducing a hybrid public-private system. None of these alternatives is optimal, but each has significant advantages over the current system.

The Current System

In contrast to acute medical care, long-term care assists those with chronic illnesses in managing their daily lives. Such care, which is provided to both the aged and the disabled, includes assistance with

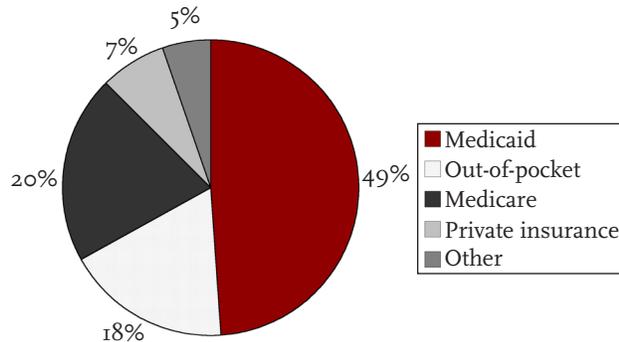
eating, bathing or toileting, and cooking or eating. It is provided at home, in a nursing home, or in an assisted living facility. About two-thirds of those who turned 65 in 2005 will need long-term care in their lives, and they will require assistance for an average of three years.³ Currently, about 10 million Americans receive some form of long-term care.⁴

Long-term care can be extremely expensive — a private room in a nursing home costs an average of \$75,000 per year and home health aides cost an average of \$18 per hour.⁵ As shown in Figure 1 on the next page, about half of paid long-term care is funded by Medicaid, the joint federal-state health program for the poor. Another 20 percent is financed by Medicare, the universal federal health insurance program for seniors. Most of the remainder is paid out-of-pocket or through private insurance.⁶ More than half of all long-term care, however, is informal unpaid assistance provided by family members.⁷

While the existing Medicaid-based system offers relatively comprehensive coverage for the poor, it is problematic for the middle class. To become eligible, people must impoverish themselves. In most states, an unmarried individual must “spend down” assets

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FIGURE I. FUNDING SOURCES FOR LONG-TERM CARE, 2005



Note: Totals do not add to 100 percent due to rounding.
Source: Komisar and Thompson (2007).

to \$2,000 to qualify. As an alternative to Medicaid, those in the middle class can purchase private long-term care insurance. However, to date the demand for such insurance has been modest due to the cost and complexity of policies and the reluctance of consumers to pre-fund for disabilities of old age.⁸ (See Box for description of major long-term care funding sources.)

Proposed changes to the long-term care system take one of three approaches. The first would use tax subsidies and other incentives to enhance private insurance. The second would create a new social insurance program, much like that in Germany, Japan, and most of the industrialized world. The third solution would meld public and private insurance.⁹ All three approaches seek to both expand coverage and reduce costs. In theory, these goals are complementary since increasing the number of people in the risk pool should make coverage less expensive.

Sources of Long-Term Care Funding Today

Medicaid — Long-term care only for those who are low-income and require a nursing home level of care.

Medicare — Only for post-hospitalization and rehabilitation, maximum of 100 days.

Private Insurance — Covers only 6-7 million. Premiums are costly (\$1,702/yr for a 60-year-old in 2005).

Enhance Private Insurance

Proposals to enhance private insurance would largely leave the current structure in place. Those with low incomes would continue to receive Medicaid, while those with higher incomes would be encouraged to purchase private coverage.

One group of incentives would come from the government. Some have proposed expanding existing federal and state tax subsidies. However, as structured, the federal tax subsidy is very limited.¹⁰ And expanding tax benefits is unlikely to significantly spur demand for the product.¹¹ Alternatively, an initiative called the Long-Term Care Partnership program would allow buyers of certain private long-term care policies to retain financial assets equal to the value of the policy — say, for example, \$300,000 — and still become eligible for Medicaid. Four states adopted this program in the 1990s, but only 218,000 policies were purchased. A number of states are currently developing new Partnership programs under more flexible federal rules.

Private market enhancements include efforts to make long-term care insurance a better “buy.” One product combines insurance coverage with reverse mortgages.¹² Another plan would marry a long-term care insurance policy to an annuity. Because healthy buyers would be attracted to the annuity while unhealthy purchasers would favor the long-term care benefit, carriers could internally hedge the risk of each. This feature, in theory, would reduce the need for underwriting and substantially lower premiums, but its significant upfront cost would tend to limit the pool of buyers.¹³

In an effort to expand private insurance in a more comprehensive way, three researchers have designed a plan called Medi-LTC.¹⁴ Under this proposal, private carriers could sell three simplified benefit packages through Medicare, similar to the way Medicare Supplemental (Medigap) health insurance is marketed today. Unlike Medigap, however, benefits could be customized, although each package would have to provide at least basic coverage. Carriers would be permitted to underwrite policies and, thus, could reject applicants based on health status. In one important feature, private insurers would pay for the nursing home and home health benefit now provided by Medicare. In return for transferring this risk to private insurers, Medicare would use its cost savings to subsidize premiums.¹⁵ The Medi-LTC proposal has several advantages. It would cost the government

relatively little. Direct marketing through Medicare would likely increase demand for private policies. And competition among plans could lower prices.

Proposals to enhance private insurance are unlikely to greatly expand long-term care coverage, however. An analysis by Georgetown University concludes that none of the proposals described above would increase the total number of policyholders by more than 4.4 million (equivalent to 13 percent of those over age 50).¹⁶ Without a significant increase in the size of the risk pool, substantial premium reductions will be difficult to achieve.

The underwriting issue would have to be resolved as well. Any market-based system must be carefully designed to avoid cherry-picking, where carriers set rates to encourage the healthiest buyers and discourage those most likely to claim. Similarly, where underwriting is permitted, government assistance would have to be made available to those who are uninsurable.

Create a Social Insurance System

A far more ambitious idea is to replace the current welfare-based system with social insurance. The program could be managed as a new Medicare benefit or through a new independent, quasi-government entity.

The Medicare Model

An enhanced Medicare structure would add a new Part E. One prototype plan, proposed by Urban Institute researchers Leonard Burman and Richard Johnson,¹⁷ would provide both home care and nursing home care to the frail elderly and younger disabled who are unable to perform at least two activities of daily living (ADLs).¹⁸ The home care benefit would be limited to 100 hours per month. Beneficiaries would pay a \$500 annual deductible and a 20-percent copayment up to \$5,000 per year. These costs would be reduced for low-income beneficiaries. Providers would be paid according to a fixed fee schedule.

The Medicare-type model has several benefits. It would largely replace the existing welfare-based Medicaid system by covering those middle-class families who cannot afford private insurance. In addition, Medicare is operated at far less cost per beneficiary

than comparable private health insurance, and it is likely that a similar long-term care program would be as well.

Several funding options are available. Germany's universal system is financed through a 1.7 percent payroll tax.¹⁹ Another option would be to introduce a new value added tax (VAT). A third financing alternative is the income tax — the Burman-Johnson prototype would rely on an across-the-board increase in individual tax rates equal to one percentage point, which would raise an estimated \$55 billion in 2007.²⁰

Any social insurance benefit would require higher taxes, however. At a time when the high costs of existing health care entitlements are

already generating severe fiscal pressures, adding a new benefit raises significant budgetary issues.

An Alternative Public Insurance Model

To avoid tax increases, the American Association of Homes and Services for the Aging (AAHSA), a trade group that represents not-for-profit long-term care providers, designed an alternative.²¹ Under the AAHSA plan, coverage would be universal or nearly so, and the vastly larger insurance pool would allow people to purchase a lifetime benefit for relatively low cost.²² One model plan would provide a lifetime daily cash benefit of \$75 after a five-year vesting period for an annual premium of about \$1,270.²³ Both benefits and premiums would be indexed to wage growth. Individuals would purchase the insurance beginning at age 21 and pay premiums to an independent, quasi-government entity outside the federal Treasury. Low-income individuals would receive a subsidy.

Among the potential advantages: Taxpayers may be more willing to accept a mandatory premium than a tax and, as with the Medicare-type plan, per-beneficiary costs should be relatively low.

However, this plan has downsides as well. For instance, if the plan permits an opt-out, it remains to be seen whether young people will participate in a new program that would require them to pre-pay for a benefit they are unlikely to receive for 60 years. In addition, a \$75 daily benefit would pay for only about four hours of home care, and less than one-third of the cost of a nursing home bed. Thus consumers would have to purchase supplemental private insurance or otherwise pre-fund additional costs. Finally, if the program does permit an opt-out, adverse selection would drive up premiums.

An effective solution will include a mix of public and private insurance.

Meld Private and Public Insurance

A third approach would create a hybrid public-private system. It would require individuals to purchase private long-term care insurance, but through a government program. In many ways it would resemble the Medi-LTC proposal described above. However, the Medi-LTC plan is voluntary, while participation in this system would be mandatory. Table 1 compares selected reform plans along key features.

In a hybrid program, such as one proposed by the Brookings Institution's William Galston, purchase would be mandatory beginning at age 40 and insurers would be required to accept all buyers without underwriting.²⁴ A prototype policy would cover \$150-day for the first five years of care. Additional care would be government-financed. Purchasers would pay market premiums, although subsidies would be available to low-income buyers. As with Medigap, insurers could offer a range of standardized benefits, though they could continue to compete on price. Such a structure would simplify purchasing decisions for buyers. By taking advantage of a similarly expanded risk pool as the AAHSA plan, premiums should fall significantly from today's market prices.

While the distinction between a dedicated long-term care tax and a premium for mandatory long-term care insurance is not economically meaningful, the latter system would reframe the debate in a more politically palatable way. The AAHSA plan follows a similar path. However, in that plan, buyers would still be paying the government for insurance. Many

may find it more acceptable to purchase insurance from private carriers.²⁵

Another form of public/private partnership, which has been developed by Senator Edward M. Kennedy (D-MA) and others, creates a modest optional government insurance benefit and explicitly anticipates the purchase of private supplemental coverage.²⁶ Enrollment would be automatic starting at age 18, with an opt-out option. After a five-year vesting period, the program would provide a benefit of \$50 a day for individuals unable to perform at least two ADLs, or \$100 for those needing assistance with four ADLs. Benefits would be paid in cash and could be used for a wide range of services. Premiums are estimated at \$30 per month and would be paid through payroll deduction. The program would be administered by the Department of Health and Human Services. Because the benefit is likely to fall short of covering all long-term care costs, the sponsors expect that many consumers will purchase supplemental private insurance.

Both the Kennedy and the AAHSA plans would provide cash benefits, much as Social Security disability does today. Such a benefit design provides the elderly, disabled, and their families the flexibility to spend the funds for such purposes as supporting family caregivers, renovating a home to accommodate a wheelchair, or obtaining assistive devices without having to navigate complex government regulations or limitations in insurance contracts.

Cash benefits, however, raise at least two important issues. One is that families of the aged are often poorly equipped for the challenges of providing long-term care. For home care to function at an optimal level, families will need to be trained both in personal

TABLE 1. COMPARISON OF SELECTED LONG-TERM CARE (LTC) REFORM PLANS BY KEY FEATURES

Plan	Mandatory	Government insurance	Private insurance	Funding source
Private insurance:				
Medi-LTC	No	Replaces Medicare LTC	Yes, at 50	Premiums
Public insurance:				
Burman/Johnson	Yes, universal for 65+	Yes, Medicare Pt. E	Supplement only	Income tax surcharge
AAHSA	Possible opt-out	Yes	Possible as supplement	Premiums
Hybrid:				
Galston	Yes, at 40	Catastrophic only	Yes	Premiums
Kennedy (CLASS Act)	No/Opt-out, but at 18	Yes	Supplement only	Premiums/ payroll deduction

Sources: Cutler, Shulman, and Litow (2007); Burman and Johnson (2007); American Association of Homes and Services for the Aging (2006); Galston (2007); and Office of Senator Edward M. Kennedy (2007).

care skills and in hiring and managing home care workers. Second, a guaranteed revenue stream might make it possible for providers, such as nursing homes and home health agencies, to raise prices.²⁷ Today, these prices are negotiated by Medicaid, the dominant payer. In a social insurance model, Medicare could serve the same function. In a system of widespread private insurance, it is not known how providers would react if millions of consumers were to receive cash benefits.

Conclusion

Successful reforms must make long-term care insurance more widely accessible. This goal may be achieved either through social insurance or private coverage. To make private insurance more affordable and reduce the need for underwriting, the number of those insured must be greatly expanded. In addition, the nature of assistance for the poor must shift from the welfare-type Medicaid to an insurance model.

Each design discussed here is flawed, yet each has the potential to improve our existing system. Long-term care experts agree that a solution that is both politically and economically viable will include some mix of public and private insurance. The challenge will be finding the proper balance between the two models.

Endnotes

- 1 Komisar and Thompson (2007).
- 2 The previous three *briefs* are Gleckman (2007a); (2007b); and (2007c).
- 3 Kemper, Komisar, and Alecxih (2005).
- 4 Komisar and Thompson (2007).
- 5 MetLife (2006).
- 6 Komisar and Thompson (2007).
- 7 Johnson, Toohey, and Weiner (2007).
- 8 Brown and Finkelstein have studied this phenomenon in several papers, including Brown and Finkelstein (2008 forthcoming). They conclude that, for all but the wealthy, long-term care insurance replaces most of the benefits that buyers would otherwise receive from Medicaid. Others argue that because few individuals are aware of the Medicaid benefit, potential buyers may not make this calculation.
- 9 For detailed descriptions of the proposals discussed in this paper, as well as several other reform plans, see Georgetown University Long-Term Care Financing Project (2007).
- 10 In 2007, individuals between the ages of 60 and 70 could deduct up to \$2,950 in premium costs but only if their total medical costs exceeded 7.5 percent of their adjusted gross income.
- 11 Cramer and Jensen (2006) estimate that even a 25 percent discount in price would increase demand by only 11.2 percent.
- 12 For an excellent review of various financial products aimed at financing long-term care, see Freiman (2007).
- 13 For a detailed description of one plan, see Warshawsky (2007).
- 14 Cutler, Shulman, and Litow (2007).
- 15 Overall premium cost savings would theoretically occur, because private insurers would be able to invest these credited funds over the lifetime of the policy, thus earning significant returns, something the federal government cannot do.
- 16 Feder, Komisar, and Friedland (2007).
- 17 Burman and Johnson (2007).
- 18 This is a standard test required by most private insurance plans. ADLs include bathing, toileting, eating, transferring, and dressing.
- 19 Gibson and Redfoot (2007).
- 20 The size of the rate increase is illustrative. The actual rate would be set to achieve long-run balance.
- 21 American Association of Homes and Services for the Aging (2006). This system is based roughly on the German model, but with a different financing mechanism.
- 22 Participation would be mandatory for everyone over 21 but perhaps with a limited opt-out option, including the right to buy private insurance in lieu of government coverage.
- 23 The Moran Company (2007). The \$1270 estimate is in 2007 dollars and assumes a mandatory program. AAHSA, however, has not yet decided whether to mandate coverage or allow consumers to opt out. An opt-out is likely to result in higher premiums for those who buy.
- 24 Galston (2007).
- 25 Private insurance under the hybrid plan would likely have higher administrative costs than the Medicare Part E plan, but lower expenses than in a pure market-based system. Because the market would be divided among many insurers, the benefits of a greatly expanded risk pool would be somewhat reduced for each individual carrier. In addition, purchasers would also need some protection against a private carrier failing before claims were paid many decades in the future. This might require some form of government reinsurance, especially against catastrophic losses.
- 26 Office of Senator Edward M. Kennedy (2007).
- 27 Finkelstein (2007) found that such a steady revenue stream through Medicare drove up prices of health care providers.

References

- American Association of Homes and Services for the Aging. 2006. *Financing Long-Term Care: A Framework for America*. Washington, DC.
- Brown, Jeffrey R. and Amy Finkelstein. 2008 (forthcoming). "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market." *American Economic Review*.
- Burman, Leonard E. and Richard Johnson. 2007. "A Proposal to Finance Long-Term Care Services Though Medicare with an Income Tax Surcharge." Working Paper 8. Washington, DC: Georgetown University.
- Cramer, Anne Theisen and Gail A. Jensen. 2006. "Why Don't People Buy Long-Term Care Insurance." *Journal of Gerontology: Social Sciences* 61: 185-193.
- Cutler, John, Lisa Shulman and Mark Litow. 2007. "Medi-LTC: A New Medicare Long-Term Care Proposal." Working Paper 1. Washington, DC: Georgetown University.
- Feder, Judith, Harriet L. Komisar and Robert B. Friedland. 2007. "Long-Term Care Financing: Options for the Future." Washington, DC: Georgetown University.
- Finkelstein, Amy. 2007. "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare." *Quarterly Journal of Economics* 122:(1): 1-37.
- Freiman, Marc P. 2007. "Can 1+1=3? A look at Hybrid Insurance Products with Long-Term Care Insurance." Washington, DC: AARP Public Policy Institute.
- Galston, William. 2007. "Reviving The Social Contract: Economic Strategies to Promote Health Insurance & Long-Term Care." Washington, DC: The Brookings Institution.
- Georgetown University Long-Term Care Financing Project. 2007. *Toward a More Efficient and Effective System of Financing Long-Term Care*. Conference papers available at: <http://ltc.georgetown.edu/papers.html>.
- Gibson, Mary Jo and Donald L. Redfoot. 2007. *Comparing Long-Term Care in Germany and the United States: What Can We Learn from Each Other?* Washington, DC: AARP Public Policy Institute.
- Gleckman, Howard. 2007a. "The Role of Private Insurance in Financing Long-Term Care." *Issue in Brief* 7-13. Chestnut Hill, MA: Center for Retirement Research at Boston College.
- Gleckman, Howard. 2007b. "Financing Long-Term Care: Lessons from Abroad." *Issue in Brief* 7-8. Chestnut Hill, MA: Center for Retirement Research at Boston College.
- Gleckman, Howard. 2007c. "Medicaid and Long-Term Care: How Will Rising Costs Affect Services for an Aging Population." *Issue in Brief* 7-4. Chestnut Hill, MA: Center for Retirement Research at Boston College.
- Johnson, Richard, Desmond Toohey, and Joshua Weiner. 2007. *Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions*. Washington, DC: Urban Institute.
- Kemper, Peter, Harriet L. Komisar, and Lisa Alecxih. 2005. "Long-Term Care Over an Uncertain Future." *Inquiry* 42: 335-350.
- Komisar, Harriet L. and Lee Shirley Thompson. 2007. "National Spending for Long-Term Care." *Fact Sheet* (Updated Version — February). Washington, DC: Georgetown University.
- Metlife. 2006. *The Metlife Market Survey of Nursing Home and Home Health Care Costs*. Westport, CT: Metlife Mature Market Institute.
- Office of Senator Edward M. Kennedy. 2007. "Kennedy, Harkin, Dingell, Pallone Introduce Class Act." *Press release with bill summary* (July 10). Washington, DC. Available at: http://kennedy.senate.gov/newsroom/press_release.cfm?id=ff644903-1844-4478-b53a-5cfb712a5850.
- The Moran Company. 2007. *Modeling a New Long-Term Care Financing Plan*. Arlington, VA.
- Warshawsky, Mark. 2007. "The Life Care Annuity" Working Paper 2. Washington, DC: Georgetown University.

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The Center for Retirement Research thanks AARP, AIM Investments, Bank of America, CitiStreet, Deloitte Consulting LLP, ING, John Hancock, MetLife, Nationwide Mutual Insurance Company, Prudential Financial, State Street, TIAA-CREF Institute, and T. Rowe Price for support of this project.

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The research reported herein was supported by the Center's Partnership Program. The findings and conclusions expressed are solely those of the author and do not represent the views or policy of the partners or the Center for Retirement Research at Boston College.